

Barriers and enablers of dementia training in healthcare workers in rural and remote Australia: A scoping review to inform future approaches to training

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Abstract

Introduction: Dementia is now responsible for the greatest burden of disease of any chronic illness in older Australians. Rural and remote communities bear the impacts of this disproportionately. Additional training and education for healthcare staff to support people living with dementia is needed.

Objective: The objective of this scoping review was to map and synthesise the evidence related to barriers and enablers of accessing dementia training for Australian healthcare workers located in rural and remote areas.

Design: This scoping review systematically searched multiple databases in January 2023 for peer-reviewed literature on the topic. Reviewers used Covidence to screen titles and abstracts of located sources, and to screen full-text articles.

Findings: From 187 articles screened, seven peer-reviewed journal articles were included in the final data analysis; all were from Australia or Canada. The most common barrier described was low staffing, precluding release of staff for dementia training. Enablers to participation in dementia training were availability of online training programs, as well as training providers collaborating with end users to ensure the training met their learning needs.

Discussion: This review provides evidence of barriers and enablers specific to rural and remote healthcare workers accessing dementia training. It also explores other approaches to training that have been trialled successfully in different settings.

Conclusion: Addressing the identified barriers and enablers may assist in developing training approaches appropriate for existing staff, and in meeting training needs for the future workforce.

KEYWORDS

barrier, dementia, education, enabler, remote, rural, staff, training

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1 | INTRODUCTION

Data released by the Australian Institute of Health and Welfare (AIHW) in 2023 revealed that dementia is responsible for the greatest burden of disease of any chronic illness in Australians aged over 65 years.¹ Current estimates of numbers of Australians living with dementia are around 400 000, with this expected to rise to 850 000 by 2058.¹ Latest data from the AIHW reveal that \$3 billion was directly attributable to health and aged care services for dementia in 2018–2019.¹ An ageing population with increasing numbers of people living with dementia poses a substantial challenge to the Australian health, welfare and aged care systems. Approximately, a third of Australians live in regional, rural and remote areas, and they face a range of challenges related to accessing health-care in comparison to Australians residing in urban areas. In general, rates of chronic disease and mortality are higher, and access to many health, specialist and support services is reduced.² Two of every five Australians living with dementia live in regional towns and rural and remote areas.³ A number of specific issues predispose rural and remote areas to greater impacts of dementia, namely rapid population ageing associated with outmigration of younger adults, growing preferences for affected adults to remain in familiar homes and communities, higher rates of dementia risk factors, and limited access to diagnostic and treatment services.⁴ In addition, the prevalence of dementia is three to five times higher in Aboriginal and Torres Strait Islander peoples (henceforth, respectfully referred to as ‘Indigenous Australians’) compared to the general Australian population.^{5–9} With 61% of Indigenous Australians living in regional, rural and remote areas, and life expectancy increasing, the burden of dementia among this population will continue to grow.¹⁰ Indigenous Australians already experience disproportionately poorer health outcomes compared to other Australians, and are impacted by enduring effects of colonisation, systemic racism, intergenerational trauma and social disadvantage. The lack of culturally safe dementia services currently available in rural and remote Australia will further compound this disadvantage.¹¹

Ensuring an appropriately educated and skilled workforce to care for people living with dementia is essential, and an international priority.¹² Existing literature (both international and domestic) reveals significant gaps in healthcare professional knowledge and skills regarding caring for people living with dementia.^{13–17} A global survey regarding attitudes to dementia revealed that 62% of healthcare practitioners believe that dementia is a normal part of ageing.¹⁸ Australian research reports that dementia education is lacking in medical school education curricula, and general practitioners (GP) frequently report they

What this paper adds

- Knowledge of the enablers and barriers that health and aged care workers in rural and remote areas face in accessing training regarding dementia care.
- Understanding of these can inform future training solutions to improve dementia care in rural and remote areas.

What is already known on this subject

- There is a shortage of health and aged care providers of dementia care who are appropriately trained to ensure the best standard of care to people living with dementia in Australia.
- These workforce shortages are even more pronounced in rural and remote areas of Australia.
- Improving the provision of care for people with dementia in rural and remote areas will require training which must take into account the context of care provision.

receive insufficient training in dementia diagnosis and care.¹⁹ The Royal Commission into Aged Care Quality and Safety in Australia recently reported four concerns for immediate attention, with dementia care being one of them, concluding ‘the quality of dementia care in the aged care system needs significant and immediate improvement’.²⁰

Rural and remote areas already experience health workforce shortages, and it is likely that in the future, demand for caregivers may exceed the current workforce.²¹ A recent evidence review of workforce education and training standards frameworks for dementia noted that ‘little attention is paid to... the rural and remote workforce. Rural healthcare workers often have different needs to their city counterparts’.²² and there are generally higher costs to attract, retain and accommodate healthcare workers in rural and remote areas. Furthermore, ensuring Indigenous Australians have access to culturally safe support services and care in rural and remote locations is imperative.

