Awareness of Elderly Care Home Residents' Families with regard to Expansion of Nurses' Medical Roles

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Key Words :
nurse
practice
elderly care facility
family
health care policy

ABSTRACT

The study aims to identify the awareness of elderly care home residents' families with regard to expansion of nurses' medical roles in the elderly care facilities, by carrying out questionnaire survey and semi-structured interviews.

The results of questionnaire 305 family members responded identified their "awareness of medical practices conducted by nurses" and "correlation between awareness of medical practices conducted by nurses and attributes of the care home residents and their families and medical care situations," among others. In addition, the semi-structured interviews with 5 family members revealed specific views of the families that support the results of the questionnaire survey.

Introduction

The government has considered the "integrated reform of social security and tax," and developed measures to further strengthen social security, by stably securing revenue through the increase of consumption tax. Among these, one measure is the establishment of "comprehensive community care" as a mechanism to receive timely medical care and nursing service, without being influenced by family structure and economic conditions. In addition, the medical service provided as one factor of this system must increase the security and satisfaction of life of each citizen.

The Ministry of Health, Labour and Welfare (2012a) pointed out that "reform of medical care and nursing service itself is inevitable due to changes in the serious, miniaturized version of human society, such as the increase in the number of senior citizens living alone and households with only aged persons produced by trends in the nuclear family." Furthermore, the Ministry (2012b) also indicated the "need to organize the service provision system for end-of-life care and times of acute exacerbation, so that aged persons with higher needs in medical and nursing care can be accepted into facilities." In other words, the needs of long-term care health facilities, especially elderly nursing homes, nursing and light expenses, and charged senior homes (hereinafter referred to as elderly care facilities) are considered to significant increase from now.

Moreover, consideration of the expansion of the discretionary authority of nurses was carried out from the viewpoint of promoting team medical care, so that quality of life of various home care patients can be further improved by care service, including the safe and prompt care by nurses who work closely with the person receiving medical care. In June 2014, the "Medical and Nursing Comprehensive Ensuring Promotion Law" was announced, and a new nurse training system to carry out specific actions in the assistance of medical care based on the manual, were established (Ministry of Health, Labour and Welfare, 2014).

From the viewpoint of the author, recognition of the expansion of the discretionary authority of nurses should be positively accepted by service users and on-site staff members so that sustainable measures can be created with the support of the citizens. One reason for this is the indication that "citizens themselves desperately want to participate in the establishment of medical policy" (Honda, 2008, pp.362-365; Kuriyama, 2010, pp.139-146). However, survey of the opinions and wishes of citizens regarding expansion of the discretionary authority of nurses according to previous studies is insufficient.

Hence, survey on recognition by home care patients who enter elderly care facilities (hereinafter referred to as "residents") is also considered needed. On the other hand, it can be assumed that in many cases, the residents may have physical disabilities such as dementia, and whether they can answer a survey with accurate understanding is questionable. Consequently, persons related by blood or marriage (hereinafter referred to as "family") who bear the role of legal representative from the judicial viewpoint, and who can best estimate the intention of the resident, are targeted in this study, and recognition of the expansion of the discretionary authority of nurses in elderly care facilities was clarified. This article discusses the results of this survey.

In addition, the author would like to consider how to utilize high level practicing nurses, who have greater discretionary capability than general nurses, in a comprehensive community care system by carrying out an awareness survey on users of medical services and their families, and the on-site nurses, from viewpoint of citizen participation in the establishment of policy. Contents included in this article are part of the survey study carried out to obtain basic resources required for this consideration.

I. Definition of Terms

1. "Medical practice"

"Medical practice" refers to activities of the medical nature, such as examinations for clinical diagnosis, judgment to carry out tests, and treatment (including the prescription of medicines), which are considered to lack safety if carried out by a general nurse.

2. "Expansion of the discretionary authority of nurses"

The authority to perform activities of the medical nature as described above is granted to nurses.

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II. Study Methods

1. Study Design

After thoroughly understanding the general condition of family awareness using a questionnaire, more specific opinions are surveyed by a semi-structured interview.

2. Survey subjects and Data collection method

1) Questionnaire Survey

Screening of questionnaire monitors throughout Japan held by a major survey company in Japan (INTAGE Inc.) is carried out under the criteria of "having a relative by blood or marriage in a long-term care health facility or senior home (special elderly nursing home, nursing, light expense, or charged). From this, 396 persons were randomly abstracted from 9,035 monitors who satisfied the criteria, and were given a questionnaire, which includes a description of the purpose of the study, methods, and meanings.

2) Semi-structured interview

Through the questionnaire, families who could be interviewed were requested. As a result, cooperation from 104 family members could be obtained. Next, whether an actual meeting with the interviewers at the survey site in Tokyo would be possible or not was confirmed for 104 family members by telephone, and written and verbal description of consent was provided to families who were considered to appropriate for the purpose of this survey. Semi-structured interviews were carried on 5 family members from whom consent was obtained.

