

La connaissance des troubles de démence dans le cadre de la pratique infirmière en région nordique

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Cette étude a pour objectif de cerner les concepts clés en matière de soins aux personnes souffrant de démence, selon le point de vue des infirmières autorisées œuvrant dans le Nord canadien. Des entrevues ont été réalisées auprès d'IA en poste dans de petites communautés nordiques isolées, portant sur leurs expériences de dépistage de la démence, la prestation de soins liée à cette maladie et leurs perceptions concernant les ressources disponibles. La méthode de théorisation ancrée utilisée dans l'analyse des données d'entrevues a mené à l'élaboration d'une théorie portant sur la connaissance des troubles de démence dans le cadre de la pratique infirmière en région nordique. Les auteures de l'étude ont cerné trois points qui influencent les connaissances des IA œuvrant en région nordique relativement à la démence : *les soins aux personnes atteintes de démence et la prestation de soins communautaires*; *les caractéristiques de l'IA œuvrant en région nordique*; et *la vie professionnelle des infirmières en milieu nordique*. Les résultats indiquent un besoin de mettre en place des programmes et des politiques de santé qui sensibilisent le personnel infirmier nordique aux troubles de démence, une mesure qui permettrait d'améliorer les soins prodigués aux populations nordiques.

Mots clés : démence, théorie

Dementia Awareness in Northern Nursing Practice

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The purpose of this study was to identify key concepts in dementia care from the perspective of registered nurses working in the Canadian north. Interviews were conducted with RNs employed in small, remote northern communities about their experiences with dementia assessment and caregiving and their perceptions about dementia care resources. The grounded theory method used in analyzing the interview data led to the development of a theory about dementia awareness in northern nursing practice. The study identified 3 categories of conditions that influence northern RNs' awareness of dementia: *dementia care and community caregiving*, *characteristics of the northern RN*, and *northern nursing worklife*. The findings suggest the need for educational programs and health-care policies that increase awareness of dementia in northern nursing practice and thereby improve the care provided to northern people.

Keywords: Aboriginal health, dementia, primary health care, rural and remote health care, theory, underserved populations

Northern nursing is commonly associated with expanded “generalist” practice roles and functions. Little is known about dementia assessment and caregiving as perceived by northern registered nurses (RNs) in Canada. Most of the literature on dementia caregiving is presented from the perspective of southern rural and urban practice settings (Morgan, Semchuk, Stewart, & D’Arcy, 2002). Although some studies have explored caregivers’ perceptions of support services for dementia care in northern locations (Loos & Bowd, 1997) and the prevalence of dementia in two northern Manitoba communities (Hendrie et al., 1993), population demographics have changed since these studies were carried out.

The present study aimed to add to the knowledge base on northern nursing by exploring a clinical area of practice, dementia assessment and caregiving, from the perspective of RNs working in northern health-care facilities. The intent was to provide insight into the exposure of northern RNs to dementia assessment and caregiving and the views of these nurses on the key issues associated with care of older adults with dementia. The intended outcome was the development of a theory on how northern RNs might develop an awareness of dementia in their practice.

Background

Dementia epidemiology, assessment, and caregiving in northern Canada is a largely unstudied area. The dearth of information on dementia assessment and caregiving in northern regions is a concern because global estimates of the prevalence of dementia diagnoses are pointing to a 100% increase between 2001 and 2040 (Ferri et al., 2005). Estimates by the Canadian Study of Health and Aging indicate that Canada will have 778,000 people with dementia by 2031 (Canadian Study of Health and Aging Working Group, 2000). A limitation of the Canadian Study of Health and Aging was exclusion of rural areas, First Nations reserves, and the northern territories: Yukon, Northwest Territories, and Nunavut. As a large portion of the northern population is Aboriginal, and the Aboriginal elderly population is projected to double by 2017 (Statistics Canada, 2005), knowledge about assessment and caregiving in northern locations is sorely needed.

