

Factors influencing attitudes toward end-of-life care by care workers at special nursing homes for the elderly A Cross-sectional study in Japan

Michiyo YAMAMOTO¹⁾²⁾, Hirofumi OHNISHI¹⁾, Asae OURA¹⁾, Takeshi YAMAMOTO³⁾,
Hisako IZUMI⁴⁾, Miwa SUZUMURA¹⁾, Mitsuru MORI¹⁾

¹⁾Department of Public Health, Sapporo Medical University School of Medicine

²⁾Department of Nursing, Hokkaido University of Science

³⁾Department of Educational Development, Sapporo Medical University Center for Medical Education

⁴⁾Department of Community Health Sciences, Kobe University Graduate School of Health Sciences

ABSTRACT

Objectives: The purpose of this study was to clarify factors influencing care workers' attitudes toward end-of-life (EOL) care characteristics at special nursing homes (SNHs).

Methods: A questionnaire was initially sent to 630 care workers at 19 SNHs in October 2012. Written informed consent was obtained from 253 of these workers (40.2%), who then completed and returned the questionnaires. Participants were asked to reply to questions covering demographic data, work environment, depression status, experiences/education concerning EOL, communication skills, and attitudes toward EOL care. The Japanese version of the Frommelt Attitude Toward Care of the Dying Scale, Form B (FATCOD-B-J) assessment instrument was used in the analysis of the data received. Using the median value of the FATCOD-B-J score, 130 subjects were allocated to the high score (HS) group (FATCOD-B-J \geq 23) and 123 to the low score (LS) group (FATCOD-B-J $<$ 23). In the LS group, the odds ratios (ORs) and their 95% confidence intervals (95% CIs) of participants exhibiting relatively negative attitudes toward EOL care were calculated and adjusted for potential confounding factors using multivariate logistic regression model analysis.

Results: Length of employment in the facilities of between 5 and 9 years (OR 0.37, 95% CI 0.16-0.87) as well as over 10 years (OR 0.39, 95% CI 0.16-0.96) was significantly associated with a decreased risk of placement in the LS group. Furthermore, moderate (OR 0.44, 95% CI 0.24-0.80) as well as high (OR 0.35, 95% CI 0.17-0.75) communication skills in accepting other opinions, were significantly associated with decreased risk of placement in the LS group.

Conclusions: After adjustments for potential confounding variables, results indicated that extended experience as a care worker and higher communication skills in accepting other opinions were significantly associated with a reduced risk of negative attitudes toward EOL care.

(Received June 3, 2015 and Accepted July 23 2015)

Key words: nursing home, end-of-life care, communication skills, cross-sectional study

1. Introduction

Japanese society has experienced dramatic demographic changes due to its aging population and, declining birthrate¹⁾. It has been estimated that from 2010 to 2035, the percentage of households whose heads are aged 65 or older will increase from 31.2% to 40.8% and the number of one-person elderly households will increase from 4.98 million to 7.62 million²⁾. These logistics will make it increasingly difficult to expect that families will be

able to provide full support for their elderly members³⁾. Although one study indicates that approximately 44% of the Japanese people would prefer to receive end-of-life (EOL) care in their homes⁴⁾, those from one-person elderly households are more likely to be placed in care facilities⁵⁾. At present, care facilities are expected to play a major role in EOL care for the elderly.

Previous studies have provided information on numerous issues related to EOL care in care facilities. These studies have primarily focused on facility

management policies, character traits often seen in residents and their family members, and characteristics of the staff. Concerning the first point, a wide number of topics have been examined, including implementation of EOL care policy⁶⁻⁹⁾, support provided by physicians during emergencies or at the moment of a patient's death^{6-8,10)}, manners in which nurses' nightshift schedules are determined⁸⁾, staff education and training^{6,9)}, efforts on the part of facilities to create a homelike environment¹¹⁾ such as providing private rooms for residents^{6,8)}, the development of facility guidelines for EOL care and financial incentives from the government⁸⁾, the regularity of staff meetings to discuss EOL care¹²⁾, and how insufficient staff numbers may hinder EOL care¹³⁾. Studies focusing on the characteristics of care residents and their family members have examined the duration of stay of residents⁶⁾, individual resident's advance directive^{8,10,11,13,14)}, whether there is suitable discussion with residents and their families about EOL care^{6,7,13)}, resident's age, frequency of resident's hospitalizations¹⁵⁾, and how diseases such as pneumonia⁷⁾ or terminal cancer¹⁶⁾ affect EOL care. Research on care staff characteristics focuses on the amount of experience workers have with providing EOL care¹²⁾, their attitudes toward care for terminal patients^{17,18)}, and communication with residents, their families, and other staff¹⁹⁻²¹⁾.