3) Survey Period

- Questionnaire Survey December 2013
- Semi-structured interviews January -March 2014

3. Survey Contents

1) Questionnaire Survey

- Family Attributes (gender, age, occupation, residence)
- Resident Attributes (gender, age)
- Frequency, place and main reason why the residents receive an examination by a physicians
- Does the resident receive 24 hour, 365 day response medical care service from a physician?
- What problems will be caused if the users cannot receive 24 hour 365 day response medical care service from a physician?
- Acceptance or rejection of nurses performing a medical examination for diagnosis and conditions for implementation
- Depending on the condition of the residents, Acceptance or rejection of the nurse determining whether an examination should be carried out, and the conditions for implementation
- Acceptance or rejection of diagnosis by nurses to determine if drug prescription is needed for treatment, and the conditions for implementation

2) Semi-structured interviews

An interview for the following contents, including the conditions to use elderly care facilities and their impression of the facilities, was carried out.

- Family Attributes (gender, age, relationship to the resident)
- Resident Attributes (disease, level of nursing care, type of facility experienced by the resident, total years as resident)
- In cases where receiving medical care by a physician in a facility is necessary but assumed as not possible, what problems, anxieties and sacrifices are expected in the life of the residents
- In cases where receiving medical care by a physicians is desired or should be received, but assumed as not possible, do they want the nurses to provide medical care (examination, judgment whether to implement an examination, drug prescription, and medical treatment)?
- The reason why "medical care by nurses is acceptable," and "medical care by nurses is better," was given as a response regarding medical care by nurses, and condition to allow such medical care
- The reason why "medical care by physicians is definitely better," was given as a response for medical care by nurses
- The reason why "either medical care is fine" was given as a response for medical care by nurses
- In cases where medical acts are presumed to be carried out by nurses, among the conditions of "specific direction by a physician," "comprehensive direction by a physician," and "direction of a physician is not necessary", which is most demanded?

4. Analysis method

1) Questionnaire Survey

For description and estimated statistics, IBM SPSS Statistics Ver. 22 (including Exact test) software for statistical analysis was used. In addition, in the implementation of estimated statistics, 9,035monitors of the survey company who satisfied the criteria for the survey were presumed as the parent group, and independent chi-square test or Fisher's accuracy probability test were carried out. Cramer's coefficient was calculated for correlation of variables showing family / residents attributes and medical care condition, and the variables showing recognition of medical care performed by nurses. Probability significance was set at less than 5%.

2) Semi-structured interviews

Discussion regarding the expansion of discretionary authority of the nurses was set as a verbatim report. Then, data segmentation was performed by underlining part which were considered to be important for the purpose of this study. Furthermore, concept names for lower abstraction levels were added to appropriately express the segmented part by using the expressions of the family as much as possible, while showing awareness to avoid reading with the prejudice or preconceived ideas of the researchers (encoding).

Next, division into concept groups with similar characteristics, and labeling to reflect the characteristics (sub-categorized) were carried out. Finally, for contents raised for the sub-categories (categorizing), labels were added for high abstraction level by gathering similar semantic contents.

The author repeatedly carried out reviews, while receiving supervision by a sociologist with extensive knowledge of qualitative research on the validity of the analysis results.

5. Ethical consideration

This study was approved by a research ethics review by the research institute to which the author belongs (Approval No. 25012, Approval Date: October 3, 2013). The purpose of this study, freedom to participate or withdrawal, and confidentiality of personal information were explained to those targeted as subjects. Moreover, an agreement for survey

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consignment was concluded with INTAGE Inc., and the survey was carried out with the exclusive survey staff according the survey plan prepared by the author. Survey data was owned by the author after a cosignment fee was completely paid.

III. Results

1. Results of the Questionnaire Survey

The number of valid respondents was 305 persons, with a valid response rate of 77.0%.

1) Attributes of family and residents

Gender of family members was almost equal, at 152 men (49.8%), and 153 women (50.2%). The age range was 19–76 years, mean age was 52.65 years. Gender of the residents was more female than male at 206 women (67.5%) and 99 men (32.5%). Mean age was 78.13 years (Table 1).

Table 1. Attributes of the family and residents (questionnaire)

n=305

Family	Gender (%)	Men	152(49.8)
		Women	153(50.2)
	Mean age ±*SD* (range)	52.65±11.35(19～76)	
	Occupation (%)	Civil servant / company workers	191(62.6)
		Full-time home makers	75(24.6)
		Unemployed / retired	31(10.2)
		Students	4(1.3)
		Others	4(1.3)
	Address (%)	Hokkaido / Tohoku region	11(3.6)
		Kanto region	216(70.8)
		Koshinetsu / Hokuriku region	7(2.3)
		Chubu / Tokai region	16(5.2)
		Kansai region	32(10.5)
		Chugoku region	5(1.6)
		Shikoku region	3(1.0)
		Kyushu / Okinawa region	15(4.9)
Residents	Gender (%)	Men	99(32.5)
		Women	206(67.5)
	Mean age ±*SD*	78.13±16.59	

2) With or without an environment to receive medical care by a physician when needed

The number of families who responded that they were in an environment where medical care by a physician could be received as needed, 24 hours, 365 days was 151 persons (49.5%), and the number of families who responded that they were not, was 154 persons (50.5%), almost same number. Of the 154 persons who responded that they were not in an environment to receive medical care by a physician when needed, 75 persons (48.7%) who were asked whether they "have trouble with not being able to receive medical care by a physician when they wanted" and responded "yes." As for one reason for trouble, more than 80% of the family answered "response to the sudden appearance of symptoms of the users."