Challenges in Diagnosing Dementia

Sternberg, Wolfson, and Baumgarten (2000) performed a secondary analysis of the data from the Canadian Study of Health and Aging and report that cognition was not a standard part of the assessment of older adults. Other authors have suggested that a lack of knowledge about dementia and the lack of local resources to support older adults with dementia have served to minimize the recognition of cognitive decline (Iliffe et al., 2005). A study of community nurses' perceptions about the identification of cognitive impairment in older adults (Manthorpe, Iliffe, & Eden, 2003) found that nurses specializing in community mental health were more apt to assess cognition in older adults than nurses with a focus on public health or nurses in other specialties practising in community settings.

A recent Canadian study by Pimlott et al. (2009) on the assessment of dementia by physicians in family practice found that the complex nature of dementia caused uncertainty in diagnosis; other challenges were pressures that put limits on the amount of time spent with a client, the need to be familiar with the client, and the importance of family involvement. Pimlott et al. propose the development of primary care teams, referral systems, and ongoing education as ways to support family practitioners in assessing and diagnosing dementia.

Because health services are population-based, small rural and northern communities have relatively few health-care resources (Romanow, 2002). In many small rural and northern communities, nurses function as the only health-care providers, responsible for delivering acute, chronic, and public health services — sometimes simultaneously. The challenge

for dementia assessment and care in these settings is the immediacy of acute health issues and relegation of non-life-threatening concerns to secondary status (Roberts & Gerber, 2003; Vukic & Keddy, 2002). In a comparison of nursing procedures in southern rural and northern remote communities (Krieg, Martz, & McCallum, 2007), the role of the northern RN was found to entail more expanded-practice skills (e.g., ability to perform minor surgical procedures) and limited continuity of care due to high turnover of health-care personnel.

Dementia Care

Care for older adults with dementia is commonly provided by family, close social contacts, and health professionals in the community. In a study on access to health services by older women in a northern Saskatchewan community, 28.5% of community members over the age of 15 reported having assisted in the care of an older adult (Krieg et al., 2007). In rural and remote communities, most caregivers are reported to be women (Parrack & Joseph, 2007) and many caregivers experience detrimental health effects associated with caregiving (Bedard, Koivuranata, & Stuckey, 2004).

One of the priorities of the National Aboriginal Health Organization has been to explore the health issues of older adults (National Aboriginal Health Organization, First Nations Centre, 2006). In the Organization's report on First Nations older adults, 48.8% of those over the age of 55 reported having a disability and 85.2% reported having one or more chronic conditions. Policy initiatives have included the expansion of home care services in the north due to the desire of northerners to be cared for in their communities by their families (van Liempt, 2006).

The Study

This study used a sequential exploratory (QUAL → quan) mixed-method approach (Morse, 2003) to explore RNs' perceptions of dementia care in remote northern communities in Saskatchewan (Andrews, 2008). The qualitative method of grounded theory (Glaser & Strauss, 1967) was chosen as the lead methodology for this exploratory study because so little is known about dementia care in the Canadian north and about the practice of northern RNs who work with cognitively impaired older adults. The use of a sequential design allowed for the concepts from the grounded theory to inform the selection of variables in the quantitative secondary analysis of survey data (Stewart et al., 2005) from a national study, *The Nature of Nursing Practice in Rural and Remote Canada* (MacLeod, Kulig, Stewart, Pitblado, & Knock, 2004). The qualitative study focused specifically on RNs working in one of

three northern Saskatchewan health regions (north of the 55th parallel), while the quantitative analyses were complementary and provided a national context and north-south comparisons for selected variables related to the theory. This article reports the findings from the qualitative grounded theory analysis (Andrews, 2008). The primary research question for the study was *What do RNs in northern Saskatchewan perceive as key issues and concerns with respect to the care of older adults with dementia?* Related questions concerned northern RNs' degree of exposure to older adults with dementia, caregiving for dementia in the north, and adequacy of services for dementia assessment, diagnosis, and care.