Special nursing homes (SNHs) are among the facilities that provide public long-term care. A SNH consists of at least one doctor (working on a part-time basis is permitted), three nurses, and 31 care workers per 100 residents²²⁾. However, there are limits to the extent of medical care that can be provided at SNHs and most care providers do not have medical licenses. For this reason, the physical condition of SNH residents who have severe disabilities²³⁾ worsen, they are transferred to hospitals^{24,25)}.

The Japanese government has been promoting EOL care in SNHs since 2006. In order to receive governmental support SNHs must employ a full-time registered nurse, have a 24-hour-on-call system in place for nurses, have a concrete policy regarding EOL care, and hold seminars on EOL care for the staff, among other conditions. However, despite the Japanese government's effort to promote EOL care in SNHs, who remain in the facilities until the end of their lives is still low (3.2%)⁷⁾.

Care workers might assume an important role in providing EOL care in SNHs. Previous reports indicate that care workers express concern about the lack of nighttime staff and the emergency response available²⁶⁾.

However, little is known about care workers' attitudes toward EOL care at SNH. The purpose of this study was to clarify factors influencing SNH care workers' attitudes toward EOL care. We defined EOL care to mean the physical, psychological, and spiritual care provided to a dying person.

2. Methods

This study took place in Sapporo, Japan and was approved by the Ethics Committee of Sapporo Medical University. First, in May 2012 addresses for all SNHs in the city, totaling 48, were obtained by accessing their websites²⁷⁾. The SNHs included in this study could accommodate about 100 residents. The study also has included facilities that promote EOL care and those that do not. Among them, administrators from 19 (39.6%) consented to participate in the current study. A questionnaire was then mailed to 630 staff members at the 19 SNHs in October 2012. 253 (40.2%) provided written informed consent, after which they completed the self-administrated structured questionnaires and returned them to us.

Subjects covered in the questionnaire included participants' gender, age, certification status (whether they were certified or non-certified care workers), length of experience as a care worker, amount of experience with EOL care in their present facility, their religion or faith, depression status, on-the-job and off-the-job training experience, knowledge about EOL care policies at their present facility, communication skills, and attitudes toward end-of-life care. Depression status was measured by the Center for Epidemiologic Studies Depression Scale (CES-D). Two types of communication skills were measured consisting of participants' willingness to express their opinions (assertiveness) and how well they accepted the opinions of others (other acceptance). Both skills were measured using the ENDCOREs which was based on the ENDCORE (encode, decode, control, and regulation) model²⁸⁾. The ENDCOREs was found to be a reliable tool²⁸⁾. It consisted of a 7-point scale, with higher scores indicating higher communication skills. Attitudes toward EOL care were measured with the Japanese version of assessment instrument of the Frommelt Attitude Toward Care of the Dying Scale Form B (FATCOD-B-J)²⁹⁾. The FATCOD-B-J scale was found to be a valid and reliable tool²⁹⁾. The version we used was comprised of 6 items on a 5-point scale, with lower scores indicating more negative attitudes toward EOL care. Using the median value of the FATCOD-B-J score,

130 subjects were allocated to the high score (HS) group (FATCOD-B-J \geq 23) and 123 were placed in the low score (LS) group (FATCOD-B-J<23).

The two-sided χ^2 -test and Student's t-test were used for the comparison of the 2 groups. In the LS group, which expressed relatively negative attitudes toward EOL care, odds ratios (ORs) and their 95% confidence intervals (95% CIs) were calculated and adjusted for potential confounding factors using multivariate logistic regression model analysis. The significance level was set at 5%. Statistical analysis was performed using SPSS version 16.