Following a review of the National Framework for Action on Dementia 2015–2019, the new National Dementia Action Plan is set to be finalised in 2023. It is expected to detail policies/procedures related to additional staff to be trained in person-centred dementia care. The extent to which the plan specifically addresses the needs of the rural and remote healthcare professional workforce remains to be seen. While general barriers to attracting and retaining a rural and remote workforce are known, there is a specific lack of understanding on the

educational needs, barriers and enablers to accessing dementia training by healthcare workers working located in rural settings.

A preliminary search of MEDLINE, the Cochrane Database of Systematic Reviews and *JBI Evidence Synthesis* did not identify existing or in process reviews on the topic of rural and remote health practitioner training in dementia care. The objective of this scoping review is to assess and describe the existing literature regarding barriers and enablers for rural and remote Australian healthcare workers in accessing dementia training.

2 | METHODS

2.1 | Search strategy

The scoping review was undertaken in accordance with the JBI methodology for scoping reviews.²³ An initial limited search of MEDLINE and CINAHL was undertaken to identify articles on the topic. The text words contained in the titles and abstracts of relevant articles, and the index terms used to describe the articles were used to develop a full search strategy for the following online databases and collections: PubMed, CINAHL, Embase, PsycInfo, ERIC, INFORMIT and Google Scholar. The search strategy, including all identified keywords and index terms (Table 1 shows example for PubMed), was adapted for each database and/or information source. Using the search strategy, all databases and platforms were searched between 10 January 2023 and 11 January 2023. The reference lists for all included sources of evidence were screened for additional studies. Studies published in a language other than English were excluded, in addition to studies published before January 2013.

2.2 | Sources of evidence

This review considered primary research or evaluation, using quantitative, qualitative and mixed methods

approaches. In addition, grey literature such as government reports, policy documents and organisational reports (such as those from large international organisations such as Alzheimer's Disease International) relating to best practice dementia care and rural and remote workforce were explored to enable a comprehensive background on issues related to the topic. Reviews, conference abstracts and text and opinion papers were not considered for inclusion.

2.3 | Source of evidence selection

Following the search, all identified citations were collated and uploaded into EndNote X20 (Clarivate Analytics, PA, USA) and duplicates removed. Following initial testing, titles and abstracts were uploaded into Covidence (Veritas Health Innovation, Melbourne, Australia) and then screened by two independent reviewers for assessment against the inclusion criteria. Those articles selected for full-text review were assessed against the inclusion criteria by two independent reviewers, with reasons for exclusion recorded. Any disagreement that arose between the reviewers at each stage of the selection process were resolved through discussion, or through involving an additional reviewer/s. The results of the search and the study inclusion process are reported in full in this article and presented in a Preferred Reporting Items for Systematic Reviews and Meta-analyses extension for scoping review (PRISMA-ScR) flow diagram²⁴ (Figure 1).