Method

Grounded theory provides a systematic and rigorous method for developing theory using qualitative data (Glaser & Strauss, 1967). Because the theory is generated inductively from the data, it is termed "grounded," or found in a particular set of data. The constructivist perspective on grounded theory (Charmaz, 2006) guided this research. Charmaz contends that the researcher is a co-participant in constructing the theory, as opposed to "discovering" it. The theory is developed through interactions with participants and is influenced by the perspectives and experiences of the researcher. In this study, the first author's experience as a northern RN was recognized and accepted as affecting and contributing to the study outcomes. The focus was on developing a substantive theory: a parsimonious understanding of the situation surrounding dementia care in a northern Canadian province through the identification of a core concept that accounted for a large portion of the variation in the data.

The grounded theory method is especially useful for making suggestions and hypotheses about common or everyday problems (Glaser & Strauss, 1967). The theory must be meaningful for and relevant to the research area; theories about northern nursing practice and dementia care may not entirely fit dementia care in urban nursing practice settings. A theory must be able to explain what has happened, predict what will happen, and interpret what is happening in the substantive area of inquiry (i.e., the process by which RNs in northern Saskatchewan develop an awareness of dementia). Finally, grounded theories are conceptual and become broader than the data, a characteristic that renders them modifiable and applicable to other social problems.

Recruitment

Theoretical sampling is a method of data collection used in grounded theory whereby sampling is aimed at seeking and collecting pertinent data to develop and refine categories in the emerging theory (Charmaz, 2006). Theoretical sampling was carried out on two levels: the commu-

nity, and the individual RN. Participants were recruited initially from four northern communities that had long-term-care facilities or home care services. It was theorized that RNs who were working in these communities would have more opportunity for interaction with older adults with dementia than RNs working in communities without these services. Theoretical sampling at the level of the participant included RNs from many areas of practice, to explore whether perspectives on dementia are influenced by type of nursing position. Finally, data were collected in a community without long-term-care or formal home care services provided by an RN, to determine whether dementia concerns are more prominent in communities that have long-term-care or formal home care services.

Seven health-care administrative bodies, from the three northern Saskatchewan health regions, were contacted and subsequently administrators consented to having their RNs approached to participate. Posters were sent to the administrators for display in the facilities, along with brochures to be distributed to the RNs. On-site visits were organized to facilitate data collection, and these proved to be more effective than the posters and brochures in recruiting RNs. Recruitment challenges included the small number of RNs in the target communities, low staffing levels during the on-site visits, and vacation leaves during the summer months.

Participants

The final sample of northern RNs for this qualitative study comprised 14 RNs who were employed in six health-care facilities in the northern half of Saskatchewan at the time of the study. The facilities were located in communities varying in size from approximately 300 to 3,000 people. One of the communities was accessible only by air; the others were accessible by road.

Only one of the participants interviewed was male. Participants ranged in age from 28 to 60 years ($M = 49.2$ years; $median = 54$ years). Three were of Aboriginal, Métis, or Inuit ancestry. Eight held a nursing degree and six held a nursing diploma. Two of the participants were registered nurse practitioners (RN-NPs). All of the participants held full-time permanent positions: two worked in administration and three in community/public health, two were NPs, one was an acute-care staff nurse, two were community health nurses (staff nurse in a nursing station/health centre), two held the position of nurse-in-charge of a nursing station/health centre, one was a home care RN, and one was a program coordinator. Nine of the nurses had 6 or more years of northern nursing experience.

The study was approved by the University of Saskatchewan Advisory Committee on Ethics in Behavioural Science Research. Nurses who volunteered to participate signed a consent form that outlined the purpose of the study, the time commitment, ethical considerations, and proposed use of the findings.

Data Collection and Analysis

The aim of data collection was to capture a wide range of experiences from which to explore perceptions of dementia and dementia caregiving. Data collection took place over the course of 1 year during the period 2006–07. Of the 14 interviews, 12 were audiorecorded and transcribed; two participants did not agree to be recorded but allowed note-taking. Two of the recorded interviews were conducted via telehealth video link, one was conducted face-to-face in an urban community, and 11 entailed travel to the northern community. The interviews were guided by a list of open-ended questions. Field notes were used to describe the interview setting as well as the interaction between participant and researcher.