3. Results

Table 1 shows a comparison between the HS and LS groups' attitudes toward EOL care. A significantly smaller proportion of certified care workers were observed in the LS group than in the HS group ($P=0.001$). Additionally, a significantly shorter duration of employment as a care worker was observed in the LS group than in the HS group ($P=0.002$). Regarding EOL care experience at participants' current facilities, survey results indicated that those in the LS group had significantly less experience than those in the HS group ($P=0.022$). Additionally,

Table 1. Comparison of the high score (HS) group and the low score (LS) group in attitudes toward EOL care among 253 study subjects

Variable	Content	Total n (%)	HS group (n=130) n (%)	LS group (n=123) n (%)	P
Gender	Female	186 (73.5)	97 (74.6)	89 (72.4)	0.684
	Male	67 (26.5)	33 (25.4)	34 (27.6)	
Age in year	Mean (SD)	37.0 \pm 10.7	37.1 \pm 10.7	37.0 \pm 10.8	0.936
Certified care worker	No	59 (23.3)	19 (14.6)	40 (32.5)	0.001
	Yes	194 (76.7)	111 (85.4)	83 (67.5)	
Durations of employment as a care worker	Mean (SD)	7.2 \pm 5.4	8.2 \pm 5.7	6.2 \pm 4.9	0.002
Experience with EOL care	No	93 (36.8)	39 (30.0)	54 (43.9)	0.022
	Yes	160 (63.2)	91 (70.0)	69 (56.1)	
Religion or faith	No	221 (87.4)	117 (90.0)	104 (84.6)	0.194
	Yes	32 (12.6)	13 (10.0)	19 (15.4)	
CES-D score	<16	151 (59.7)	83 (63.8)	68 (55.3)	0.166
	\geq 16	102 (40.3)	47 (36.2)	55 (44.7)	
Experience in on-the-job Training	No	127 (50.4)	59 (45.7)	68 (55.3)	0.130
	Yes	125 (49.6)	70 (54.3)	55 (44.7)	
Experience in off-the-job training	No	226 (89.3)	110 (84.6)	116 (94.3)	0.013
	Yes	27 (10.7)	20 (15.4)	7 (5.7)	
Knowledge of EOL care policies at present facility	No	91 (36.0)	39 (30.0)	52 (42.3)	0.042
	Yes	162 (64.0)	91 (70.0)	71 (57.7)	
Communication skills (assertiveness)	Low	51 (20.2)	25 (19.2)	26 (21.1)	0.295
	Moderate	106 (41.9)	51 (39.2)	55 (44.7)	
	High	96 (37.9)	54 (41.5)	42 (34.1)	
Communication skills (acceptance of others)	Low	103 (40.7)	41 (31.5)	62 (50.4)	0.003
	Moderate	97 (38.3)	56 (43.1)	41 (33.3)	
	High	53 (20.9)	33 (25.4)	20 (16.3)	

SD: standard deviation. EOL: end-of-life. CES-D: Center for Epidemiologic Studies Depression Scale

Attitudes toward EOL care were divided into the high score group (FATCOD-B-J \geq 23) and the low score group (FATCOD-B-J<23).

those in the LS group had significantly less off-the-job training than participants in the HS group ($P=0.013$). Other results showed a significantly smaller proportion of well-grounded EOL care policies at the current facilities in the LS group than in the HS group ($P=0.042$). Finally, when compared to the HS group, a significantly larger proportion of participants in the LS group had low-level communication skills when it came to accepting the opinions of others ($P=0.003$). However, communication skills in assertiveness were not significantly different between the two groups.

