

策の策定を行うという CQI アプローチの理念は、医師や医療機関における個別的な対応を単位基盤として、より広範な地域や国家レベルでの総合的かつ持続的な取り組みがあつてこそ、その社会における医療の「質」の向上に資するのではないだろうか。

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## Effect of long-term care insurance on communication/recording tasks for in-home nursing care services

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### Abstract

The purpose of this research was to clarify the possible changes brought about by the introduction of the long-term care insurance system in terms of number of communication/recording tasks, related nursing services in use, and when and where these tasks were performed. By examining the detailed content of communication/recording tasks, this study also sought to explore the advantages of introducing information technology (IT) systems in nursing service settings. The study was designed before-and-after study in two sessions, February 2000 and August 2000, namely before and after the introduction of Japan's long-term care insurance system. Participants were clients using the institution's in-home nursing services and all staff in a medical institution located in the Mikawa region of Aichi Prefecture, Japan. Following measurements were performed: (1) nursing service in use, (2) type of job, (3) date and time, (4) from whom, (5) to whom, (6) communication tool and (7) content, related to a particular communication. Communication/recording tasks were frequently performed around the starting and closing time of services. Following the adoption of the new system, these tasks tended to occur mostly around the starting time of services. As for the staff, the involvement of the professional carers increased. Regarding content of communication/recording, reports, confirmation and instruction increased. In conclusion, the use of IT driven devices is recommended

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to streamline the performance of communication/recording tasks as well as to ease the rush of these tasks thereby improving the quality of nursing services.

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## 1. Introduction

The aging of society is a phenomenon affecting many developed countries today (Itouji, 1996; Adachi, 1998; Hattori et al., 2000; David et al., 2001; Esping-Andersen, 2001; Robert, 2002), and the need to establish nursing care systems that adequately meet the increasing related demands is thus evermore pressing (Adachi, 1998; Hilary, 2001).

In April 2000, Japan introduced a social insurance system for elderly care based on the principle of Socialization of Elderly Care (Masuda et al., 2001; Matsuda, 2002), whereby the burden of the care for the elderly is shared by society as well as the family (Hattori et al., 2000; Hilary, 2001). Prior to the introduction of the system, some had predicted a shortage in nursing service provision (Ueda et al., 1994; Hashimoto, 1996; Itouji, 1996). A quantitative increase in nursing service demand was reported after the adoption of the system (Miyatake, 2001), and the shortage of services seems to have intensified.

Moreover, under this insurance system, the professional carers are faced with the additional task of administrating the service provision. In order to provide a greater range of services, more precise planning is needed, and care plans must be carefully implemented and evaluated. Additional exchanges of information or communication/recording tasks among the professional carer are also required. Such tasks include face-to-face conversations, record entries, telephone calls, facsimiles, voicemail, and others. With the increasing demand for nursing services covered by the insurance, the associated communication/recording tasks may lower the quality of nursing services.

With the rapid advance of information technology (IT) in recent years, the trend can be found in medical sectors as in many other industries toward improving operational efficiency of services with the help of IT driven management systems (Laerum et al., 2001; Stamouli and Mantas, 2001). These systems allow for efficient processing of electronic medical charts, order entry, administration of materials and laboratory results, etc. In nursing settings also, carers can resort to IT systems to reduce their communication/recording workload, thereby spending more time and energy providing nursing services.

The purpose of this research is to clarify the possible changes induced by the introduction of Japan's new insurance system in terms of number of communication/recording tasks, related nursing services in use, and when and where these tasks occurred. Furthermore, during the periods of time when significant increases in the number of communication/recording tasks were observed, the detailed content of communication/recording was examined to explore the possibility of introducing IT systems to improve the efficiency of the nursing service settings.

## 2. Methods

### 2.1. Subject and sessions of research

The subject of this research is a medical institution located in the Mikawa region of Aichi Prefecture, Japan. The institution consists of a clinic with a rehabilitation facility (Clinic), a geriatric intermediate care facility (GICF) (providing a certain amount of medical care), an In-home nursing support center, a helper's station, and a visiting care station, providing nursing services such as visiting medical care, visiting rehabilitation, rehabilitation for outpatients, visiting nutrition guidance, and short-stay services.

The research was conducted in two sessions in February 2000 and August 2000, namely before and after the nationwide introduction of the elderly care insurance system. At each session, all the communication/recording tasks that occurred in relation to nursing service provisions during a continuous 48 h were recorded.

Given the fact that no significant variation in terms of number of users on workdays was shown in a preliminary research, Tuesdays and Wednesdays were selected for both the February and August sessions.

### 2.2. Content of research

A fill-out-type questionnaire was designed and used for the research (see Fig. 1). The items to fill out were: (1) nursing service in use, (2) type of job, (3) date and time, (4) from whom/what, (5) to whom/what, (6) communication tools and (7) content. The entry was performed by the staff carrying out each particular communication task. A preliminary meeting was held for orientation and instruction as well as to identify any problems with the procedure. The management of the forms was conducted by off-duty staff trained in advance. They were stationed at each facility and their duty was to check and collect the forms as appropriate.