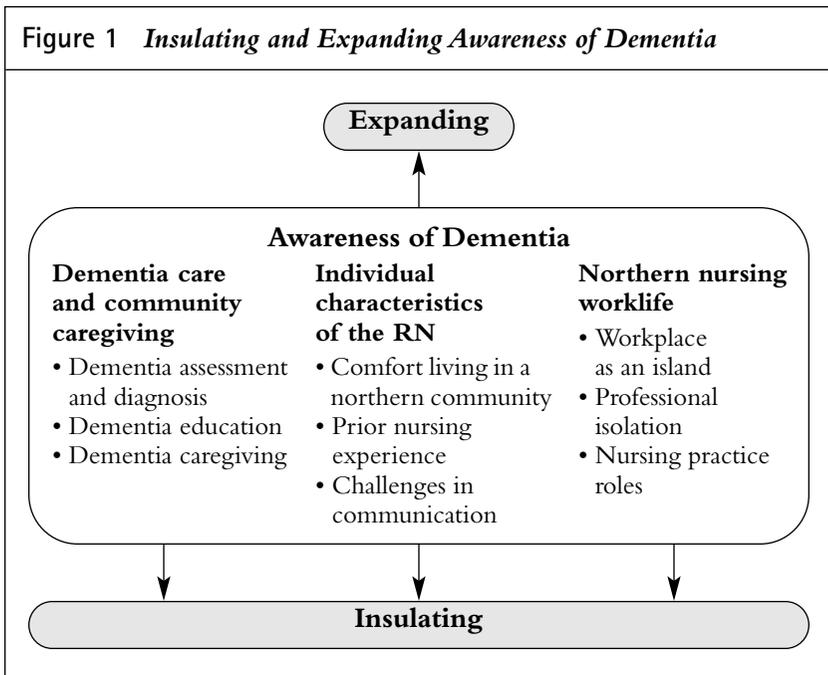
Interview transcripts and field notes were used as the data set for the analysis. The goal of data analysis was to maximize the variation in conceptual elements that emerged from the data (Charmaz, 2006). Constant comparative analysis, whereby all new data are compared to data already collected, was used to identify patterns (Glaser & Strauss, 1967). Data analysis began with initial coding (coding all instances until a pattern of differences and similarities appears), focused coding (to develop categories), and theoretical sampling (to fill gaps in categories and patterns in the data) (Charmaz, 2006). Memos were used to describe and document the ongoing analysis and theorizing about categories. Data collection and analysis were continued throughout the project until patterns reappeared in the coding, indicating that theoretical saturation (maximization) of the concepts had been reached. Strategies used to ensure credibility and rigour included an audit trail of interview data, field notes, and analytical memos; verbatim transcripts of interviews; first and second author review of all transcripts; and analytical discussions with members of the research team. NVivo software was used to facilitate data management.

Findings

The context of this study, or the main concern that centred the analysis (Glaser & Strauss, 1967), was that dementia assessment and caregiving were not perceived as prominent issues in the practice of northern RNs. Reasons for this perspective included the small number of older adults seen in the practice settings and communities of northern RNs and a perception that northern RNs' knowledge about dementia was limited

and outdated. On reflection, participants characterized older adults as an “overshadowed” or “forgotten” population in northern health services, which are more focused on meeting the acute and preventative health-care needs of the large younger demographic.