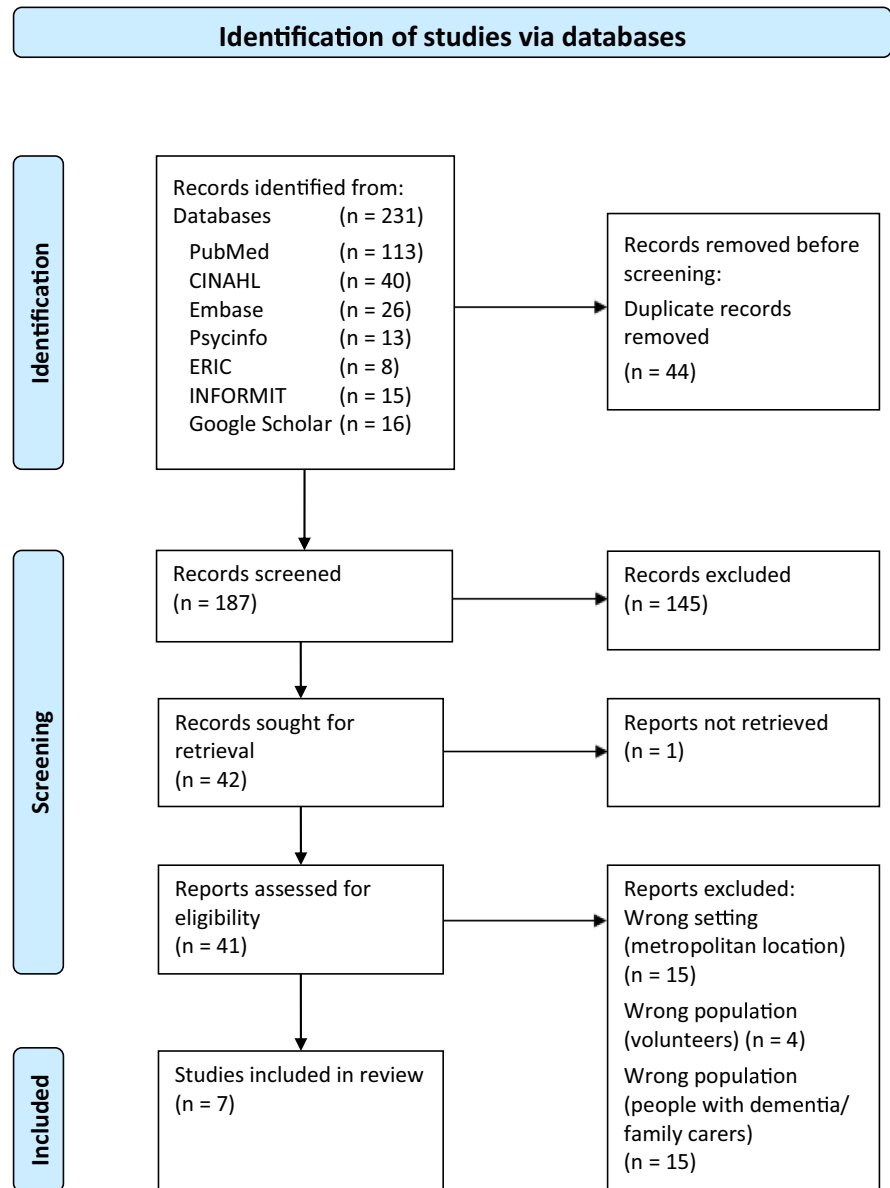
2.4 | Data extraction

For data extraction, a Microsoft Excel spreadsheet was used, as it facilitated comparison. Data regarding study characteristics and location, methodological approaches, data collection and key findings relevant to the review question were extracted by one reviewer and checked for completeness and accuracy by a second reviewer. Any disagreements that arose between the reviewers were

TABLE 1 Example of Search Terms Used (for PubMed).

Index terms	Keywords
1. Dementia	'Dementia'[Mesh] OR dementia[tw] OR Alzheimer*[tw] OR 'Cognitive decline'[tw] OR 'cognitive impairment'[tw]
2. Training	'Inservice Training'[Mesh] OR 'Health Personnel/education'[Mesh] OR 'Education, Professional'[Mesh] OR education[tw] OR training[tw] OR learning[tw]
3. Rural/remote	'Rural Health Services'[Mesh] OR 'Rural Population'[Mesh] OR Rural[tw] OR Remote[tw] OR Regional[tw]
4. Health professionals	'Health Personnel'[Mesh] OR 'aboriginal health worker'[tw] OR 'aboriginal health practitioner'[tw] OR 'personal care worker'[tw] OR 'personal care attendant'[tw]

FIGURE 1 PRISMA flow chart.



resolved through re-reading and discussion, or through discussion with additional reviewer/s.

3 | RESULTS

The search of seven databases yielded 231 records and subsequent assessment of identified articles is shown in [Figure 1](#). After removing duplicates, 187 records remained, with 42 full-text reports sought for retrieval after title and abstract screening. At this stage, one report was identified as a poster presentation and excluded. After the 41 full-text articles were screened by two reviewers, seven articles met the eligibility criteria. Fourteen other sources of evidence were initially identified – eight from citation searching of the eight full-text articles comprising the review, and six from grey literature searching of dementia-related

organisational websites – all were screened, with none meeting the eligibility criteria.

Of the seven studies included, four were from Australia, and three from Canada. The years of publication spanned 2016–2021. The research was performed solely in a rural setting in five of the seven articles, with two studies taking place in both rural and metropolitan settings. A summary of each of the included studies is reported in [Table 2](#).

3.1 | Synthesis of results

For studies focussing on residential aged care, most of the studies were Australian and provided training to all staff in the aged care centre. Only one study focussed on GPs across Australia. The three Canadian studies were all focussed on rural home care providers. There were

TABLE 2 Characteristics of evidence sources.

