

高齢者の「予想される死」の援助場面における グループホーム看護師による「呼吸停止確認」の現状

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Respiratory arrest confirmation by group home nurses in their supporting scenes of an older adult's expected death

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Abstract

To elucidate respiratory arrest confirmation for expected deaths of older adults, we administered a mail-in questionnaire survey of nurses at group homes for older adults with dementia (GHs). Nine nurses responded (6% response rate). We qualitatively analyzed free descriptions.

Two nurses had conducted respiratory arrest confirmation. Five had not. Two categories of reasons why nurses experiencing it advocated respiratory arrest confirmation were “Because a physician is likely to be late, nurses can deal with a death watch” and “nurses have the ability to explain it to their family members.” A category of reasons for selecting “yes and no” was “Given the situation, it is not unavoidable.” However, a category of reasons why nurses with no respiratory arrest confirmation experience “objected” to it was “Death certification is the responsibility of a physician.” Categories of reasons for “yes and no” responses were “I do not know it because I have never experienced it or I have no opinion,” “I lack the confidence to do it,” and “it varies depending on the place to do a death watch.”

Results suggest that respiratory arrest confirmation in GHs should require circumstances under which physicians are always with a patient, or should require that a late physician confirm the death and explain it to the family.

Key words : expected death, respiratory arrest confirmation, group homes, nurse,
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I . Introduction

Given the rapid aging of the population and extremely low birthrate, Japan is expected to confront an unprecedented super-graying society with a higher rate of mortality than the world has ever seen. The population is expected to continue to age further by 2025, when the baby boomer generation will become over 75 years old ¹⁾.

To the present day, although physicians eligible to write a death certificate according to Medical Practitioner Act have been by older adults' bedside on a round-the-clock basis when a person dies, the Health, Labour, and Welfare Ministry conducted a "review of regulation related to deathwatch in home-based care" in 2015. On September 28, 2016, the Cabinet Office announced easing of regulations related to death certification to reform those related to deathwatches in home-based care²⁾. As stated, after a physician and a nurse mutually communicate sufficiently, such as having prearrangement of steps to take in the terminal phase, and after gaining a consensus from the patient and the family, then a nurse can confirm the patient's death. Furthermore, on September 12, 2017, the ministry notified governors of respective prefectures about how to address death certificates and other matters using information communication technology (ICT). Those changes have brought heightened attention to how deathwatches should be conducted in daily life scenes. Above all, care related to nurses' death certification has been an important issue related to old adults' peaceful way to die. Additionally, nurses' medical practices have expanded rapidly as the training of nurses' special practices has developed nationwide³⁾.

However, since the nursing insurance system was introduced, as older adults have come to select more various places to live, needs have never been higher for end-of-life care health facilities, nursing homes for elderly people, and group homes for elderly people affected by mild dementia (hereinafter, GH; nursing homes for elderly people with dementia) ⁴⁾. Among them, GHs have increased rapidly nationwide to more than 13,000 because of reform of the Long-term Care

Insurance Act passed in 2005⁵⁾. Because they have targeted elderly people with mild dementia, they are characterized by their main users, whose level of care needed is 2-3⁴⁾. However, because more families are likely to want older adults to live in their familiar GHs to their death without their life prolonged⁴⁾, they are expected to conduct death watch duties actively to meet those needs in addition to more serious levels of needed care or end-of-life care⁶⁾, which suggests that care related to death certification by nurses will also be an important issue in GHs.