#### 2.2.1. Category of nursing services in use

Utilized in-home nursing services in relation to specific communication tasks were categorized as follows: daycare service at clinic, daycare service at GICF, short-stay service at GICF, in-home helper service, visiting nursing, visiting nutrition guidance, visiting rehabilitation, visiting medication, and others.

#### 2.2.2. Job type

The job types of the staff involved in communication tasks were categorized as follows: physician, nurse, pharmacist, radiological technologist, physical therapist (PT), occupational therapist (OT), trainer, professional carer, consultant, secretary, nutritionist, cook, driver, and others.

#### 2.2.3. Date and time

The specific dates and times when communication tasks occurred were recorded.

#### 2.2.4. From whom/what and to whom/what

When a communication event occurred, the names of the persons involved were recorded in the columns 'From' and/or 'To whom'. When information was referenced and/or recorded

Nursing service in use	Daycare at Clinic	Daycare at Center	Short-stay at Center	Helper	Visiting care	Visiting nutrition guidance	Visiting rehabilitation
User's name	Mr./Ms.			Home visit	( )	Others	
Entered by:				Medical Doctor	Nurse	Pharmacist	Radiological Technologist
Type of Job	PT	OT	Trainer	Nursing staff	Consultant	Office worker	
	Nutritionist	Cook	Driver	Others			
Date/hour of occurrence	Date: day, dd/mm/yy am./pm.		Hour: hh/mm				
From whom	Family	User	Staff	Others ( )			
From what	Form/Notes/Voicemail/Others						
To whom	Family	User	Staff	Others ( )			
To what	Form/Notes/Voicemail/Others						
Communication tool	Message	Face-to-face conversation	Voicemail	Notes	Wiseman barcode		Wiseman keyboard
	Extension	Outside line	Facsimile	Entry in charts	Others		
Brief content	Instruction (prescription)		Info	Report	Consultation	Record	Confirmation

Fig. 1. Questionnaire on communication tasks.

in some medium such as recording forms, the type of medium was entered in the column 'To what' and/or 'From what'. Entries in the 'From/To whom' column indicate the involvement of some person categorized as family, user, staff or others. Entries in the 'From/To what' column indicate the involvement of some recording medium categorized as forms, notes, voicemail or others. Forms are any recording medium of paper such as medical records. Notes represent Notes<sup>®</sup>, a groupware of Lotus. Groupware is any type of software designed for groups and for communication, combining various software for supporting collaboration among a group of people with functions such as email, document management and schedule management.

#### 2.2.5. *Communication tools/media*

The communication tools/media used in communication/recording tasks were categorized as follows: message, face-to-face conversation, voicemail, Notes, Wiseman Barcode, Wiseman Keyboard, extension call, outside line call, facsimile, medical record entries, references to other forms, and others.

Wiseman Barcode<sup>®</sup> and Wiseman Keyboard<sup>®</sup> represent the utilization of the nursing information management system of Wiseman<sup>®</sup>, making use of barcodes and keyboards, respectively, for data entry. Wiseman Barcode<sup>®</sup> barcodes date, treatment, person-in-charge of treatment, and vital signs, and then reads them via a reader device. Wiseman Keyboard<sup>®</sup> utilizes a keyboard for data input.

#### 2.2.6. *Content*

The content of communication/recording was categorized as follows: instruction (prescription), information, report, consultation, record, confirmation and others. Information means an unofficial communication which does not require reporting or recording.

### 2.3. *Analysis*

The changes between the two sessions of research were analyzed in terms of number of users, number of occurrences of communication/recording tasks, and category of service in use in relation to communication/recording tasks that occurred. To eliminate the influence on the number of communication/recording tasks induced by the change in total number of users, the data of the same users (153) was analyzed in both sessions.

Further, for these 153 users, a detailed analysis was conducted for a period of time where a significant change in the number of occurrences of tasks was found.

Data analysis was performed by Statview 5.0. For testing statically significant differences, the chi-square test was utilized with  $P < 0.05$  as criteria.

## 3. Results

### 3.1. *Total number of users and number of occurrences of communication/recording tasks*

Table 1 shows the total number of users and the number of occurrences of communication/recording tasks. The total number of users was 400 in February and 442 in the August

Table 1  
Number of occurrences of communication/recording tasks

	February	August	<i>P</i>
Overall			
Total number of users	400	442	
Occurrences of tasks	2811	4235	<0.001
153 subjects			
Total number of users	232	249	
Occurrences of tasks	1883	2244	0.300

Note: A chi square test was conducted between February and August sessions on the total number of users divided by the number of occurrences of the task.

session and the number of occurrences of communication tasks was 2811 and 4235, respectively. The increase in the number of occurrences of communication tasks was statistically greater than the increase in the number of total users ( $P < 0.001$ ).

In the analysis of the 153 users whose data was obtained in both sessions, no statistical difference was found in the total number of utilized services, nor in the increase in the number of occurrences of tasks in comparison with the increase in the number of times at which they utilized these services.