First author, year and title	Purpose	Methods, participants and setting	Relevant findings
Casey et al. (2020) GP awareness, practice, knowledge and confidence: evaluation of the first nation-wide dementia-focused continuing medical education program in Australia	To evaluate the effectiveness of a nationwide continuing medical education (CME) program for GP's	<i>Methods:</i> Mixed methods – GP participant surveys at one or more time points (pre, post program, 6–9 months post follow-up), program evaluations by GP's, process evaluation by facilitators <i>Participants/sample:</i> <i>n</i> = 3923 GP's participating in education, varied numbers completing post-education surveys <i>Setting:</i> Australia wide – 36% GP's practised in regional and remote areas	<i>Barriers:</i> Large geographical distances, as well as relatively smaller numbers of health professionals in rural areas, was an impediment to face-to-face attendance at workshops. Unreliable access to high-speed internet affected online participation <i>Enablers:</i> Option for online participation, in addition to collaboration with local Primary Health Networks to improve reach into regional, rural and remote areas
Doyle et al. (2016) Videoconferencing and telementoring about dementia care: evaluation of a pilot model for sharing scarce old age psychiatry resources	To evaluate expansion of a pilot project expanding rural and remote access to psychogeriatric services in Australia	<i>Methods:</i> Mixed methods – pre, midpoint and post-implementation semi-structured interviews and surveys <i>Participants/sample:</i> Eighteen dementia service staff <i>Setting:</i> Weekly remote education and case conferences delivered online to rural Victoria and Northern Territory Dementia Behaviour Management Advisory Services (DBMAS) clinics	<i>Barriers:</i> Difficulties with IT, particularly with regards to sound quality and audio feedback <i>Enablers:</i> Online administration reduced need for travel, clinician ability to request certain topics, multidisciplinary approach preferred compared to profession specific education
Hamiduzzaman et al. (2020) Towards personalised care: Factors associated with the quality of life of residents with dementia in Australian rural aged care homes	To identify factors associated with quality of life in residents with dementia in Australian rural aged care homes	<i>Methods:</i> Qualitative – interviews, workshops and focus groups with residential aged care staff <i>Participants/sample:</i> <i>n</i> = 104 clinical managers, nurses and care workers <i>Setting:</i> Five rural aged care homes in Queensland and South Australia – two private, one public, one not-for-profit and one Aboriginal community controlled	<i>Barriers:</i> Lack of staff access to ongoing training and education opportunities 'A lack of education on dementia was evident among the staff that restricted their capacity to provide personalised dementia care to the residents when needed' <i>Enablers:</i> Suggested a full-time trainer role to be implemented in each home who could facilitate training for staff
Williams et al. (2021) Residential aged care staff awareness of and engagement with dementia-specific support services and education	To examine Australian residential aged care staff awareness of and engagement with dementia education and support	<i>Methods:</i> Mixed methods – cross sectional survey <i>Participants/sample:</i> <i>n</i> = 179 patient care assistants, nurses, nurse managers and other staff not defined <i>Setting:</i> Mixed – metropolitan (20%), regional (45%) and rural (28%)	<i>Barriers:</i> Low staffing levels mean staff could not take time away from clinical duties to undertake education <i>Enablers:</i> Online access to education

TABLE 2 (Continued)

First author, year and title	Purpose	Methods, participants and setting	Relevant findings
Bayly et al. (2018) Development and implementation of dementia-related integrated knowledge translation strategies in rural home care	To address rural home care providers unmet dementia-related educational needs by employing a knowledge broker (KB) to facilitate the development and implementation of integrated knowledge strategies within two rural home care centres in Canada	<i>Methods:</i> Qualitative – longitudinal case study – semi-structured interviews with participants at baseline, 6 months, and following termination of KB role <i>Participants/sample:</i> <i>n</i> = 19 home care professionals (nurses, health care aides, case managers) providing support to people with dementia <i>Setting:</i> Two rural Canadian home care centres	<i>Barriers:</i> Staff described limited resources such as a lack of staff and lack of funding, staff time constraints due to high workloads <i>Enablers:</i> Collaborative development of education with end users, alignment between organisational values/culture and developing education with staff members, regular communication between KB, management and staff
Morgan et al. (2016) Dementia-related work activities of home care nurses and aides: Frequency, perceived competence and continuing education priorities	To examine the frequency and perceived competence of home care staff in performing 20 dementia-related work activities, and identify continuing education priorities in a rural region of Canada	<i>Methods:</i> Quantitative survey <i>Participants/sample:</i> <i>n</i> = 82 home care providers (nurses, case managers and nursing aides, social workers) <i>Setting:</i> One regional home care provider in rural Canada	<i>Barriers:</i> Not addressed by research <i>Enablers:</i> Matching educational needs to job role, collaborating with staff to develop education suitable to their needs
Kosteniuk et al. (2016) Focus on dementia care: Continuing education preferences, challenges, and catalysts among rural home care providers	To determine whether the professional role of home care staff in a predominantly rural region of Canada was associated with preferences for delivery formats of dementia-specific continuing education programs, and challenges and catalysts to attending continuing education on any topic	<i>Methods:</i> Quantitative survey <i>Participants/sample:</i> <i>n</i> = 82 home care providers (nurses, case managers and nursing aides, social workers) <i>Setting:</i> One regional home care provider in rural Canada	<i>Barriers:</i> Low-staffing levels, geographic distances too far to travel, insufficient work time, not a formal requirement of employment <i>Enablers:</i> Locally offered programs, paid time off usual duties to allow attendance at training, availability of relief staff and employer encouragement to attend training