3) Recognition of the medical practices performed by nurses

Table 2 shows recognition of medical practice performed by nurses by families of a resident living in an elderly care facility. Furthermore, subjects were divided into those who "unconditionally accepted," "accepted with conditions," and "refused," and the rates of each were clearly described.

More than 70% of the families showed recognition to accept the medical practice performed nurses with conditions. Moreover medical examinations for diagnosis by nurses, the rate of requesting conditions was high, such as "experience and acquired medical knowledge of the nurse," and "receive permission of a physician beforehand." For drug prescriptions, among the rate of requesting conditions, "receive permission of a physician beforehand" was the highest, followed by "experience and acquired medical knowledge of the nurse." In the recognition of "judgment whether to implement an examination", less than 80% of the families answered that such could be accepted with conditions. The condition supported with the highest rate was implementation "within the range of the permission of a physician beforehand." Also, recognition that such is acceptable when "implementation of examination in case of emergency," and "experience and acquired medical knowledge of the nurse" was observed.

The rate families accepted medical care with no conditions was 24.6%, 11.8% for drug prescription, and 10.2% for examination. On the contrary, the rate families answered that they wanted medical care by physicians was 3.6%, 17.0% for drug prescription, and 9.8% for judgment whether to implement an examination.

4) Relationship of recognition of medical practices performed by nurses, and attributes of the family and resident, and medical care conditions

Following data shown in Table 2, correlation between recognition of medical practices performed by nurses, and attributes of the family and residents, and medical care conditions, was summarized in a cross table, along with chi-square test or Fisher's accuracy probability test in Table 3, and then *Cramer's V measurement* was added.

Considering these estimated values, significant difference using the 5% standard was observed only in the correlation between gender of the family member and implementation of examination by nurses (p = .015). For the strength of this association, *Cramer's V* was .166. Regarding variables showing family attributes, frequency of medical care of the resident, with or without environment to receive 24 hour medical care by a physician, and recognition of medical care performed by the nurse, no conclusive correlation was observed in the results.

2. Results of the semi-structured interview survey

1) Attributes of the family and resident

Of the 5 family members who received an interview survey, two were women, three were men, and range of age was with the late 40s to the late 60s. Degree of nursing care need of the residents was 3 and higher, and experienced multiple facilities. Moreover, average years of residency in these facilities were approx. 6 years (Table 4). Average time for the interview was 48 minutes.

2) Recognition of the expansion of discretionary authority of nurses by families of residents in elder facilities

According to discussion on the expansion of the discretionary authority of nurses with the family, three categories and 13 sub-categories could be abstracted (Table 5). Hereinafter the categories are shown by【 】, and sub-categories are shown by [ ].

【Hope that expansion of discretionary authority of nurses connects to expansion of the medical service provision system】could be abstracted from 6 sub-categories. Some

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Table 2. Recognition of medical action performed by nurses (questionnaire)

n=305

Medical care performed by nurses	*n* (%)	Rate of Acceptance / Rejection	Drug prescription by nurses	*n* (%)	Rate of Acceptance / Rejection	Determining whether to perform an examination by the nurse	*n* (%)	Rate of Acceptance / Rejection
Unconditionally accepted	75 (24.6)	Unconditionally accepted 24.6%	Unconditionally accepted	36 (11.8)	Unconditionally accepted 11.8%	Unconditionally accepted	31 (10.2)	Unconditionally accepted 10.2%
Accepted if the nurse has many years of experience	13 (4.3)	Accepted with conditions 71.8%	Prescription can be accepted if the nurse has many years of experience	13 (4.3)	Accepted with conditions 71.1%	Can be allowed if the nurse has many years of experience	12 (3.9)	Accepted with conditions 79.9%
Accepted if the nurse has many years of experience, and acquired medical knowledge	79 (25.9)		Prescription can be accepted if the nurse has many years of experience, and acquired medical knowledge, such as medicine and pharmacy	52 (17.0)		Accepted if the nurse has many years of experience, and acquired medical knowledge	54 (17.7)	
Accepted if the medical care is 24 hours response	37 (12.1)		Prescription by nurses can be accepted if the medical care is 24 hours response	15 (4.9)		Accepted only when needed as emergency examination	55 (18.0)	
Accepted if less expensive than by a physician	6 (2.0)		Prescription by nurses can be accepted if less expensive than by a physician	7 (2.3)		Accepted if less expensive than by a physician	1 (0.3)	
Accepted if the nurse is frequently involved	21 (6.9)		Prescription if the nurse is frequently involved	14 (4.6)		Accepted if the nurse is frequently involved	20 (6.6)	
Accepted if approved by a physician beforehand	48 (15.7)		Prescription by nurses can be accepted in the range of permitted by a physician beforehand	116 (38.0)		Examination can be permitted in the range of specified by a physician beforehand	102 (33.4)	
Accepted if symptoms are stable	15 (4.9)		Strong desire drug prescription by a physician	52 (17.0)	Reject 17.0%	Strongly desire judgment of implementation performed by a physician	30 (9.8)	Reject 9.8%
Wish to have medical care performed by physician	11 (3.6)	Reject 3.6%						