### 3.2. Category of services

Table 2 shows the type of utilized in-home nursing service in relation to a particular communication/recording task. In both sessions, more than 80% of all utilized services belonged to one of the three most popular categories, i.e., daycare at clinic, daycare at GICF and short-stay at GICF. In August, both daycare at clinic and daycare at GICF were more often used ( $P = 0.002$ ,  $<0.001$ ) while short-stay at center was less often used ( $P < 0.001$ ) than in February (Table 3).

Table 2  
Number of occurrences of in-home nursing service by category

Service category	February ( <i>N</i> = 1883)	August ( <i>N</i> = 2244)	<i>P</i>
Daycare at clinic	340	493	0.002
Daycare at GICF	781	1071	<0.001
Short-stay at GICF	558	390	<0.001
In-home helper	102	107	0.381
Visiting care	86	95	0.656
Visiting rehabilitation	8	11	0.938
Home visit	2	2	0.999
Others	2	7	0.282
Unknown	4	68	<0.001

Note: A chi square test was conducted between February and August sessions. GICF: geriatric intermediate care facility.

Table 3  
Number of occurrences of in-home nursing service by place

Place	February ( $N = 1883$ )	August ( $N = 2244$ )	$P$
Clinic	302	464	<0.001
GICF	1263	1434	0.036
At home	143	67	<0.001
Others	172	192	0.550
Unknown	3	87	<0.001

Note: A chi square test was conducted between February and August sessions. GICF: geriatric intermediate care facility.

### 3.3. Time of occurrence

Fig. 2 indicates the time of occurrence of communication/recording tasks. Peaks were found in the 8:00–12:00 and 14:00–18:00 periods. Also, the number of occurrences was on the rise between February and August in the 8:00–9:00 and 10:00–11:00 periods.

### 3.4. Detailed analysis of 8:00–9:00 and 10:00–11:00 time periods

Regarding the communication/recording tasks that occurred in the 8:00–9:00 and 10:00–11:00 time periods, when an increase in tasks was observed, was further analysis was

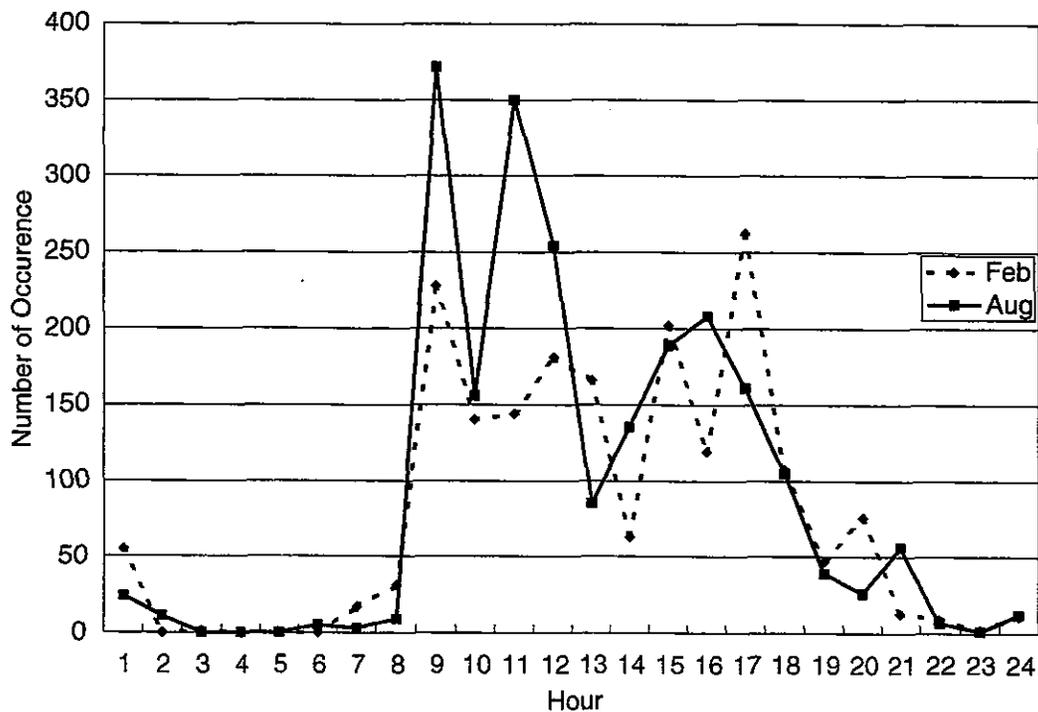


Fig. 2. Time of occurrence of communication/recording tasks. The number of occurrences was on the rise between February and August in the 8:00–9:00 and 10:00–11:00 time periods.