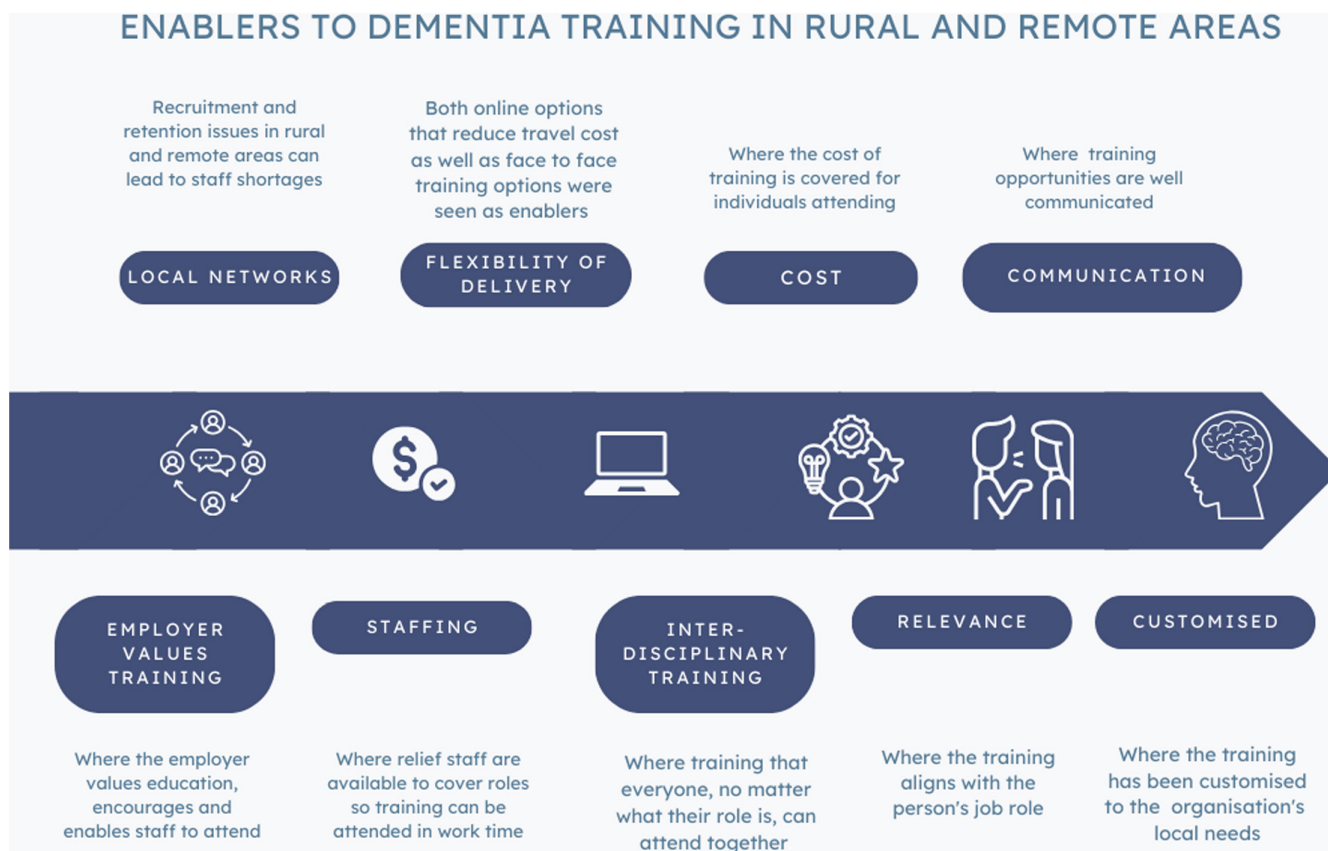


FIGURE 2 Enablers to dementia training in rural and remote areas.

no randomised controlled trials, and the studies used a variety of methods to evaluate the impact of training initiatives; qualitative, quantitative and mixed methods. The number of rural health workers in evaluated training interventions was generally quite small. There were several enablers (Figure 2) and barriers (Figure 3) to access and uptake of training in dementia identified, some specific or exacerbated by their rural location. While online training offered some advantages, challenges with internet access and quality sometimes impeded learning opportunities. A summary in Table 3 shows the barriers and enablers to uptake of training by level of intervention (micro, meso and macro).