families, while seeking rapid response by the facility in cases of poor resident condition and painful symptoms, showed the possibility that nurses could contribute to this matter. From these codes, [Expectation to contribute to the easing of pain of the resident] could be configured. Furthermore, in cases where the resident requires a medical examination at the hospital, there is concern that much time would be needed to receive such medical care and lead to physical burden and worsened symptoms of the resident. To address such cases, medical practices by nurses is expected to expand and enhance medical services of the facility. Hence, the sub-category [Expectation leading to the reduction of burden of the residents] could be abstracted. Some families felt burdened by the situation where facility will call each time the resident of the elderly care facility needs to visit the hospital, and must go to the hospital with the resident. Even in cases where the facility staff goes to the hospital, the families are faced with the financial burden of being separately billed for medical fees which are not included. As a result of expansion of medical services in the facility by medical practice of the nurses, the families have the [Expectation of reduced burden on the resident].

Moreover, worries regarding further loss of cognition and muscle power due to hospitalized treatment, and feelings that expansion of medical services are needed, and fear that [Quality of life in the facility will be reduced by hospitalization], leads to the approval of medical care implemented by nurses. In addition, for the residents, since the elderly care facility is where they live, they would like to receive medical services at the facility where they are accustomed. Hence residents, indicate approval of expansion of the discretionary authority of nurses in response to [Medical services needed where residents live].

All five family members spoke about their plans for end-of-life of the residents in the facility. If expansion of the discretionary authority of nurses is carried out with the purpose of supplementing [Expansion and enhancement of end of life medical service in elderly care facilities], this measure is considered to match trends of the generation.

In addition to realizing the above described requests through the expansion of the discretionary authority of nurses, families showed five【conditions to bear medical practices】. One condition is [clarification of the medical range carried out by nurses]. Determining to what degree medical practices the nurses are permitted to carry out is considered important, and the need to divide medical practices by the

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Table 3. Relationship of recognition of medical care performed by nurses, and attributes of the family and residents, and medical care conditions

		Medical care performed by nurses					Drug prescription by nurses					Determining whether nurses should perform examinations				
		Unconditionally accepted	Accepted with conditions	Strong wish to have medical care performed by physician	*Cramer's V*	Probability significance[a]	Unconditionally accepted	Accepted with conditions	Strong desire for drug prescription by a physician	*Cramer's V*	Probability significance[a]	Unconditionally accepted	Accepted with conditions	Strong desire to have judgment by a physician	*Cramer's V*	Probability significance[a]
Gender of the family member (*n*=305)	Men	44 persons (28.9%)	101 persons (66.4%)	7 persons (4.6%)	.119	.111	23 persons (15.1%)	105 persons (69.1%)	24 persons (15.8%)	.104	.191	23 persons (15.1%)	116 persons (76.3%)	13 persons (8.6%)	.166	.015*
	Women	31 persons (20.3%)	118 persons (77.1%)	4 persons (2.6%)			13 persons (8.5%)	112 persons (73.2%)	28 persons (18.3%)			8 persons (5.2%)	128 persons (83.7%)	17 persons (11.1%)		
Age of the family member (*n*=305)	Less than 50 years	17 persons (16.7%)	83 persons (81.4%)	2 persons (2.0%)	.112	.099	13 persons (12.7%)	73 persons (71.6%)	16 persons (15.7%)	.043	.893	10 persons (9.8%)	82 persons (80.4%)	10 persons (9.8%)	.007	.999
	50-64 years	47 persons (28.8%)	108 persons (66.3%)	8 persons (4.9%)			19 persons (11.7%)	117 persons (71.8%)	27 persons (16.6%)			17 persons (10.4%)	130 persons (79.8%)	16 persons (9.8%)		
	65 years or older	11 persons (27.5%)	28 persons (70.0%)	1 persons (2.5%)			4 persons (10.0%)	27 persons (67.5%)	9 persons (22.5%)			4 persons (10.0%)	32 persons (80.0%)	4 persons (10.0%)		
Frequency of regular medical care by physician for the residents (*n*=256)	1 time or more / month	39 persons (23.9%)	116 persons (71.2%)	8 persons (4.9%)	.061	.899	18 persons (11.0%)	112 persons (68.7%)	33 persons (20.2%)	.090	.368	12 persons (7.4%)	133 persons (81.6%)	18 persons (11.0%)	.078	.647
	Approx. once / 2-3 months	4 persons (19.0%)	17 persons (81.0%)	0 persons (0.0%)			3 persons (14.3%)	15 persons (71.4%)	3 persons (14.3%)			1 persons (4.8%)	19 persons (90.5%)	1 persons (4.8%)		
	Carried out as needed	18 persons (25.0%)	52 persons (72.2%)	2 persons (2.8%)			6 persons (8.3%)	58 persons (80.6%)	8 persons (11.1%)			9 persons (12.5%)	57 persons (79.2%)	6 persons (8.3%)		
(for the residents) With or without an environment to receive medical care by a physician in a timely way, 24 hours (*n*=305)	Yes	38 persons (25.2%)	107 persons (70.9%)	6 persons (4.0%)	.024	.910	18 persons (11.9%)	109 persons (72.2%)	24 persons (15.9%)	.030	.868	16 persons (10.6%)	123 persons (81.5%)	12 persons (7.9%)	.063	.544
	None	37 persons (24.0%)	112 persons (72.7%)	5 persons (3.2%)			18 persons (11.7%)	108 persons (70.1%)	28 persons (18.2%)			15 persons (9.7%)	121 persons (78.6%)	18 persons (11.7%)		