The grounded theory analysis resulted in the theory “insulating and expanding the awareness of dementia in northern nursing,” which explains the conditions under which northern RNs do or do not develop an awareness of dementia in their practice community (Figure 1) (Andrews, 2008). These conditions were conceptualized as insulating (decreasing the RN’s ability to form an awareness of dementia) or expanding (increasing the RN’s ability to form an awareness of dementia), clustered into three categories: *dementia care and community caregiving*, *individual characteristics of the RN*, and *northern nursing worklife*. The identified conditions tended to be more in the direction of insulating awareness than expanding awareness of dementia. The word “insulating” is used as a metaphor. Insulation is a barrier that prevents the transfer of heat or energy to the outside of a building. In this context, insulating was used to conceptualize the conditions (e.g., the demands of acute and emergency care, inability to speak the local language) that collectively became a barrier to the development of an awareness of dementia as a health concern for older adults in northern communities.



Dementia Care and Community Caregiving

Awareness of dementia was influenced by personal and professional exposure to older adults with dementia. This awareness included perceptions of dementia assessment and diagnosis, education about dementia, and caregiving in the community. None of the participants reported caring for an older adult with dementia in their role as a northern RN.

Dementia assessment and diagnosis. Participants believed that responsibility for diagnosing dementia was within a physician's role and not the role of an RN. Family members were most often cited as the source of information about behavioural concerns, because most of the older adults did not speak English and were not often seen in clinics. The participants had conflicting perceptions about whether family members would voice their concerns or conceal troubling behaviours out of respect for the older adult.

Participants noted that recognition of dementia may have been hampered by physicians and nurses viewing memory loss as normal in older adults and by the dearth of provincial resources for geriatric referrals. Few of the RNs were aware of or used geriatric resources. Resources for assessment in the community included psychologists, but participants reported that psychologists were "overloaded" with acute issues. When questioned about diagnosis and assessment, one RN stated, "I'm trying to think how many patients in the north that I actually knew had dementia, never mind having it documented. . . . I don't think I ever saw any documented." Another participant, who spoke Cree, explained that language and cultural differences only added to the assessment challenges: "There's no such word that I know of that refers to dementia."

Dementia education. All of the participants expressed a need for professional, caregiver, and community education on dementia. They identified challenges to the dissemination of information on dementia, such as the regional distribution of specialized services in the north versus the training of community members to function in an outreach capacity. Additionally, in communities with long-term-care facilities, participants reported difficulty obtaining expert assistance with the management of behavioural symptoms and the lack of secure units when needed. RNs reported that their successful efforts at managing behavioural issues created the impression that additional resources were not required. Further, the participants stated that available continuing education programs were not presented from a northern perspective: "They always try to lump northern and rural together . . . but what goes on in [a southern town] is pretty different from what goes on in [a northern community] . . . having more northern content would be beneficial."

Participants also expressed the view that education and training in assessment skills ought to be extended to Licensed Practice Nurses

(LPNs) and Community Health Representatives (CHRs) employed by northern health-care agencies, since LPNs and CHRs have more contact with older adults in the community than RNs. When discussing LPNs and CHRs, the participants said, “[they are] community people,” “they know the community,” “they’re in the homes,” and “they see it first.” One RN said, “The nurses traditionally are stuck in the station [nursing station or health centre].” Another added, “To my knowledge, there have been no educational opportunities for families to learn how to deal with people at home, but often, because of the number of beds and things, that is how people are dealing with it.”

Dementia caregiving. Participants saw the challenges in providing care for older adults as related to the remoteness of northern communities, limited caregiving resources, limited financial resources, and the respect for older adults that is inherent in northern cultural values. They described the dependence on family members to serve as caregivers for older adults as similar to situations they had encountered in the south. The support system for older adults was viewed as larger in northern communities. However, there were concerns that the increasing mobility of the younger generation would serve to reduce the number of family members available to provide care in the future.

The participants explained that when institutional care was required, even if the community had a long-term-care facility the limited number of beds available often meant that older adults had to leave the community for care. They expressed the view that when such facilities were not available in the community, nurses’ knowledge about older adults in the community was limited by the relocation of individuals to facilities outside the community. The high turnover of nurses in the north also served to reduce RNs’ familiarity with older members of the community and thus their ability to detect changes in cognitive and physical functioning. In communities with long-term-care facilities, LPNs commonly provided direct care, further distancing RNs from knowledge about dementia and dementia care.