4 | DISCUSSION

This review sought to identify barriers and enablers for rural and remote healthcare workers in accessing dementia training in Australia to inform approaches for how future training efforts could better meet their mark. Only seven articles met our study criteria, a surprisingly low number given the increasing prevalence of dementia associated with the changing demography of population ageing in Australia, and the need for trained staff to respond appropriately in caring for people with dementia.

Despite the broad range of research questions covered by the included articles and the range of methods and findings, some common themes emerged. The barriers reported by health professionals in the studies identified were unsurprisingly related to the demands upon the staff with limited time for education and professional development while at work, face-to-face training often not delivered in their location and the time and costs associated with travel to where it might be available considered too great. In many instances, there were difficulties accessing web-based training due to poor or unreliable internet connections. As well, some studies identified that training in dementia was not a mandatory requirement for many of those working in aged care so was not prioritised over mandated training.

Variable access to a high-quality internet connection was reported as a barrier in two studies.^{25,26} Unfortunately, rural and remote Australian areas often have poor internet speeds and unstable internet connections.²⁷ The Australian National Broadband Network (NBN) is a key infrastructure network with the aim of delivering high-speed broadband fibre connection to 93% of the Australian population, with the rest having access to fixed wireless and satellite internet.²⁸ However, the telecommunications infrastructure has failed to provide the promised speed and reliability, and many remote communities have no access

BARRIERS TO DEMENTIA TRAINING IN RURAL AND REMOTE AREAS



FIGURE 3 Barriers to dementia training in rural and remote areas.

to high-bandwidth internet services.²⁹ The World Health Organisation (WHO) advocates for education and training programs to be available for rural and remote health practitioners from their home locations – in order to meet this goal, infrastructure must be improved.³⁰ A recent article asserted that ‘smart infrastructure is positioned as central to the liveability and viability of rural and regional towns in Australia’.³¹

The health workforce in rural and remote Australia is known to be persistently impacted by worker shortages and high turnover, reflecting difficulties with attraction and retention, compared to metropolitan areas. There are more registered clinical health professionals working in Australia’s major cities than in all regional and remote areas of Australia combined.³² The most recent Aged Care Workforce Census in 2020 provides a snapshot of the health workers in aged care. Personal care workers make up the largest proportion of the direct care workforce at 70%. Currently, the minimum qualification for a personal care worker does not require any education regarding dementia.³³ The remainder of the direct care workforce is nurses (23%), and allied health professionals (7%).³³ The census differentiates between the residential aged care workforce and the workforce providing home

care support. Dementia care training was offered (but not mandatory) to direct care staff in 82% of residential aged care facilities, and to 55% of home care staff.³³ Multiple surveys of the aged care workforce have revealed that aged care staff want ongoing, comprehensive dementia training.^{17,34}

Rural and remote health services have proportionately smaller workforces than their metropolitan counterparts, and three of seven studies noted that these services cannot absorb staff absences to attend education/training, as care provision will be directly affected.^{3,35,36} Learning about dementia may not be prioritised over other mandatory trainings. In addition to this, providing education and training with smaller numbers of staff is less cost-effective for training providers. These factors ultimately feed into the larger issue of a lack of opportunities for training and education. While healthcare staff can request and advocate for more training and education, it is ultimately the responsibility of the service provider to facilitate this for their staff.

The Royal Commission into Aged Care Quality and Safety in Australia concluded in 2021, and its final report recommended fundamental reform of the aged care system. In particular, with regards to the aged care

TABLE 3 Summary of identified barriers and enablers by system level for intervention.