Note 1) a= chi-square test or Fisher's accuracy probability test
Note 2) * : p <0.05
Note 3) "Frequency of regular medical care by physician for the residents": Due to residents who did not receive medical care by physician in past six month

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Table 4. Attributes of the family and resident (Semi-structured interview)

No.	Gender of the family member	Age of the family member	Relationship to the resident	Disease of the resident	Degree of nursing care needed by the resident	Type of facility experienced by the resident	Total years as resident
1	Woman	Late 40s	Daughter-in-law	Mental disorder / dementia	5	Nursing Elderly Health Facilities Special elderly nursing homes	Approx. 3 years
2	Woman	Late 40s	Daughter	Respiratory disease / dementia	4	Nursing Elderly Health Facilities Special elderly nursing homes	Approx. 5 years
3	Man	Early 50s	Son	Cerebrovascular diseases/ dementia	5	Nursing Elderly Health Facilities Special elderly nursing homes	Approx. 5 years
4	Man	Late 50s	Son-in-law	Bone / muscle diseases / dementia	3	Nursing Elderly Health Facilities Special elderly nursing homes Charged senior homes	Approx. 7 years
5	Man	Early 60s	Son	Cerebrovascular diseases/ left side paralyzed	5	Nursing Elderly Health Facilities Special elderly nursing homes	Approx. 10 years

physician and those permitted to be performed by nurses must be pointed out. Next, the condition that [Education and training which corresponds to bearing medical practices is required] has been indicated for nurses to bear new medical practices, even in coordination with a physician, while recognizing that [Coordination with the physician is essential] by some kind of direction by the physicians. As the fourth point, some families consider [Placing responsibility only on the nurses is not realistic]. The reasons for this are; since a high emotional burden is placed on nurses, an increase in the number of nurses able to bear high level medical practices cannot be expected, and in addition to dividing responsibilities will be advantage of the nurses, there was recognition that there is a sense ease if responsibility is placed both on the nurses and the physician. The last condition is the opinion of [hope that the nurses maintain the attitude to fulfill the responsibilities associated with implementation of medical practice]. If nurses with new authority are created, it is hoped that they are prepared to bear the responsibilities. In addition, the families said that they think that persons who bear the medical practice should be evaluated by the responsibilities they bear, rather than as physicians and nurses.

Some families feel there is a need to implement【measures to address the lack of manpower in elderly care facilities】. Including concern as to whether sufficient nursing care of the residents is provided, the families have [dissatisfaction in the quality of care itself due to the lack of manpower] since facility staff changes so often. Furthermore, concern that nurses with extensive knowledge and high skills will soon leave, could be seen since [low facility retention rate of nurses and the nursing staff] was significant. Nurses who bear high level medical practices may not stay at the elderly care facility, as long as no fundamental measures are taken for the nurses and care workers to stay at the facilities.

IV. Discussion

1. Expectation of improvement in the quality of life of the resident and family

Disease composition of the residents in elderly care facilities has diversified, and residents with chronic disease have significantly increased. Regarding recent trends, cases of residents entering a facility right after completing acute phase treatment at a hospital, and those with care needs during end of life in the facility have increased. However, it is also indicated that maintenance of the environment to provide services which comprehensively understand the health condition of the residents is insufficient, while focusing on the support of the life of the residents (Hirose, 2012, pp.314-316). When describing this condition, about half of the families answered that the resident is not in an environment where they can receive medical care by physician when needed, as shown in the results of the questionnaire survey of this study. Request for further improvement in qualitative service at the facility could also be heard in the interview survey results.

The family may predict that if the medical practice of the nurses leads to expansion of medical services at the facility, this would lead a reduction in the burden of the family. Recognition to approve expansion of the discretionary authority of nurses was shown in the desire【Hope the expansion of discretionary authority of nurses leads to expansion of the system to provide medical services】, because sufficient satisfaction of current services at the elderly care facility has not been achieved.

Hence, maintaining an environment in order to enhance and expand medical service at the facility is required to ensure the life of residents in the place where they have lived for a long time. The expansion of discretionary authority of nurses is a part of such maintenance. If medical practice based on the accurate symptom management leads to improvement in symptoms and relief of pain of the residents, at least has the possibility of avoiding a burdensome visit to the hospital.

2. Reasons for the family to value the nurses

Some families perceive nurses as a close presence. Furthermore, it is clear that the potential needs of the implementation of medical practices of nurses can be extracted.

Why does the family perceive nurses as a close presence? One reason can be said to be the strong “closeness” between the family and the nurses.

Reasons for the goodwill and attractiveness in this human relationship are accessibility, physical attraction, similarities, complementarity, reciprocation of goodwill, etc. By simple repetition, familiarity with one another increases, and as a result, develops into goodwill.