Individual Characteristics of the RN

Personal and professional characteristics of the participants influenced their awareness of dementia. These individual characteristics were as follows: comfort living in a northern community, prior nursing experience, and challenges in communication.

Comfort living in a northern community. Community integration and social isolation were found to influence the nurses’ awareness of dementia. Community integration can be described as the nurses’ level of comfort with their social interactions in the community. Nurses who had grown up in a small community were more comfortable working in a

small community and interacting with older adults. Professional status and the lack of anonymity created a sense of separateness from the community, as the RNs felt that community members identified them as “the nurse” in all social situations. This separateness inhibited the nurses’ ability to develop relationships within the community and hence their knowledge of the community and its older members. Other factors that contributed to the participants’ sense of social isolation were lack of experience living in a northern community in a non-professional role and not having family members residing in the community.

Prior nursing experience. Participants described nursing experience in acute care as a requirement for northern nursing practice. The chances of being recruited for a northern nursing position with only long-term-care experience were described as “pretty slim.” This focus on experience in acute or emergency care when hiring northern nurses contributed to a lack of comfort and skills needed when working with older populations, including those with dementia. The development of home care positions in the north was seen as expanding the knowledge base on dementia and promoting the integration of RNs into the community. Home care was viewed as increasing the potential for the monitoring of cognitive function and behavioural changes in older adults. However, the benefits of home care services were tempered by the belief that “not everybody is totally receptive to home care.” One of the participants used the following rationale to describe the need for expanded resources and services for older adults:

The lifestyle in the north is changing and people are living longer, and so we’ll see the trend change in the north as it has in the south. We’ll actually see more people living longer but more of the same health issues that we’ve had in the past, because as they grow older we’re going to get a lot more heart failure, we’re going to get a lot more cases of hypertension, and we’re certainly seeing an increase in diabetes. It continues to evolve as they grow older. So I think we’ll actually see more dementia in the north.

Challenges in communication. The inability of most of the participants to speak the community language had the largest influence on insulating the nurses’ awareness of dementia. The participants explained that “a nurse with the language is going to be able to take care of that person 100% better than I am.” They stated that the language barrier affected their ability to assess cognitive function because it limited their social interaction with older adults. Nurses who had considerable experience interacting with patients through interpreters had developed a level of comfort with this type of communication and reported less difficulty due to language differences.

Northern Nursing Worklife

The work setting was described as having a significant influence on the RNs' awareness of dementia. Conditions related to nursing worklife included the perception of the workplace as an island, perspectives on professional isolation, and characteristics of nursing practice roles. The overall view was that health services offered in small northern communities do not address the needs of older adults.

Workplace as an island. Nursing work settings were conceptualized as islands within the community. Participants believed that their perspective of the community was a function of "what's coming through the door." They saw their work as demanding and driven by the "trauma and drama" of acute care. However, one RN admitted that the phrase "we're too busy" was often used to avoid developing health promotion programs. Further, although the "trauma and drama" were perceived as demanding, this work also appeared to provide a great deal of job satisfaction. One nurse described the best parts of her job as "watching them [clients] get well" and the "autonomy."

Since the participants perceived that very few older adults were attending the clinics, and community services specific to older adults were scarce, the nurses placed a low priority on improving their skills related to dementia care. All of the communities offered a chronic disease management clinic (e.g., diabetes, hypertension, cardiovascular disease) that monitored individuals with chronic disease across all age groups. Participants believed that these programs let medically stable or well older adults with cognitive deficits "slip through the cracks" and that available programs did not have a focus on mental health, including cognitive assessment.

Perspectives on professional isolation. Isolation from other health professionals influenced the participants' awareness of dementia. The demands of northern nursing practice limited their ability to attend educational events and to collaborate with other health professionals. For example, one participant said that telehealth was a useful tool for continuing education but that most sessions had to be videotaped as few RNs were able to attend the live presentations.