Barriers	Enablers
Micro level factors (individual level, intra and interpersonal factors)	
Individual training factors	
<ul style="list-style-type: none"> High workload 	<ul style="list-style-type: none"> Collaborative development and delivery of training Customised learning through matching educational needs to job role Face-to-face training and opportunity to network Multidisciplinary approach to training facilitated interprofessional learning and support
Meso level factors (local community, organisations, groups of people)	
Organisational factors	
<ul style="list-style-type: none"> Low-staffing levels precluding existing staff from engaging with training Small workforce in rural and remote areas means face-to-face training is not cost effective 	<ul style="list-style-type: none"> Employer encouragement to complete training Availability of relief staff Paid time off work to attend training Aligning organisational culture/values to staff training Regular communication between management and staff regarding training
Access to training	
<ul style="list-style-type: none"> Limited training opportunities, funding or resources devoted to staff training Access to training impacted by geographic distances -too far for staff or training providers to travel 	<ul style="list-style-type: none"> Access to knowledgeable/ high quality facilitators Access to local training programs Staff trainer role in every aged care facility Multidisciplinary approach to training
Online training and supervision	
	<ul style="list-style-type: none"> Online training platform highly valued as it mitigates challenges to travelling (geographical distance, time and expense related to travel) Learn at own pace
Local health networks	
	<ul style="list-style-type: none"> Collaboration with local Primary Health Networks to promote and run training programs
Knowledge translation	
<ul style="list-style-type: none"> Inadequate time for learning from training to be implemented into practice 	<ul style="list-style-type: none"> Collaborative development of education/training with end users
Training to support First Nation's people with dementia	
<ul style="list-style-type: none"> Significant gap in the literature regarding training in best practice in care for First Nations Australians living with dementia 	<ul style="list-style-type: none"> Implementation of emerging evidence from research with First Nations into resources for training
Macro level factors (Healthcare systems, economy, laws and legislation, policy, political sub-systems)	
Health workforce	
<ul style="list-style-type: none"> Health worker shortages and high turnover 	<ul style="list-style-type: none"> Ongoing investment in rural workforce training and incentives for rural and remote practice

TABLE 3 (Continued)

Barriers	Enablers
Regulation of training standards	
<ul style="list-style-type: none"> Participation in dementia training is not a formal requirement. 	<ul style="list-style-type: none"> Participation in quality training in dementia a requirement for health and aged workers working in settings with many patients with dementia
Infrastructure	
<ul style="list-style-type: none"> Limited access to high-speed, high-quality internet connection 	<ul style="list-style-type: none"> Investment to improve the national rural and remote broadband and telecommunications infrastructure

workforce, recommendations were made in regard to ensuring the aged care workforce becomes regulated, with mandatory minimum education standards, and ongoing training requirements.²⁰ Another recommendation stated that all healthcare workers in aged care services should undertake regular training and education about dementia.²⁰ This review identified that a barrier to undertaking dementia training was the lack of it being a specific, formal requirement of employment; therefore, until it is mandated that all direct care staff undertake dementia training, care of people living with dementia is likely to suffer. The Australian National Dementia Action Plan consultation paper describes seven objectives in support of providing people living with dementia with the best quality of life possible. Objective Six is 'Building dementia capacity in the workforce' but little mention is made of the rural and remote environment.³⁷

One article emphasised the importance and effectiveness of involving the local primary health network in advertising and running the training event.¹⁹ Collaboration with local networks could help ameliorate barriers such as low staff numbers at individual facilities; by utilising regional health networks, a larger overall number of staff from different towns within the region may be able to attend an educational or training opportunity, and increased participant numbers would make the training a more attractive prospect to training providers. In addition, local health networks have valuable knowledge about issues pertinent to local areas and services, and existing relationships with service providers that may be leveraged to ensure the training reaches as many staff as possible.

Three studies reported that the ability to use an online platform rather than physically travel to the training, was highly valued by staff.^{28,35,36} Online administration removes the barriers of geographical distance and the time and expense related to travel. The format of the training varies but it may enable learners to access the training at a time that is convenient to them, to move through modules at their own pace, and potentially to concentrate on specific areas that are particularly relevant to their roles. Both international and Australian research recognise that

online modes of training and education are generally valued by healthcare staff, and sometimes even preferred over travelling to attend sessions face-to-face.^{5,15,16,25,38–40} That said, the ability to offer some face-to-face sessions is also highly valued, particularly for rural and remote workers, as it provides a vital networking opportunity.²⁸ Some customisability of topics covered during training was also valued.²⁸ While the evidence has revealed that training and education should be relevant to staff and their specific role, a multidisciplinary approach was also seen as an enabler in one study, as it promoted interprofessional learning and discussions.¹¹