Moreover, Wakimoto and Fujiwara indicated the phenomenon

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Table 5. Recognition of the expansion of discretionary authority of nurses by families and residents in elderly care facilities (Semi-structured interview)

Category	Sub-category	Code
Hope that expansion of discretionary authority of nurses connects to expansion of the medical service provision system	Expectation to contribute to the easing pain of the resident	Because I want something to be done as soon as possible in cases of painful symptoms such as "the injury hurts," "can't eat because I don't feel good," if the nurse on hand can provide medical care, it will be helpful.
		When I visit, I frequently observe bad condition (of the resident) and inform the facility staff, but they only respond as "I tell (the physician) on the next visit," but it doesn't appear any kind of treatment was provided. So I want the nurses or someone to provide some kind of treatment.
		Because (the resident) himself/herself and family want to relieve pain which hinders the life that suits the resident, so won't they understand if something happens as a result of medical practices by the nurse?
	Expectation leading to the reduction of burden of the resident	Especially when in a bad condition and the resident requires a medical examination at the hospital, there is concern that much time would be needed to receive such medical care and lead to physical burden and worsened symptoms of the resident. To address such cases, medical practices by nurses are expected to expand and enhance medical services of the facility.
		The resident is not in the condition to receive medical care although he or she wants to, taking the person to the hospital for medical care "because here is not a hospital" is incorrect.
		Although being in a facility with a view of emergency response, it seems that a quick response for the symptoms is not provided, so I want medical care by nurses to lead to solution of the present situation.
		As long as there are aged people with disease, I think facilities which provide medical care will be needed more than ever. I would accept the expansion of discretionary authority of nurses to do so.
	Expectation leading to the reduction of burden of the family	The facility calls each time the resident needs to visit hospital, and requests for the family accompany the resident to the hospital. It is a large burden. If nurses can provide medical care at the facility as much as possible, the family would also appreciate it.
		Sometimes the family asks the facility to judge whether the resident should go to the hospital or not. If high level nurses are needed for this judgment, it should be established.
		The facility additionally bills us for medical expenses every time the resident needs to go to the hospital. I want medical care response to be expanded within the facility, so if the nurses can play an active roles in this, I want such nurses to be trained.
	Quality of life at the facility will decrease by hospitalization	If the resident is admitted to the hospital, the problem may get better, but dementia and muscle power will decrease, and quality of life of the person will be reduced after returning to the facility, so an environment in the facility which can respond should be organized as much as possible.
		When (the resident) is admitted to the hospital for treatment of disease, response clearly worsens, maybe due to the change in the environment.
	Medical service needed for the residents to live	Symptoms such as fever, etc. occurred regularly, so the facility where the resident lives should respond to a certain degree.
		The facility considers the life and comfort of the resident, so I want the facility to provide medical care if possible. I can agree to the expansion of discretionary authority of nurses for this reason.
		The resident essentially hates hospitals, and wishes the facility where the resident lives for a long time can treat diseases and symptoms to some degree. If expansion of the discretionary authority of nurses is needed, it should be carried out as soon as possible.
	Expansion and enhancement of end-of-life medical service in elderly facilities	Medical care to minimize pain during end-of-life is needed. I think expansion of authority for not only physicians, but also participation in medical care by nurses who are close to the resident, is the natural progression in this generation.
		End-of-life care at elderly facilities is considered to increase from now, so I think it is important for facilities to have system to provide a certain degree of medical care, not only hospital.
Conditions for nurses to bear medical practices	Clarification of the range of medical practices performed by nurses	Determining to what degree nurses are permitted to carry out medical practice is considered important, and dividing medical practices which can be performed only by the physician and those which can be performed by nurses should clearly identified.
		When the condition of the (resident) does not change, and changes in medication are not needed, I think the nurses can also handle this.
		The mechanism that physicians perform things that only a physician can do, and nurses bear things which nurses can also do, is considered needed. If these roles can be clearly differentiated, I don't think this would be a problem.
		I think there is big gap between medical practices for internal organ diseases, and minor symptoms occurring in daily life. For drug prescription and treatment of minor symptoms, I think nurses can also handle it.
	Coordination with physician is an essential condition	For medical practices performed by nurses, I want such medical care to be performed under the direction of a physician.
		Final judgment regarding medical care should be carried out by a physician. Instead of the idea of medical practices being carried out as determined by the nurse only, it would be better to consider how to focus on smooth coordination with the physician.
		The range of medical practices for nurses to perform can be expanded, but I want a mechanism where the physician can make the final judgment on the validity of the medical practices.
	Require education and training which corresponds to bearing medical practices	A method that grants certification to participate in clinical training which is carried out for physicians, also to nurses who have certain clinical experience should be considered.
		New authority can be granted to the nurses who have a solid education and training, not nurses as they are now.
		Nurses have not been educated to make diagnoses and to prescribe medicine, so education in order to bear new medical practices is needed and should be firmly provided.
	Placing responsibility only on the nurses is not realistic	Allowing nurses to bear the responsibility on their own is practically impossible. Even if it does occur, I don't think many people will want to be a nurse who must bear such high level medical practices.
		I wish that both physicians and nurses have positions of responsibility. For nurses, it is better to perform medical practices under some kind of direction of the physician.
		When thinking about the mental burden on nurses, performing medical practices where the responsibility is placed only of them seems impossible. As a family member, I feel it would be better if the physician bore responsibility.
	Hope that the nurses maintain an attitude to fulfill the responsibilities associated with the implementation of medical practices	Instead of thinking only within the range of the physicians and nurses, persons who bear the medical practices should be evaluated.
		If the nurses are given new authority, I want them to be prepared to firmly carry the responsibilities.
Measures to address the lack of manpower in elderly care facilities	Dissatisfaction in the quality of care due to the lack of manpower	If the facility staff changes often, I worry if resident received sufficient nursing care, so ensuring enough staff members should also be considered.
		(The resident) is always in bed. This may be due to few staff members, so I worry if dementia and loss of muscle power will worsen.
	Low facility retention rate of the nurses and the nursing staff	I think the caregiving staff and nurses are not treated well, and the staff changes so often. I worry if good nurses can be retained in such workplace.
		At workplaces with a low retention rate, I think kind nurses with extensive knowledge and skill will quickly leave.