Table 2 compares attitudes toward EOL care between the two groups, with logistic regression analysis used to adjust for odds ratios (ORs) and 95% confidence intervals (CIs) in the data from the LS group. Variables that were significantly different in Table 1 were chosen as independent variables. As a result of the univariate analysis with the logistic regression model, non-certified care workers (crude OR 2.82, 95% CI 1.52-5.21; $P=0.001$) were significantly associated with an increased risk of belonging to the LS group. Length of experience as a care worker (P -trend=0.002), experience with EOL care (crude OR 0.55, 95% CI 0.33-0.92; $P=0.022$), experience in off-the-job training (crude OR 0.33, 95% CI 0.14-0.82;

$P=0.016$), knowledge of EOL care policies at their facilities (crude OR 0.59, 95% CI 0.35-0.98; $P=0.043$), and high communication skills in accepting other opinions (P -trend=0.004) were all significantly associated with a decreased risk of being in the LS group.

For multivariate analysis using the logistic regression model, all variables shown in Table 2 were simultaneously included in the model. As a result, length of work equal to or longer than 5 years (OR 0.37, 95% CI 0.16-0.87; $P=0.022$) as well as equal to or longer than 10 years (OR 0.39, 95% CI 0.16-0.96; $P=0.041$) was significantly associated with a decreased risk of being in the LS group. Furthermore, moderate (OR 0.44, 95% CI 0.24-0.80; $P=0.008$) as well as high (OR 0.35, 95% CI 0.17-0.75; $P=0.007$) communication skills in accepting other opinions were significantly associated with a decreased risk of being in the LS group. None of the other variables was significantly associated with a risk of being in the LS group.

4. Discussion

A longer duration of experience as a care worker was significantly associated with a reduced risk of negative attitudes toward EOL care after adjusting for potential confounding variables. Although there was no significant

Table 2. Factors related to the low score group in attitudes toward EOL care

Variables	Contents	Crude ORs (95% CIs)	<i>P</i>	Adjusted ORs (95% CIs)	<i>P</i>
Certified care worker	Yes	1.00		1.00	
	No	2.82 (1.52-5.21)	0.001	1.61 (0.75-3.44)	0.225
Durations of employment as a care worker	<3 years	1.00		1.00	
	≥3 - <5 years	1.07 (0.54-2.10)	0.849	0.52 (0.21-1.29)	0.157
	≥5 - <10 years	0.68 (0.40-1.16)	0.157	0.37 (0.16-0.87)	0.022
	>10 years	0.62 (0.36-1.09)	0.095	0.39 (0.16-0.96)	0.041
			<i>P</i> - trend=0.002		<i>P</i> - trend=0.041
Experience with EOL care	No	1.00		1.00	
	Yes	0.55 (0.33-0.92)	0.022	0.76 (0.42-1.38)	0.368
Experience in off-the-job training	No	1.00		1.00	
	Yes	0.33 (0.14-0.82)	0.016	0.42 (0.16-1.09)	0.076
Knowledge of EOL care policies at present facility	No	1.00		1.00	
	Yes	0.59 (0.35-0.98)	0.043	0.82 (0.46-1.50)	0.525
Communication skills (acceptance of others)	Low	1.00		1.00	
	Moderate	0.66 (0.40-1.01)	0.112	0.44 (0.24-0.80)	0.008
	High	0.57 (0.31-1.06)	0.077	0.35 (0.17-0.75)	0.007
			<i>P</i> - trend=0.004		<i>P</i> - trend=0.003

EOL: end-of-life.

Attitudes toward EOL care were divided into the high score group (FATCOD-B-J≥23) and the low score group (FATCOD-B-J<23).

difference in age between participants in the HS group and LS groups, on average those in the HS group first started employment at a younger age than LS group participants and therefore had more years of experience. It is mostly assumed that, health care professionals are able to integrate their experiences and knowledge after several years of working at the same job. According to a previous study, care workers who had experienced EOL care had a higher professional efficacy and had worked at their positions for a longer time than inexperienced care workers³⁰. Participants' replies in this study suggested that care workers are able to integrate their experiences and knowledge after working at the same job for over 5 years.

Higher communication skills in accepting other opinions were significantly associated with a reduced risk of negative attitudes toward EOL care after adjusting for potential confounding variables. However, there were no significant differences seen between the two groups regarding assertiveness. However, there were no significant differences seen between the two groups regarding assertiveness. At a month before death 27% of people had limited decision making, this increased to 67% in the last week of life³¹. Those residents could not appropriately express their individual opinions. Care workers should put more effort into understanding residents' opinions and status. Thus, in EOL care opportunity, care workers utilized higher communication skills in accepting other opinions than assertiveness.