Table 4  
Number of occurrences of communication/recording tasks by involved staff's job type

Job type	8:00–9:00		<i>P</i>	10:00–11:00		<i>P</i>
	February ( <i>N</i> = 228)	August ( <i>N</i> = 372)		February ( <i>N</i> = 144)	August ( <i>N</i> = 350)	
Physician	3	0	–	0	5	–
Nurse	75	68	<0.001	42	40	<0.001
Pharmacist	0	0	–	0	4	–
Radiological technologist	1	0	–	2	0	–
PT	3	4	0.999	2	5	0.999
OT	0	0	–	0	7	–
Trainer	0	0	–	0	0	–
Professional carer	99	266	<0.001	49	187	<0.001
Consultant	11	7	0.071	20	20	0.004
Secretary	12	12	0.307	9	54	0.009
Nutritionist	0	7	–	14	1	<0.001
Cook	0	0	–	0	1	–
Driver	5	2	0.150	4	18	0.359
Others	19	0	–	2	1	0.425
Unknown	0	6	–	0	7	–

Note: A chi square test was conducted between February and August sessions. (–) Indicates that the test could not be conducted. PT: physical therapist; OT: occupational therapist.

conducted to determine the possible changes in job types of the staff involved, communication routes, tools or media in use and contents of communication/recording.

Table 4 shows the job types of staff involved in communication/recording tasks that occurred in the 8:00–9:00 and 10:00–11:00 periods. From 8:00 to 9:00, more professional carers were involved in communication/recording tasks in August (71.5%) than in February (43.4%) ( $P < 0.001$ ). A significant decrease in the number of nurses involved in communication/recording tasks was also observed between August and February ( $P < 0.001$ ).

From 10:00 to 11:00, more professional carers carried out some kind of communication/recording task in August (53.4%) than in February (34.0%) ( $P < 0.001$ ), while significantly less nurses and consultants were involved in communication/recording tasks ( $P = 0.004$ ,  $<0.001$ ).

Table 5 shows the communication routes in relation to the tasks that occurred at various time periods. In the 8:00–9:00 period, more staff-staff communication took place in August (54.3%) than in February (37.7%) ( $P < 0.001$ ), while less staff's recording to forms was observed in August ( $P < 0.001$ ). However, in the 10:00–11:00 period, the rate of staff-staff communication decreased in August ( $P = 0.002$ ).

Table 6 shows the means by which communication was conducted at various time periods. In the 8:00–9:00 period, face-to-face conversations were most frequently seen in both sessions (79.8% in February, 71.2% in August). However, despite the increase in the number of occurrences of direct conversation, the rate of overall communication decreased ( $P = 0.025$ ). Also, in the 10:00–11:00 period, a decreased rate of direct conversation was found ( $P < 0.001$ ), and voicemail was more frequently used ( $P = 0.019$ ). In this period, a prominent increase in the number of staff using forms was observed, jumping from 0 to 74 times.

Table 5

Number of occurrences of communication/recording tasks during the periods of 8:00–9:00 and 10:00–11:00 by communication route

Communication route	8:00–9:00		P	10:00–11:00		P
	February (N = 228)	August (N = 372)		February (N = 144)	August (N = 350)	
Staff ⇒ staff	86	202	<0.001	55	83	0.002
Staff ⇒ records	85	21	<0.001	45	134	0.169
Staff ⇒ others ('What')	19	28	0.841	8	16	0.817
Staff ⇒ user(s)	6	1	0.026	1	7	0.514
Records ⇒ staff	2	9	0.292	0	3	–
User(s) ⇒ staff	2	3	0.999	1	5	0.823
Family ⇒ staff	1	8	0.184	1	4	0.999
Records ⇒ records	1	1	0.999	1	8	0.406
Staff ⇒ family	1	0	–	0	3	–
Staff and/or records ⇒ staff	0	41	–	0	3	–
Staff and/or others ('What') ⇒ staff and/or others ('What')	0	19	–	0	1	–
Staff and/or records ⇒ staff and/or records	0	0	–	0	24	–
Others	22	36	0.999	30	54	0.186
Unknown	3	3	0.853	2	5	0.999

Note: A chi square test was conducted between February and August sessions. (–) Indicates that the test could not be conducted. 'What' refers to medium.

Table 6

Number of occurrences of communication/recording tasks during the periods of 8:00–9:00 and 10:00–11:00 by communication tool

Communication tool	8:00–9:00		P	10:00–11:00		P
	February (N = 228)	August (N = 372)		February (N = 144)	August (N = 350)	
Messages	3	3	0.853	3	14	0.429
Direct conversation	182	265	0.025	65	87	<0.001
Voicemails	1	1	0.999	2	25	0.019
Notes	0	0	–	0	0	–
Wiseman Barcode	6	0	–	18	10	<0.001
Wiseman Keyboard	6	3	0.150	4	24	0.117
Extension calls	3	1	0.311	9	0	–
Outside calls	7	10	0.984	1	16	0.061
Facsimiles	0	4	–	0	2	–
Record entries	7	0	–	15	0	–
Reference to forms	9	6	0.131	0	74	–
Others	4	44	<0.001	27	60	0.767
Unknown	0	35	–	0	38	–

Note: A chi square test was conducted between February and August sessions. (–) Indicates that the test could not be conducted.