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where "Within the reasons as to why the other person has the same attitude, confirmation of validity of one's own attitude can be raised, and this comfortable emotional reaction connects to gaining familiarity" (1997, pp. 85-96). Consideration of self, rather than consideration of others, is a strong motivation in self-approval. High communication skills are needed to acquire and maintain such self-approval (Okegawa, 2011, pp.23-34). Furthermore, to manage and maintain a close relationship, communication which reflects considerations such as seeking self-disclosure, expressing acceptance and respect of the other person, and expressing one's feelings to develop a mutual relationship, are required (Daibou, 2004, pp.1-10).

Truly, communication skills based on the above described points exist in the life assistance by nurses. For example, showing a sympathetic attitude as an attitude of understanding of the pain of the residents, and intentionally praising the resident by finding his or her good points, in order to raise improve one's ability such as empowerment and self-management. One aspect of sharing problems and suffering with the residents and family is a basic attitude of nursing care.

Hence, nursing is a medical expert job with high familiarity, and requires relative medical practices and life assistance, the family is considered to find presence value in those who could bear medical practice.

3. Conditions for nurses to bear medical practice

Results of questionnaire survey showed a tendency of non-approval for discretionary authority without conditions, even though there is leeway in the acceptance of medical practices by nurses. Furthermore, the interview survey could clarify some reasons why such discretionary authority with conditions is preferred. The main reason is concern for safety in medical practices performed by nurses.

Families consider safety to the maximum limit, and demand a clear distinction in medical practices which should be performed by a physician and those which can be handled by nurses as well. Furthermore, the need to coordinate with physician is also pointed out. Accordingly, the author considers that current recognition of the family is that they do not want to medical practices to be decided and practiced only by the judgment of the nurse. Don't they want a system that can ensure a safe and secure life at the facility more than ever, by determining team medical care established on multi-occupational cooperation, and selecting nurses as candidates of human resource? Hence, regarding medical practice performed by nurses, the need for coordination with the physician is high.

Kitahama (2011, pp.292-294) and Takahashi (2011, pp.354-357) indicated that there is a difference in the level of knowledge and skill in medical care when comparing nurses in Japan and Nurse Practitioners and Physician Assistants in the U.S. Nurses in Japan have not received fundamental education regarding medical care operations such as diagnosis and treatment. From the legal viewpoint as well, these cannot be carried out as part of daily operations. In other words, there is no contradiction by the existence of both evaluations for nurses in Japan. This means that because nurses do not have sufficient knowledge and skill to bear medical practice, the appropriate education and training will be needed if new discretionary authority is given to nurses.

Perhaps because families are aware of this point, they request education and training which is appropriate to bear medical practice for operations performed by nurses. They are considered to judge "conventional knowledge and skill held by the nurses cannot ensure safe medical practice." Furthermore, there is a tendency not to completely reject the fact that some nurses can bear medical practice. It may be that the families can sense the possibility that such a nurse training education system will connect to safe and effective medical service.

Regarding another condition, some families showed recognition that [Placing responsibility only on the nurses is not realistic].

Clarification of responsibilities assigned to medical practice of the nurses is an important issue of this political measure. In addition, the families themselves do not wish to make snap decisions and leave this point unclear.

In case an unexpected event occurs to a resident due to the medical practice of a nurse, provisions such as "professional negligence resulting in bodily injury" and "professional negligence and involuntary manslaughter" of Penal Code, and "illegal acts" and "non-fulfillment of obligation" in Civil Code can be applied.

Recently, the number of medical lawsuit cases have drastically increased, and the number of cases under dispute in local court is approximately 3,000 cases (Koizumi, 2009, pp.113-119). One reason for this increase is that, although wonderful achievements have been made in modern medicine in many ways, and invasive examinations and treatment methods have decreased due to progress in medical techniques, there is also growing public awareness that receiving medical services does not guarantee a good result (Koizumi, 2009, pp.113-119).

The author is concerned that under the current conditions, accelerating the medical practice of nurses may increase the number of medical lawsuits. Families who may wish to sue nurses who cannot be said to have a high social status, who fail to fulfill the obligations of the medical contract existing between the service provider and receiver, are predicted to increase, in addition to feeling that medical practice by underdeveloped knowledge and skill has a high possibility of leading to failure. Some families are thought to show recognition that [Placing responsibility only on the nurses is not realistic], since they cannot remove all doubt that if nurses in charge of providing safe medical practice will not be held responsibility for "illegal acts" and "non-fulfillment of obligation," can they be accountable for implementation, and be liable in cases of lost lawsuits?