Hamiduzzaman and colleagues advocated for the creation of a full-time staff trainer role in every aged care facility, in order to facilitate training for staff.³ While such a goal might be out of reach, the idea has merit, with a full-time trainer role in each region more feasible. If established, they could coordinate training for staff and cover a wider geographical area. Additional international research found that a key facilitator of staff implementing dementia training into practice was support from within their organisation, including supportive leadership, regular mentorship and peer support networks – all which could be provided by a regional trainer.⁴⁰ Bayly and colleagues detailed a number of employer-related factors that can act as enablers for staff to prioritise dementia training – regular communication from facility/program managers encouraging and promoting staff training events, as well as demonstrating the linkage of organisational values with ensuring staff are appropriately trained to deliver the best possible care.⁴¹ One article noted that staff felt enabled to attend dementia training when they were aware that relief staff were available to cover their time away from directly caring for patients.²⁵ The same article reported that ensuring staff were paid for the time they spent undergoing training was an enabler of them taking up training opportunities.²⁵

Given the higher proportion of Indigenous Australians in rural and remote locations and their higher rates of dementia,¹⁰ and despite the inclusion of training information from Australia, there is a gap in the literature

regarding training in best practice in care for Indigenous Australians living with dementia. Indigenous Australians face additional challenges in accessing dementia care, such as the stigma associated with dementia, fear of leaving Country, lack of culturally secure services and other complex competing issues.⁴²

Experts in the dementia education and training field have formulated key features of dementia training that are likely to be effective, related to content, duration, delivery and context.¹¹ These findings were also identified in a systematic review examining effective dementia education and training for the health and social care workforce, in addition to general facilitators and barriers for staff to translate learning into practice.⁴⁰ While the systematic review was not specific to the rural workforce, their findings align with aspects of the current review findings. A key facilitator for translating training into practice was interactive, face-to-face training that was relevant to participants' role and needs.⁴⁰ The most frequently reported barriers to training related to a lack of resources including time, financial issues and staff issues.⁴⁰

The research carried out by Bayly et al. examined the use of a knowledge broker in a rural aged care facility to facilitate knowledge translation strategies, and found that this approach was beneficial for both healthcare workers and people living with dementia.⁴¹ Broadly speaking, a knowledge broker acts as an intermediary and facilitates the transfer and exchange of expert knowledge from where it exists to where it is needed. In Bayly et al.'s research, knowledge brokers were used to help translate research evidence into policy and practice, facilitate knowledge and training, and enhance teamwork and relationships within aged care facilities. A key enabler of this method that was particularly valued by participants was collaborative development of education/training with end users – a finding also replicated in another recent Canadian study.^{38,41}

Another study identified by the review is worthy of note. Doyle and colleagues described a metropolitan old age psychiatry consultation service and tested a model for medical supervision and clinical governance for staff within regional and remote areas using videoconferencing.²⁸ Participants were dementia service staff who participated in a case conferencing process. The evaluation described many benefits including enhanced professional development resulting from specialist input into patient management, confirming existing practice and identifying new strategies, input into education topics without the time needed to travel, improved collaboration and feeling part of a team. However, not all aged care environments were supportive, with the barriers including difficulties with information technology, cultural differences relevant to the location and the timing and frequency

of sessions. Nevertheless, using specialist input to support education around dementia management of specific cases for which rural staff are involved seems a promising strategy.

A recent review of the use of telehealth in education and training for rural and remote health practitioners found that while the applications for telehealth are still evolving, overall, the benefits of telehealth education far outweigh the negatives.³⁰ Calleja and colleagues noted that there is robust evidence for using telehealth to provide patient education and follow-up appointments, but currently little evidence to guide the use of telehealth for education of rural healthcare workers.³⁰ Interestingly, they also noted that there appear to be no definitions or agreed consensus as to what constitutes quality when using telehealth to deliver education.³⁰

5 | CONCLUSION

Upskilling of the existing rural and remote health workforce in dementia care is urgently needed. Overall, this scoping review contributes to understanding of the barriers and enablers that rural and remote health workers face in accessing dementia training. Relevant literature based on our search criteria was only identified from Canada and Australia and this review identified barriers to accessing training that are similar in both countries. Addressing these barriers and understanding enablers of take up of training is needed to enable the upskilling of the rural and remote health workforce in dementia care through training of existing staff and the future workforce.

AUTHOR CONTRIBUTIONS

Sandra Thompson: Writing – review and editing; supervision; conceptualization; validation; investigation. **Heidi Shukralla:** Investigation; writing – original draft; writing – review and editing; project administration; formal analysis; data curation; validation. **Katrina Fyfe:** Funding acquisition; conceptualization; writing – review and editing. **Ellie Newman:** Conceptualization; funding acquisition; writing – review and editing. **Kathryn Fitzgerald:** Writing – review and editing; investigation; validation; visualization.

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CONFLICT OF INTEREST STATEMENT

The authors report no conflicts of interest related to this review.


ETHICS STATEMENT

This research of published peer-reviewed research did not require Ethics review.

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