Table 7

Number of occurrences of communication/recording tasks during the periods of 8:00–9:00 and 10:00–11:00 by content

Communication Tool	8:00–9:00		<i>P</i>	10:00–11:00		<i>P</i>
	February ( <i>N</i> = 228)	August ( <i>N</i> = 372)		February ( <i>N</i> = 144)	August ( <i>N</i> = 350)	
Instruction	0	1	–	1	17	0.048
Information	180	148	<0.001	58	42	<0.001
Reporting	6	30	0.011	17	17	0.010
Consultation	3	3	0.853	5	5	0.265
Recording	20	13	0.010	51	131	0.750
Confirmation	19	106	<0.001	11	25	0.998
Others	0	33	–	1	9	0.320
Unknown	0	38	–	0	104	–

Note: A chi square test was conducted between February and August sessions. (–) Indicates that the test could not be conducted.

Table 7 shows the breakdown of contents of communication that occurred in the various periods. In the 8:00–9:00 period, information decreased from 78.9 to 39.8% ( $P < 0.001$ ), but more reporting and confirmation were observed ( $P = 0.011$ ,  $<0.001$ ). In the 10:00–11:00 period, information decreased again from 40.3 to 12.0% ( $P < 0.001$ ) while instruction increased ( $P = 0.048$ ). With respect to reporting, the rate in all communication tasks decreased significantly ( $P = 0.010$ ).

#### 4. Discussions

##### 4.1. Background of the increase in total number of users and communication/recording tasks

This research reveals an increase in total number of users after the introduction of Japan's elderly care insurance system. Even before the implementation of the system, a quantitative increase both in number of users and provision of services (Wada, 1996) had been predicted. In fact, traditionally, the administration (Hattori et al., 2000) determined the nursing services to be provided to users (Hashimoto, 1996; Wada, 1996), but under the new system, users are able to chose the nursing services they wish to receive. The findings of this research seem to support this prediction.

On the other hand, although the overall rate of increase in the number of occurrences of communication/recording tasks was greater than that of users, the analysis of the 153 users who had already used some nursing services before the new system was launched did not reveal any significant increase in the number of occurrences of communication/recording tasks for such users. This suggests that the increase in communication/recording tasks for new users after the adoption of the system was reflected on the overall increase in the number of occurrences of communication tasks. In addition, the possible lack in necessary medical and/or nursing-related information on these new users may have lead to greater information exchange among staff.

Meanwhile, the 153 former users may have benefited from the fact that such information had already been gathered in the institution as they had started using services before the system was launched. However, no trend toward a decrease in the number of communication/recording tasks was observed among these users. The introduction of the elderly care insurance system has undoubtedly brought about some increase in communication tasks. For example, the system requests preciseness in procedure such as the preparation of care plans and the management of nursing service provision, both of which necessarily involve more frequent information exchanges. Also, following the adoption of the system, changes in the type and frequency of services made by users may trigger an increase in communication/recording tasks. According to a report, daycare service provisions increased and short-stay service decreased after the system was introduced in Japan (Miyatake, 2001), and this could also be the case in the subject institution. Changes in users' choices from short-stay service to daycare may prompt an increase of communication/recording tasks because the latter is provided per day and requires more information exchange among staff in comparison with the former. The types and frequency of services in use were not studied in this research. However, an increase in daycare and a decrease in short-stay were observed in the category of utilized services in this research, in agreement with the above-mentioned report.

#### *4.2. Time of occurrence of communication/recording tasks*

Firstly, communication tasks were observed more often in the 8:00–11:00 and 14:00–17:00 time periods. The subject institution is open from 9:00 to 16:30, and at 8:30–9:00 and 16:00–16:30, short staff meetings are held for the purpose of exchanging information on short-stay users. The peaks of occurrence of communication/recording tasks in the morning and the afternoon fall respectively around the opening and closing times of this institution, presumably because of these correspond to those times when greater information exchange occurs and patient updates are provided.

Secondly, there are various possible factors behind the steep increase in the number of communication/recording tasks in the 8:00–9:00 and 10:00–11:00 time periods. As mentioned above, these periods fall around the opening time of the institution. In fact, it is inferable that the 8:00–9:00 period corresponds to the time when patient updates and information exchanges take place before opening.

Regarding job types of staff, a more prominent increase in the number of professional carers was noticed as compared to other staff. This suggests that the introduction of the new insurance system may have increased the number of communication/recording tasks performed by the professional carers during specific periods of time. Meanwhile, some reports have indicated that a greater number of inpatient falls occurred during those periods of time when the nurses were busy performing a communication or recording task (Taira et al., 1999; Kanemura et al., 2000). In facilities where nursing care services are also provided, the rush of communication tasks may deteriorate the quality of nursing services and increase the risk of accidents on the part of users. It thus appears necessary to take some measures to prevent such concentration of communication tasks. However, this study is limited in the sense that it does not shed adequate light on the burden put on the professional carers for the following reasons: (1) the study focused on the number of communication

tasks, not the needed time for a task to be performed, (2) the study did not take into account the number of such tasks performed by each professional carer, and (3) the number of professional carers rose from 72 to 78 between the two sessions of this research.

