学位論文の要旨

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学位論文名　Characteristics of Geriatric Health Service Facilities Designated as Sites of Death

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論文内容の要旨

INTRODUCTION

There are many deaths occurring among the elderly population in Japan. Most elderly persons die after undergoing prolonged medical and nursing care. Elderly persons receiving facilities services can have possibilities to face death in facilities, not in hospitals.

Geriatric Health Service Facilities (GHSFs) offer physical therapy to elderly people, to support their everyday living functions and provide other assistance, so that they can resume independent living at home. The role played by GHSFs is that of "intermediate" facilities, that is, facilities with multiple functions, including functioning as hospitals or other facilities and home, or providing in-home nursing care. Additionally, the Japanese government established the nursing care benefit for site-of-death care at GHSFs in 2009. They also play a role in end-of-life care. However, the physical signs first noticed by staff at the end-of-life period are not well known in GHSFs. Most previous studies on end-of-life care in GHSFs targeted facilities designated as sites of death only. There are few studies involving a comparison of GHSFs designated as sites of death and those not designated.

The aim of our study is to clarify the characteristics of and related factors in GHSFs, including the end-of-life physical signs noticed by staff at these facilities, through a nationwide survey in Japan.

MATERIALS AND METHODS

The subjects were 3,971 GHSFs registered on the Long-term Care Insurance Services Informational Publication System, adopted by all the prefectures in Japan, as at January 2015.

We administered a questionnaire to 3,971 GHSFs. Of the 1,032 respondents, 7 did not give informed consent and 171 did not give the complete data needed for analysis, such as missing and invalid responses. Finally, 854 eligible responses remained in the study: 21.5% (854/3971) of all subjects and 82.8% (854/1032) of the respondents.

The contents of the survey included the characteristics of the facilities [presence of branches of medical institutions (hospital, clinic with beds, and clinic without beds), provision of other services to elderly persons, the number of beds in facilities, the average care-need level, the average home return rate, and location of facilities]. We also asked about the procedures relating to the site of death in the GHSFs (whether the facility has a basic policy on end-of-life care or not, whether there is a preference for individuals to have a documented living will or not). The facilities were asked about the number of residents who had died therein within the past one year (from April 2013 to March 2014). Then, we obtained information on physical signs, which most staff members noticed first among end-of-life residents — reduced oral intake, sleepiness during daytime, less vigor, oliguria, dyspnea, edema, and complaints of pain.

GHSFs designated as sites of death were defined as facilities in which at least one death had occurred within the past one year. Student t-tests and χ^2 tests were used to compare GHSFs designated as sites of death with those not designated. A multiple logistic regression analysis was used to assess the contribution of each independent variable, including characteristics and physical signs, toward GHSFs designated as sites of death. All probability values were two-tailed and all confidence intervals were estimated at the 95% level.

All the procedures of this study were reviewed and approved by the Institution Review Board of Shimane University Faculty of Medicine.

RESULTS AND DISCUSSION

Both basic policies on end-of-life care and documented preferences in the form of a living will were more common in GHSFs designated as sites of death. The average level of care needs in GHSFs designated as sites of death was higher than that of those not designated (the average level of care needs 3.3 ± 0.4 vs 3.2 ± 0.4). The average number of deaths in GHSFs designated as sites of death was 9.1 ± 8.5. There were fewer standard types of GHSFs under the notification system in the long-term care insurance, in GHSFs designated as sites of death than in those not designated. There were many more clinics without beds, which were either primary or affiliate institutes of medical care, in GHSFs designated as sites of death than in those not designated. The GHSFs designated as sites of death were slightly less independent of medical institutions than were those not designated.

On the physical signs that most staff members noticed first at the end-of-life period, the proportions of "reduced oral intake", "sleepiness during daytime", and "less vigor" were higher in GHSFs designated as sites of death than among those not designated, and "reduced oral intake" and "sleepiness during daytime" had statistically significance. On the other hand, the proportions of "oliguria", "dyspnea", "edema", and "complaints of pain" were lower in GHSFs

designated as sites of death; statistical significance was obtained for "dyspnea" and "complaints of pain."

Using multiple logistic regression analysis, both basic policies and preferences documented at end-of-life care facilities were positively associated with GHSFs designated as sites of death. There were fewer "complaints of pain", as a physical sign first noticed by most staff members at the end-of-life period, in GHSFs designated as sites of death. Though none of the relationships reached statistical significance, we also observed that GHSFs designated as sites of death had positive relationships with "clinic as primary medical institutions", "average care-need level", "sleepiness during daytime", and "reduced oral intake", which most staff members noticed at the end-of-life period among residents.