Additionally, in Japan, the curriculum for care workers includes very little training on EOL care^{32,33}. As such, care workers express concern about the lack of nighttime staff and the emergency response available²⁶. Care workers might not have confidence in their own judgment in EOL care. It is known that EOL care training, support, and networking contribute to increased knowledge of EOL care and enhanced confidence³⁴. It is necessary that education is provided in order to increased knowledge of EOL care and training for communication skills so that EOL situations can be conveyed accurately to other professionals.

Several limitations of this study should be noted. Firstly, we were unable to determine a causal relationship due to the cross-sectional design of the experiment. Secondly, because the response rate was not especially high, and our sampling for the study subjects was conducted only from Sapporo City, our results cannot be confidently generalized for the whole of Japan. Thirdly, although we measured attitudes toward EOL care, we did not

evaluate the actual quality of EOL care. Further research is required to measure the effect of attitudes toward EOL care on its overall quality.

5. Conclusions

A reduced risk of negative attitudes toward EOL care was significantly associated with worker's length of employment. Moreover, after adjusting for potential confounding variables, it was determined that higher communication skills in accepting other opinions were significantly associated with a reduced risk of negative attitudes toward EOL care.

Conflict of Interest

No potential conflicts of interest were disclosed

Acknowledgments

This study was supported by a grant from Special Medical Research Support by Sapporo Medical University. The authors thank Greg Wheeler for his help with the manuscript.

References

1. The Comprehensive Reform of Social Security and Tax[Internet]. Ministry of Health Labour and Welfare. [cited 2015 May 21]. Available from http://www.mhlw.go.jp/english/social_security/kaikaku_1.html
2. Household Projections for Japan 2010-2035 Outline of Results and Methods[Internet]. National Institute of Population and Social Security Research. [cited 2015 Feb 28]. Available from http://www.ipss.go.jp/pp-ajsetai/e/hhprj2013/hhprj130304_DL.pdf
3. Lai OK. Long-term care policy reform in Japan. *J Aging Soc Policy* 2001; 13: 5-20.
4. Fukui S, Yoshiuchi K, Fujita J, Sawai M, Watanabe M. Japanese people's preference for place of end-of-life care and death: A population-based nationwide survey. *J Pain Symptom Manage* 2011; 42(6): 882-892.
5. Imai H, Fujii Y, Fukuda Y, Nakao H, Yahata Y. Health-related quality of life and beneficiaries of long-term care insurance in Japan. *Health Policy* 2008; 85: 349-355.
6. Hirakawa Y, Masuda Y, Kuzuya M, Iguchi A, Uemura K. Director perceptions of end-of-life care at geriatric health services facilities in Japan. *Geriatr Gerontol Int* 2007; 7: 184-188.
7. Ikegami N, Ikezaki S. Japan's policy of promoting end-of-life care in nursing homes: Impact on facility and resident characteristics associated with the site of death. *Health Policy* 2012; 105: 303-311.
8. Chiba M, Watanabe M, Hosoda E, Matsuzawa Y, Sone C. [Policy and systems for end-of-life care in nursing home: Comparisons between facilities with and without approaches