Although professional isolation was a concern for them, the participants did identify avenues for expanding their knowledge and decreasing their isolation. One of their suggestions was to expand the use of communication technologies. A few of the participants found these technologies very useful in their practice:

It's still remote, because we're still a distance away, and we still have to wait for a plane to come in to get emergency health care, so that makes us remote. But in terms of being isolated, we're not. You and I are sitting here,

you in _____ and I'm living in _____ [yet] we're looking at each other right now and talking to each other, so we're not isolated. Our technology is the same in the north as it is in the south. We use satellite phones, we use two-way radios around the town, but . . . we don't have cell service, so in that way we're a little bit isolated, but we have cable . . . Our physicians are only a phone call away as well, and we do have telehealth with our physicians if we need to, and digital cameras. We can actually take a really good picture and send it off, and have somebody down south tell us exactly what they think . . . with the technology we're not really isolated.

However, resistance to learning about new communication methods and integrating technology into practice routines were perceived as barriers to expanding the use of technology in the north.

Characteristics of nursing practice roles. Nursing practice roles in the north were seen as unstructured in that nurses need to be available to attend to a variety of issues. At the same time, however, nursing roles were seen as structured, with a set of mandated functions or tasks that each nursing position is responsible for fulfilling or carrying out. Participants noted that one of the challenges in developing a program to increase awareness of dementia would be nurses' opposition to restructuring their roles, as restructuring roles might result in increased workloads without additional personnel or formal training. They felt that there might be interest in developing general services for older adults but that interest in dementia-specific information would be minimal unless there were a number of residents affected by dementia: "They [the community] have to buy into it or it won't work."

A few of the RNs had broadened their practice and created new programs. One participant had developed a seniors' foot-care program. This program became a gathering place for older adults that included food and entertainment while also providing the nurses with a means to monitor the health status of the community's older population.

Discussion

The findings of this study offer a perspective from which to view the development of dementia awareness in northern nursing practice. In keeping with the fundamentals of grounded theory (Charmaz, 2006), the purpose was to provide an understanding of the present situation, make predictions about the future, and explore the consequences of dementia as a concern in northern health care.

The participants were older, in terms of average age (49.2 years), than rural and small-town nurses in Canada generally, as reported in a national database (42.9 years) (Canadian Institute of Health Information, 2002). Other differences between this sample and the characteristics reported in

the national database include the proportion reporting a university degree as their highest level of education (8 of the 14 in the present study, vs. 18% nationally). However, the length of time the RNs had been practising in northern communities and their experience and knowledge in varied nursing practice settings contribute to the strength of the findings.

The study identified conditions that had the effect of *insulating* or *expanding* northern nurses' awareness of dementia. These terms were chosen as metaphors because they appear to fit and have relevance for northern nursing. The central theme of the study was that a number of conditions influence the ability of RNs working in remote northern settings to recognize, assess, and care for older adults with dementia. More insulating conditions were found than expanding ones. Insulating conditions that are similar to those reported by other studies are as follows: the language barrier and the need for interpreters, which were seen as reducing nurses' ability to assess cognition (Cattarinich, Gibson, & Cave, 2001); lack of familiarity with the client and the client's family (Pimlott et al., 2009); lack of availability and acceptance of home care (Forbes et al., 2008); and limited community education and resources for older adults (Iliffe et al., 2005). A condition that expanded awareness of dementia — also reported in the literature — was the development of assessment and caregiving resources in the community.

A condition not addressed in this study is the perception of aging and cognitive loss from the perspective of community members. An understanding of the cultural meanings associated with dementia and aging in the north would be useful for the development of culturally appropriate dementia-assessment protocols and caregiving supports. Family and community education about dementia might serve to highlight memory concerns and could lead to earlier identification and treatment of cognitive problems.