Regarding communication route, significantly more staff-staff communication and less staff-form recording were observed in the 8:00–9:00 period. In terms of tools, including form of communication, a prominent increase in face-to-face conversation was recorded. This suggests that information exchange in the form of direct conversation among the staff increased. In the 10:00–11:00 period, however, the rate of staff-staff communication decreased. The use of voicemail, keyboard and reference to records seemed to decrease the rate of direct conversation and staff-staff communication. In terms of tools, a significant increase was seen in the use of voicemail and keyboard as well as reference to records, and the rate of direct conversation in all communication/recording declined. The promotion of the use of such tools in the 8:00–9:00 period also can be expected to curb the rate of increase of communication/recording tasks.

With respect to contents, the following were observed: a decrease of information and an increase of report and confirmation in the 8:00–9:00 period, as well as a decrease of information and an increase of instruction in the 10:00–11:00 period. The possible reasons for the decrease of information in both periods are: (1) the call for a more precise implementation of care plans following the introduction of the system, (2) the increased number of reports and confirmation in place of information, and (3) the diminished necessity for simultaneous communication such as short staff meetings to share information thanks to IT driven devices. Meanwhile, the increase of report, confirmation and instruction around the opening time is presumably due to the preciseness requested by the new insurance system both in the contents of tasks and the time to provide services.

#### 4.3. Possibility of applying information technology

The outcome of this research highlights the necessity for greater operating efficiency of communication/recording tasks. IT driven devices such as groupware are effective as they facilitate sharing, storage, retrieval and reutilization of information (Shintani, 2000; Nishimura, 2001; Rowe and Brimacombe, 2003). In this research, an increase of report, confirmation and instruction was observed in terms of content of communication. The use of IT driven devices on users and individual progress reports may help reduce the need for report and confirmation (Rowe and Brimacombe, 2003). Also, instruction can be more efficiently conducted when past instructions have been easily stored and can be retrieved and reutilized as needed.

Moreover, when IT driven devices are used, the staff can work more freely with less restrictions of time or space (Nishigaki, 1994; Nishimura, 2001). IT devices also contribute to alleviate the rush of communication/recording tasks, as previously suggested in this research.

Other benefits of IT systems can also be expected for users as the time normally devoted to communication tasks may be spent on the nursing service itself.

Although the use of IT is undoubtedly beneficial, as demonstrated above, we should nevertheless solve some of the most pressing disincentives which include cost, safety, staff

education, and delayed development of user-friendly peripheral tools, in order to efficiently apply IT driven devices.

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## 6) 「高齢者の終末期の医療およびケア」に関する 日本老年医学会の「立場表明」

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Key words：高齢者，終末期医療，立場表明，倫理委員会，日本老年医学会

(日老医誌 2004；41：45-47)

### はじめに

日本老年医学会では平成10年9月より倫理委員会が発足し，老年医療分野における終末期医療に関する倫理的諸問題について議論が始まった。第一回の倫理委員会で浮き彫りになった問題点は，①高齢者への差別，いわゆるエイジズム，②高齢患者の自己決定，③家族・介護者の意向，④技術的な問題，⑤終末期医療および看護教育，⑥医療経済，⑦医療過誤などの法律問題，であった。倫理委員会では，以上の諸問題に対して日本老年医学会の「立場表明」を作成する方向で討議を進めた。その目的は，「すべての人が有する最善の医療を受ける権利を擁護・推進する」ことにある。

### 「立場表明」発表までの経緯

平成13年6月の日本老年医学会学術集会で「高齢者の終末期の医療およびケア」に関する日本老年医学科会の「立場表明」が表明されたが，この間，倫理委員会は5回開催されている。また，最初の倫理委員会案の作成から「立場表明」公表までに以下のプロセスを経た。

- ①平成11年9月の「老年医学」市民公開講演会における意見聴取
- ②平成12年6月の日本老年医学会学術集会で討議
- ③以上の議論を踏まえ，修正を加えた「立場表明案」に対する，日本老年医学会の学術評議員全員へのアンケート調査
- ④アンケート結果を踏まえて倫理委員会での最終案作成

### 「高齢者の終末期の医療およびケア」に関する日本老年医学会の「立場表明」

#### 1. 基本的立場

「人の老化と死に向かい合う老人医療は，生命科学で得られた成果を基盤にした生命倫理を重視した全人医療であるべきである。」

立場—1—：高齢であることや自立能力が低下しているなどの理由により，適切な医療およびケアが受けられない差別に反対する。

(論拠) 適切な医療およびケアを受ける権利は侵すことのできない基本的人権である

立場—2—：高齢者の終末期の医療およびケアは，患者個々の価値観や思想・信仰を十分に尊重して行われなければならない。

(論拠) 病名や病態に関する情報開示が高齢者である，あるいは患者個々の価値観や思想・信仰の故に，不十分であってはならない。考えられる予後や「終末期の医療やケア」に伴って起こりうる病状経過についての話し合いと合意が必要である。話し合いでは患者が希望することを尊重すべきである。