- to end-of-life care]. *Nihon Kango Fukushi Gakkaishi* 2010; 15(2): 163-175. Japanese.
9. Hirakawa Y, Masuda Y, Kuzuya M, Iguchi A, Uemura K. Non-medical palliative care and education to improve end-of-life care at geriatric health services facilities: A nationwide questionnaire survey of chief nurses. *Geriatr Gerontol Int* 2007; 7: 266-276.
 10. Shimada C, Horiuchi F, Tsuruwaka M, Takahashi R. End-of-life care in nursing homes and related institutional factors. *Jpn J Gerontol* 2013; 34(4): 500-509. (In Japanese)
 11. Brazil K, McAiney C, Caron-O'Brien M, Kelly ML, O'Krafka P, Sturdy-Smith C. Quality end-of-life care in long-term care facilities: Service providers' perspective. *J Palliat Care* 2004; 20(2): 85-92.
 12. Yanagihara K, Karasawa K. Analysis: [How professional staffs at a Japanese nursing home consider terminal care, and why they consider so]. *Bulletin of Niigata Seiryō University* 2003; 3: 223-232. Japanese.
 13. Hashimoto M, Ono S. Factors hindering end-of-life care at special nursing homes for the elderly (special nursing homes): An attitude survey involving the staff of special elderly nursing homes, what had difficulty promoting "end-of-life care". *Shi no Rinsho* 2014; 37(1): 142-147. (In Japanese).
 14. Foo WT, Zheng Y, Kwee AK, Yang GM, Krishna L. Factors considered in end-of-life care decision making by health care professionals. *Am J Hosp Palliat Med* 2013; 30: 354-358.
 15. Hirano M, Ogiwara M, Sakamoto Y, Yamagiwa K, Moriguchi K, Iijima S. [End-of-life care in a special elderly nursing home characteristics of patients who died in nursing home facilities and current status of end-of-life decision-making]. *Nippon Ronen Igakkai Zasshi* 2011; 48(5): 509-515. Japanese.
 16. Uemura S. [A terminal cancer study at a special elderly nursing home]. *Konan Women's University studies in nursing and rehabilitation* 2009; 3: 69-76. Japanese.
 17. Matsui M, Braun K. Nurses' and care workers' attitudes toward death and caring for dying older adults in Japan. *Int J Palliat Nurs* 2010; 16(12): 593-598.
 18. Miyashita M, Nakai Y, Sasahara T, Koyama Y, Shimizu Y, Tsukamoto N, Kawa M. Nursing autonomy plays an important role in nurses' attitudes toward caring for dying patients. *Am J Hosp Palliat Med* 2007; 24: 202-210.
 19. Zheng NT, Temkin-Greener H. End-of-life care in nursing homes: The importance of CNA staff communication. *J Am Med Dir Assoc* 2010; 11(7): 494-499.
 20. Hall S, Goddard C, Stewart F, Higginson IJ. Implementing a quality improvement programme in palliative care in care homes: A qualitative study. *BMC Geriatr* 2011; 11-31.
 21. Sinuff T, Dodek P, You JJ, Barwich D, Tayler C, Downar J, Hartwick M, Frank C, Stelfox HT, Heyland DK. Improving end-of-life communication and decision-making: The development of a conceptual framework and quality indicators. *J Pain Symptom Manage* 2015; 49(6): 1070-1080.
 22. Ikegami N, Yamauchi K, Yamada Y. The long term care insurance law in Japan: Impact on institutional care facilities. *Int J Geriatr Psychiatry* 2003; 18: 217-221.
 23. Imai H, Fushimi K. Factors associated with the use of institutional long-term care in Japan. *Geriatr Gerontol Int* 2012; 12: 72-79.
 24. Iwata M, Kuzuya M, Kitagawa Y, Ohmiya T, Iguchi A. Transfer of elderly patients from health care facilities to emergency departments: Prospective observational study of the emergency department in Japan. *Geriatr Gerontol Int* 2003; 3: 250-255.
 25. Arendts G, Quine S, Howard K. Decision to transfer to an emergency department from residential aged care: A systematic review of qualitative research. *Geriatr Gerontol Int* 2013; 13: 825-833.
 26. Tsukada H, Asami H. Current trends and issues in terminal care at public aid-covered designated facilities and provision of long-term care to the elderly in Ishikawa prefecture. *Ishikawa Journal of Nursing* 2012; 9: 61-70.
 27. 独立行政法人福祉医療機構WAM. WAM NET [Internet]. 独立行政法人福祉医療機構WAM [cited 2012 May 28]. Available from: <http://www.wam.go.jp/content/wamnet/pcpub/kaigo/service/>
 28. Fujimoto M, Daibo I. ENDCORE: [A hierarchical structure theory of communication skills]. *Jpn Soc Personal Psychol* 2007; 15: 347-361. Japanese.
 29. Nakai Y, Miyashita M, Sasahara T, Koyama Y, Shimizu Y, Kawa M. [Factor structure and reliability of the Japanese version of the Frommelt attitudes toward care of the dying scale (FATCOD-B-J)]. *J Jpn Soc Cancer Nurs* 2006; 11: 723-729. Japanese.
 30. Abe K, Ohashi A. Positive effects of experience in terminal care on nursing home staff in Japan. *Am J Hosp Palliat Care* 2011; 28(6): 389-392.
 31. Kaspers PJ, Onwuteaka-Philipsen BD, Deeg DJH, Pasman HRW. Decision-making capacity and communication about care of older people during their last three months of life. *BMC Palliat Care* 2013; 12:1.
 32. 厚生労働省. 2年課程 新しい介護福祉士養成カリキュラムの基準と想定される教育内容の例 (案) [Internet]. 厚生労働省 政策について 生活保護・福祉一般 [cited 2015.May.20]. Available from: <http://www.mhlw.go.jp/bunya/seikatsuhogo/dl/shakai-kaigo-yousei03.pdf>
 33. Ministry of Health, Labour and Welfare. Certified social workers and certified care workers [Internet]. Ministry of Health, Labour and Welfare. Annual Health, Labour and Welfare Report 2008-2009. 8. Social Welfare and Relief for War Victims [cited 2015.May.5]. Available from: <http://www.mhlw.go.jp/english/wp/wp-hw3/dl/8-11.pdf>.
 34. Badger F, Plumridge G, Hewison A, Shaw KL, Thomas K, Clifford C. An evaluation of the impact of the Gold Standards Framework on collaboration in end-of-life care in nursing homes. A qualitative and quantitative evaluation. *Int J Nurs Studies* 2012; 49: 586-595.