The literature documents concern about a projected increase in the number of older adults diagnosed with dementia in the coming years (Canadian Study of Health and Aging Working Group, 2000). Similarly, some of the participants in the present study were concerned about the potential for dementia to become more prevalent in northern communities. The high hospitalization rates reported for northern areas (Irvine & Stockdale, 2004) and the increasing prevalence of diabetes and chronic diseases warrant the availability and accessibility of a wider scope of health services. In a retrospective study, Whitmer, Sidney, Selby, Claiborne Johnston, and Yaffe (2005) found that the presence of risk factors for cardiovascular disease (e.g., diabetes) at midlife had a 20% to 40% increased associated risk for the development of vascular dementia with advancing age.

Improving links to urban health care and specialized services has the potential to reduce the professional isolation experienced by northern RNs. The challenge, in terms of insulating or expanding awareness of dementia, is that nurses were not aware of the existence of services in urban settings. The development of clinical pathways to disseminate knowledge about dementia services to northern RNs would benefit both the nurses themselves and the recipients of care in northern communities. Increasing access to communication technologies and helping northern RNs to integrate the use of these technologies into their practice could facilitate access to services for dementia assessment, diagnosis, and management.

Social isolation has long been a characteristic of northern nursing practice (Vukic & Keddy, 2002). Although nurses who relocate to a northern community have made a personal choice to do so, it appears that the social isolation reported by RNs in this study was conferred by their professional status, which served to limit their participation in the community and affected their self-perception as community members. Physical isolation within the clinic, as a function of the acute-care focus of most nursing positions, also had the result of limiting their awareness of dementia.

It is important that the development of educational resources to improve dementia awareness among northern RNs be carried out from the standpoint of their work in the north. The needs and health issues addressed by health services in the north are perceived as different from those addressed in southern rural communities. The development of education programs with content specific to northern health-care settings, and delivered in the north, may result in increased access to and interest in continuing education that is focused on dementia.

The findings of this study suggest that older adults with dementia in northern Canada could be considered vulnerable given their location in isolated communities and the limited resources available locally to diagnose, treat, and support family caregivers. Historically, northern health care has focused on acute-care needs, which were the impetus for the development of northern outpost nursing stations (Waldram, Herring, & Young, 2006). The perception persists that a handful of RNs can address acute health-care concerns in addition to the ever-widening range of services needed by a community. The practice of hiring RNs based on their skills in acute and emergency care serves to isolate the nurses within acute-care settings and to hinder the development of their clinical knowledge with regard to dementia, dementia caregiving, and dementia resources.

Limitations

The goal of theory development is to describe patterns and relationships in the data and to conceptualize the conditions under which these patterns and relationships develop. A caution in theory development is to view the resulting theory as representing only one understanding of a situation. Therefore, the present findings may not be transferable to nurses practising in other remote northern communities. Research into nursing care in remote northern locations in Canada can be challenging with respect to sample size, given the small number of RNs working in northern communities, the time demands on the clinical work of RNs, and the difficulties inherent in the retention of RNs.

Conclusion

This exploration of dementia care in northern nursing practice and in northern communities has identified the complexity entailed in developing an awareness of dementia. Suggestions for northern policy development with respect to dementia assessment and care include the provision of resources to address the health concerns of older adults living in the north and the inclusion of northern health-care concerns in continuing education programs for RNs practising in the north. Future studies on dementia care in the north might focus on developing an understanding of dementia from the perspective of northern residents and the challenges encountered in assessing older adults from the perspective of translators.

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Acknowledgements

We would like to thank all the nurses who participated in this project, as well as the following agencies, which provided formal and in-kind funding: Canadian Institute for Health Research (doctoral scholarship associated with Strategies to Improve the Care of Persons With Dementia in Rural and Remote Areas, a New Emerging Team); Northern Scientific Training Program, Saskatchewan Northern Medical Services; and Telehealth Saskatchewan. We also thank Dr. M. L. P. MacLeod, who was the principal investigator for the overall project, The Nature of Nursing Practice in Rural and Remote Canada, for which the national survey was one of four methods. We appreciate the work of all the investigators, decision-makers, professional associations, and funders (Canadian Health Services Research Foundation and partners) for this project.

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