The establishment of a basic policy regarding sites of death in GHSFs helps staff members realize that end-of-life care forms part of their duties in the facilities and facilitates attitudes geared towards supporting elderly persons. The role of documented preferences, as communication tools, is to promote decision making regarding the drawing of living wills by both patients and their families. Our results may suggest that the documentation of preferences enables the elderly persons, their families, and staff at the facilities to prepare for the elderly's deaths and for the remainder of their lives. The GHSFs have multiple functions in their support of elderly persons during provision of the long-term care. The GHSFs designated as sites of death identified reduced activity levels and behaviors, as opposed to vital signs, as early end-of-life signs.

CONCLUSION

The GHSFs designated as sites of death had more basic policies relating to end-of-life care facilities, as well as documented preferences in the form of a living will than those not designates. These GHSFs were also less likely to identify pain as a first end-of-life physical sign. We suggest that GHSFs identify earlier symptoms, such as reduced oral intake and sleepiness during daytime, in the end-of-life period, by improving end-of-life care through the implementation of basic policies and those relating to the documentation of preferences. We hope that the strengthening of intermediate facilities would render the role of GHSFs important, in the provision of end-of-life care to elderly persons in Japan.

論文審査及び最終試験又は学力の確認の結果の要旨

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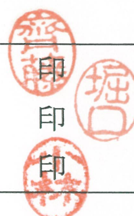

論文審査の結果の要旨

わが国は急速な高齢社会に伴い多死社会を迎え，看取りの場や終末期ケアのあり方が問われている。本研究は，死の看取りを行っている介護老人保健施設（以下，老健）の特徴や関連要因を明らかにすることを目的とした。各都道府県が管理している介護サービス情報公表システムに登録されている全国の老健3,971施設の管理者を対象に，施設の属性，看取りの体制，スタッフが看取りの時期ではないかと最初に気づく入所者の身体兆候などについて質問紙調査を実施した。調査票の回答数は1,032件（回答率26.0%）で、このうち無効回答178件を除外し，有効回答854件（有効回答率21.5%）を解析対象とした。過去1年間における老健内での死亡者有りを「看取りあり群」，同死亡者無しを「看取りなし群」と定義した。2群間の比較検定には，t検定またはχ^2検定を用いて分析した。また，看取りあり群の関連要因は、ロジスティック回帰分析を用いて検討した。その結果，看取りあり群（n=698）は看取りなし群（n=156）と比較して，看取りの方針や事前指示書の作成を明確にしている施設が多かった。また，看取りあり群のスタッフが看取りの時期ではないかと最初に気づく変化は、食事量の低下などであった。さらに、看取りを行う関連要因の分析では、老健内で看取りを行う方針があり，事前指示書を作成しており，痛みの訴えにより看取りの時期と気づくことが少ないといった要因で、統計的有意差がみられた。また、看取りを行っている老健は，食事量の低下のような日常の軽微な変化により，看取りの時期を判断している可能性が示唆された。また，老健が事前指示書を活用しながら，看取りの時期までをどのように過ごしたいかといったことについて、スタッフが入所者や家族と一緒に考えることが、終末期ケアを提供する場として重要であると考えられた。

最終試験又は学力の確認の結果の要旨

申請者は、看取りの場としての老健の現状と特徴をアンケート調査により解析した。看取りあり群と看取りなし群の比較から看取りができるためには施設の方針と事前指示書などの整備が重要であることを明らかにした。医療介護制度の包括化に寄与する成果であり、学位授与に値すると判断した。

（主査）齋藤　洋司

本研究は、看取りの場やその在り方、あるいはその実態が充分には検討されていないわが国の現状を鑑みると、老健でのそれらの実態を明らかにした重要な研究であると考えられ、今後の体制の確立に多大な示唆を与える貴重な研究である。申請者のこの方面の知識も十分で在り、学位授与に値すると考えられた。

（副査）堀口　淳

申請者は、老健での看取りを行う上で、施設として看取りの方針を明確にし、事前指示書に基づきスタッフが入所者や家族と一緒に考えることの重要性を示唆した。また食事量の変化のような軽微な変化から看取りの時期の徴候を捉えていることを明らかにした。高齢社会での看取りのあり方に関する貴重な研究と考える。公開審査では的確に質疑応答し、関連知識も豊富であることから学位授与に値すると判断した。

（副査）小林　裕太

（備考）要旨は，それぞれ４００字程度とする。