Correspondence:

Michiyo Yamamoto
 Department of Nursing, Hokkaido University of Science.
 7-15-4-1 Maeda, Teine, Sapporo, Hokkaido, 006-8585 Japan.
 Tel: +81-11-688-7149
 Fax: +81-11-688-2274
 E-mail: yamamoto-m@hus.ac.jp

特別養護老人ホームにおける介護職の看取りに対する態度に関連する要因：日本における横断研究

山本道代¹⁾²⁾, 大西浩文¹⁾, 大浦麻絵¹⁾, 山本武志³⁾,
和泉比佐子⁴⁾, 鈴木美和¹⁾, 森 満¹⁾

¹⁾札幌医科大学大学院医学研究科公衆衛生学講座

²⁾北海道科学大学保健医療学部看護学科

³⁾札幌医科大学医療人育成センター教育開発研究部門

⁴⁾神戸大学大学院保健学研究科地域保健学領域

緒言：本研究は、特別養護老人ホーム（以下、特養）に勤務する介護職の看取りに対する態度に影響を与える要因を明らかにすることを目的とした。

対象と方法：札幌市内の19施設に勤務する介護職630人に自記式質問紙調査を郵送し、253人から回答を得た（回収率40.2%）。調査票は基本属性、職場の環境、看取りに関する経験や教育、コミュニケーションスキル等の項目で構成し、看取りに対する態度は、Frommelt Attitude toward Care of Dying scale, Form B (FATCOD-B-J) 日本語版を用いた。看取りに対する態度の中央値で高群（130人）、低群（123人）に分類し従属変数とした。その他の変数を独立変数

として統計的に分析した。分析には χ^2 検定、 t 検定および多重ロジスティック回帰分析を用いた。

結果：介護職としての経験年数5年以上10年未満（OR 0.37, 95% CI 0.16-0.87）と10年以上（OR 0.39, 95% CI 0.16-0.96）、および、他者受容のコミュニケーションスキルが高レベル（OR 0.35, 95%CI 0.17-0.75）と中レベル（OR 0.44, 95%CI 0.24-0.80）は、看取りに対する消極的な態度を低減する要因であった。

結論：勤務年数の長さとは他者受容のコミュニケーションスキルは、交絡因子の調整後も看取りに対する消極的な態度を低減する要因であった。