Some families want [nurses who maintain the attitude to fulfill the responsibilities associated with implementation of medical practice]. If the discretionary authority of nurses is expanded, the range of responsibility to be carried out will also be expanded. Nurses who accept this medical practice and are prepared to accept this responsibility are approved. Moreover, because safety is highly valued, nurses who have confidence and have prepared all the processes of implementation, are supported.

Hence, as a condition of expansion of the discretionary authority of nurses, this authority should be given to nurses who have a conviction called "a sense of mission," shouldn't it? Moreover, to bear medical practice, having this qualification or not should be evaluated by the educational agency, etc. Furthermore, consideration of an educational program to develop this quality also corresponds to an important point of focus.

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4. Concerns regarding lack of manpower at elderly care facilities.

Some families feel the need to take【measures to address the lack of manpower in elderly care facilities】in order to retain nurses who bear a large part of medical practice in elderly care facilities.

Shimazaki (2013, pp.333-340) predicted the "when estimating the percentages of the labor population in 2025, the nursing staff will be 3.1%, caregivers 3.9%, and overall staff in the medical and nursing field will be 10.2%." Furthermore, for the labor population who can bear medical and nursing care must remain at approx. 10% of the total population, measures to ensure human resources with a realistic viewpoint and to increase these numbers are needed. Also the point that good human resources will not be attracted if the appeal for nursing and care giving jobs is relatively low in the labor market and it is difficult to prevent leaving a job and reappointment to a job.

In other words, improvement and standardization of educational standards of nursing and caregiving jobs are needed, and setting a payment suitable for the labor is also needed. How the national budget can be distributed to these fields is thought to influence improvement in elderly care facility functions demanded by society.

5. Relationship of recognition of medical care performed by nurses, caregiving conditions, etc.

Regarding the correlation between recognition of medical care performed by nurses, attributes of the family and resident, and medical care conditions, only the gender of the family member and recognition of judgment to carry out examinations was significant according to a 5% standard. Moreover, *Cramer's V* was .166, so this correlation is considered to be negative. Also, between other variables, estimated values cannot be said to necessarily be related, are shown. The following points regarding the results are pointed out by the author.

One value of medical service held by most families is the recognition that no other job can practice medical care better than that of the physician. However, families also predict that, with the expansion and enhancement of medical service as a result of increase in the discretionary authority of nurses, there is a possibility of connecting to better service with higher convenience for the residents in elderly care facilities and their family. Hence they support [clarification of the medical range carried out by nurses] and [Education and training which corresponds to bearing medical practices is required], in addition to coordination with physicians and diffusion of medical practice responsibilities as conditions for nurses to bear medical practice, and think that, if these conditions can be met, they will lead to stable services and not cause safety issues. In other words, it was presumed that because families value medical service which is not affected by conditions of medical care of the residents and attributes, etc. of the residents and family, so the correlation between their recognition for the medical care performed by nurses, and caregiving conditions, etc. is connected to rejection.

6. Limits and Issues of the results of the survey results

Regarding respondents of this survey, there is bias in the occupation and address of the family cooperating in the questionnaire survey, in addition to a major survey company carrying out monitoring. Furthermore, the number of family members targeted in the semi-structured interview survey was five persons. In consideration of these points, when families with residents in elderly care facilities throughout Japan are presumed to be the survey target group, selection bias towards recognition of the expansion of discretionary authority of nurses cannot be denied. Consideration of a survey method which minimizes bias of the respondents is needed in the future.

Conclusion

Regarding the expansion of discretionary authority of nurses, clarifying recognition by families with residents in elder facilities is set as the goal of this study, and a questionnaire survey and semi-structured interview survey were carried out. As a result, the following conclusion was obtained.

As a result of the questionnaire survey, the rate of families who show intention to approve expansion of medical practice performed by nurses with conditions was more than 70%. Furthermore, as a result of consideration of the interview survey results, three points were shown as the outcome expected by the families, namely 1) connection with increase in peace of mind and convenience for the resident and family, 2) connection to the service that values the life of the residents, and 3) connection to the expansion and enhancement of terminal phase medical care.

Regarding conditions indicated by the families, five points were raised, as 1) thorough education and training which corresponds to bearing medical practice, 2) practice based on coordination with the physician, 3) delegation of responsibility of medical practice, 4) nurses who have attitude to complete the responsibilities associated to implementation of medical practice, and 5) clarification of the range of medical practice performed by nurses. The reason why these conditions appeared is that families do not want for nurses to decide the details of the medical practice and perform it only by judgment by the nurses from the viewpoint of safety, and they wanted to establish a system which could ensure a safe and secure life at the facility more than ever, by establishing team medical care based on multi-occupational cooperation.

Due to the above reasons which can be said to be the viewpoint of how medical service was valued, these are thought to connect to the rejection in the correlation between recognition of the medical practices performed by nurses, attributes of the families and the residents, and medical care conditions.

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