立場—3—：終末期医療では，患者の生活の質(QOL)の維持・向上に最大限の配慮がなされるべきである。

(論拠) 患者のQOLを維持，向上するための医療やケアが終末期の医療およびケアの主体となるべきである。終末期の医療およびケアとは，「痛みやその他の身体的症状を和らげるのみならず，患者の心理的・精神的な要求を真摯に受けとめ，援助し，患者のQOLを向上させる医療およびケア」であると考えられる。

立場—4—：終末期の医療およびケアには，患者本人だけでなく家族などのケアも含まれる。

(論拠) 終末期の医療およびケアにおいて，患者の家族は重要な役割を担う。患者の病状を家族に説明するとともに，そのことにより生じた家族の悲しみを和らげる

The terminal care of the elderly: A position statement of the Japan geriatric society

Kazumasa Uemura: 名古屋大学大学院医学研究科病態内科学

表1 倫理委員会委員

委員長	井口 昭久	名古屋大学老年科教授
委員		
飯島 節	筑波大学心身障害学系教授	
井藤 英喜	東京都多摩老人医療センター院長	
遠藤 英俊	国立療養所中部病院内科医長	
加藤 正弘	江戸川病院院長	
小出 五郎	NHK 解説委員	
佐々木英忠	東北大学老年・呼吸器内科教授	
袖井 孝子	お茶の水女子大学生活学部教授	
鳥羽 研二	杏林大学高齢医学教授	
野口美和子	自治医科大学看護学部教授	
松下 哲	勝楽堂病院 (元東京都老人医療センター副院長)	
(幹事)		
植村 和正	名古屋大学病態内科学講師	
顧問	高村 浩	高村法律事務所 弁護士

など、医療者は家族に対して積極的に支援する必要がある。ここで述べる「家族など」とは、家族、患者の友人や介護者など患者の終末期に関わる人たちのことを言う。

## 2. 技術的課題

立場—5—：終末期における医療およびケアは医学のみならず看護・介護、社会・心理など、幅広い領域を含む集学的医療およびケアである。

(論拠) 終末期において死にゆく患者を対象とした医療およびケアは集学的に実施されることが望ましい。集学的チームのメンバーには、医師、看護師、ソーシャルワーカー、介護サービスの担当者、リハビリテーションの担当者、臨床心理士、ボランティア、家族などが含まれる。各々チームのメンバーは、患者の死にゆく過程で持ち得る知識と技術のすべてを患者の必要に応じて提供すべきである。

立場—6—：終末期医療およびケアにおいて施行される医療処置は、患者への利益が医学的に保証されたものであるべきである。

(論拠) あらゆる医療処置やケアに関して、「得られる利益に関する科学的裏付け」の獲得、および「標準化」を目指す努力が継続されるべきと思われる。「標準化」は医師の「恣意性」を排除して、患者の「自律性」を保証することを目標としたものになるであろう。

立場—7—：患者の「尊厳」や「自律性」の尊重は、個々の文化的背景などに配慮すべきである。

(論拠) 日本人には、医療の専門家に対する従順性や自らの境遇に対する運命論的受容など、欧米文化とは異なる「死生観」を生み出した文化的背景がある。高齢者では、情報が開示されることを拒絶する場合すらある。

このような背景を無視し、十分な援助の準備もない告知は単に死の通告に他ならない。

## 3. 教育的課題

立場—8—：終末期患者が最善の医療およびケアを受ける権利を保障するために、医療者は実践的な教育を受けるべきである。

(論拠) 終末期患者の症状の管理技術、介護技術、患者とのコミュニケーション技術等について実践的な教育がなされるべきである。

立場—9—：「終末期の医療およびケア」は、終末期患者のQOLの向上に役立つものであることを、国民が理解することが望まれる。そのためには国民に対しての「終末期の医療およびケア」および「死の教育」が必要である。

(論拠) これにより、「終末期の医療およびケア」が終末期患者の尊厳を損なうものではないことが理解されるであろう。

## 4. 医療制度的課題

立場—10—：あるべき「終末期の医療およびケア」の実現のためには、社会制度的支援が不可欠である。

(論拠) 包括点数による診療報酬請求体系等の現行の医療制度があるべき高齢者の「終末期の医療およびケア」の実現を阻んでいる側面がある。

## 5. 研究に関する課題

立場—11—：十分な資金提供のもとに、あるべき「終末期の医療およびケア」の実現を目指す研究の推進が必要である。

(論拠) 症状緩和に関する研究、高齢患者の「自律性」を重んじた「終末期の医療およびケア実現」の方策、QOLの客観的評価法、在宅終末期医療およびケアの研究、などが必要である。さらに、日本人の「死生観」に根差した社会・心理的研究が必要とされている。

## 6. 国民的合意/社会への公開に関する課題

立場—12—：終末期における医療やケア行為の是非を検証できるような、第三者をいれた「倫理委員会」を各医療機関に設置し議論を行うと同時に、そこでの議論を広く公開し国民の意見にも耳を傾けるシステムをつくるべきである。

## 7. 「立場表明」の位置づけ

立場—13—：この立場表明は過渡期的な意見表明であって、今後科学的な手法を用いた検討により、この立場表明の妥当性自体が検証されるべきものである。

(論拠) 現在の我が国における「高齢者の終末期の医療およびケア」を取り巻く課題には、単に医学的見地のみからでは結論の出せないものが多くある。日本老年医

学会は学術団体として、これらの諸課題に対する調査・研究を行い、その結果を国民に提示し、議論を喚起する責任を負っていると考える。日本老年医学会の「立場表明」の公表は、あるべき「高齢者の終末期の医療およびケア」を実現するための活動の第一歩であると考えている。

### 倫理委員会の今後の活動方針

以上、「立場表明」を概述したが、今後はこの「立場表明」を踏まえて、さらに理想的な終末期医療実現のための活動が求められる。今後の倫理委員会の活動方針について述べる。

#### 1. 高齢患者の自己決定実現に向けての活動

まずは、「インフォームド・コンセント」の現状把握から始めたい。最終的には「インフォームド・コンセント」のガイドライン作成を目指している。

#### 2. 終末期医療やケアの診療ガイドラインの作成に向けての活動

これがおそらく最も困難な活動になると考えられる。なぜなら、個別性の高い終末期医療において、一律の診療指針はときに患者の人権を侵しかねないからである。まずは、地道な実証的研究が必要となろう。具体的には、①高齢者終末期の症候、徴候の把握、②高齢患者への病状説明の現状把握、③実際に施行されている医療措置の把握、などがその対象となると考えられる。最終的には

疾患ごと、あるいは症候や徴候ごとの診療ガイドラインの作成に取り組めれば望ましいと考えている。

#### 3. 終末期医療やケアの教育の充実と改善に向けての活動

まずはやはり現状調査から始めるべきであろう。具体的には、終末期医療に関する教育カリキュラムの有無とその内容に関する調査を踏まえ、最終的には終末期医療・ケア教育のモデルカリキュラムの作成に向かいたい。

#### 4. 各医療機関の「倫理委員会」活動に対する支援に向けての活動

これも現状調査を先行させたいと考える。「倫理委員会」の設置状況、活動内容の調査に加えて、具体的事例の収集などがその対象となろう。高齢者の終末期医療に関する「倫理委員会」のネットワークが構築できれば望外の喜びである。

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## 高齡者のターミナルケア

End of life care for the elderly



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◎遠からず“死”が避けられない状態となり患者の身体的苦痛・精神的苦痛の除去が医療の主眼となるとき、これを“ターミナルケア”とよぶ。“ターミナルケア”の目的は、苦痛・苦悩の緩和により患者のQOLを維持・向上することにある。高齡者の“ターミナルケア”の特徴を考えるとすることは、高齡者に特徴的な“終末期”に対する適切なケアのあり方を考えるということである。高齡者の“終末期”に対しては特徴的なケアがありうるということではない。

**Key word** : ターミナルケア, 高齡者, 終末期の定義, 自己決定

### 高齡者における終末期とは

“不治”かつ“末期”の状態が“終末期”と定義されるが、“不治”，すなわち非可逆的進行性の疾患に対して根治が不可能な状態は医学的に定義しやすい。一方，“末期”という用語は時間概念を含み、一般的に定義が困難である。現在罹患している疾患で遠からず死亡すると認められた時点から“終末期”ということができるとは、時間的にはおおよそ6カ月かそれ以内とすることが多い<sup>1)</sup>。

以上が一般的な“終末期”の定義であるが、これはおおよそ非高齡者の悪性腫瘍を想定してのものであり、高齡者の場合は具体的定義がさらに困難でいまだ確立されたものはない。このことを受けて現在、終末期ケア、とくに高齡者の終末期ケアに関してはターミナルケアという用語を使用せず、“End-of-life Care(エンドオブライフケア)”という表現を使用することもある。さらには日本老年医学会は終末期の定義から時間概念を省略し、「病状が不可逆的かつ進行性で、その時代に可能な最善の治療により病状の好転や進行の阻止が期待できなくなり、近い将来の死が不可避となった状

態」と“終末期”を定義した(表1)<sup>2)</sup>。本稿では表題のようにターミナルケアという用語を使用する。

### 高齡者のターミナルケアの特徴

#### 1. 高齡者の悪性腫瘍の場合

悪性腫瘍に対するあらゆる根治療法(手術, 放射線, 化学療法)が無効で、放置すれば“死”に至る状態となった時点“終末期”とすれば、これを判断することは困難ではない。しかし、高齡者の場合は悪性腫瘍の進行速度が非常に緩やかで“終末期”が6カ月を優に超える場合も珍しくない。また、経過が長くなれば、この間に肺炎や心不全、脳卒中など他の急性疾患に罹患し死亡することも多くなり、“死”に至る過程を予測することは非高齡者よりもかなり困難である。

#### 2. 慢性疾患での“終末期”

透析療法が拒否された末期の腎不全、慢性閉塞性肺疾患、治療に不応性の重症心不全、高齡がゆえに手術不能な脳出血やくも膜下出血などが該当する。末期の腎不全や致死的な脳出血の場合は予後(余命)の判断は比較的容易であるが、慢性の心