For daily life scenes such as home and facilities for elderly people, earlier reports have described that death which can be certainly expected from the progress of disease (i. e. expected death) has been partially confirmed by a nurse of the death watch system, with death caused by rapid situation changes or accidents and abuse excluded as difficulties ⁷⁾. Furthermore, our studies of respiratory arrest confirmation in scenes of supporting older adults in their expected death or needs for end-of-life care education targeting the authors' home-care nurses and nurses working for long-term care health facilities or welfare facility for elderly people ⁸⁻¹⁰⁾ revealed that nurses do virtual confirmation of death by confirming their patient's cardiopulmonary arrest, respiratory arrest, explaining them to the family, and providing bed baths before a physician arrives at the patient's bedside. Moreover, at long-term care health facilities and welfare facilities for elderly people, the death watch process is maintained by middle-aged nurses. In fact, 20 (32.3%) of 62 nurses who responded about respiratory arrest confirmation conducted it as a routine activity ^{8, 9)}. The time period during which they conducted a death watch was often on weekday nights or on weekends, when doctors were absent. Furthermore, even if the respiratory arrest confirmation was understood and supported by the family of an elderly person, nurses themselves perceived ethical or emotional difficulties such as whether they allowed to announce a person's end of life^{8, 9)}. With GHs, however, although earlier researchers have examined death watches^{11,12)}, few have actually targeted nurses. For that reason, the actual situation of and consciousness about respiratory arrest

confirmation remain unclear. To support older adults' peaceful death and death as what completes their life¹³⁾, one must elucidate the current circumstances and issues in the scenes of GHs, for which social needs have been expanding in recent years.

Consequently, this research, targeting nurses of GHs, was conducted to elucidate the current situation and issues of respiratory arrest confirmation by nurses when supporting older adults in cases of imminent, expected death.

II. Definition of terms

As terms related to death confirmation or death certification, "respiratory arrest confirmation," "cardio-respiratory arrest confirmation," "death confirmation," "death certification," and "certificate publication" are currently used. Their definitions are vague. Consequently, for this study, we define respiratory arrest confirmation as a package of processes related to practical death confirmation, such as explaining a patient's respiratory arrest (one of three major indicators of death) to the person's family and starting to perform the last duties such as end-of-life care before the physician arrives at the bedside. That is true because the description of death confirmation was not considered appropriate in the present situation in which nurses are not legally eligible to confirm their patient's death.

III. Research methods

1. Research participants and methods

As of October 1, 2012, facilities currently in operation among GHs across the country are 11,770, according to research investigating care service facilities and business facilities conducted by the Health, Labour, and Welfare Ministry in 2012. Randomly extracting 150 GHs registered on the web page of a society of GHs for elderly persons with mild dementia, we chose one from each facility's nurses who had consented to participate in our study.

As the method, we conducted a mail-in questionnaire survey. We mailed a questionnaire to a

nurse at each facility to ask that they select one nurse interested in death watch studies. Then we asked the nurse to respond to the anonymous questionnaire and return it to us. The research period was January-February in 2015.

2. Research contents

1) Subjects' basic attributes

As participants' basic attributes, they were asked about sex, age, length of career in bedside nursing, length of career in GH nursing, acquired certification, and career nursing education. To assess their career nursing education, we asked specifically about whether they had received training from nursing education or "respiratory arrest confirmation."

2) Whether respiratory arrest confirmation is conducted and whether the participant agrees with it or not

We asked them whether they conducted respiratory arrest confirmation when supporting older adults in scenes of their expected death. When they conducted it, we asked them to select one item from the following and freely write the reasons: (1) I do not think that a nurse should do it; (2) I agree to it; and (3) Yes and no. When they did not, we asked them to select the following and freely write the reasons: (1) I think that a nurse should do it; (2) I think that a nurse may do it if conditions are met; (3) I disagree to it; and (4) Yes and no. Additionally, we considered the expression in the question items to help nurses to respond while imagining actual supporting scenes.

3) Significant points for nurses to do death watch and their opinions and views

We asked them to describe freely what they thought they should take care about when doing death watch duties, in addition to their opinions and views.

3. Analytical method

We conducted a simple tabulation of participants' basic attributes and their responses about whether respiratory arrest confirmation is conducted and whether they agree or disagree to it.

We received free descriptions of reasons why they agreed or disagreed to respiratory arrest confirmation,

Table 1: Basic attributes of subjects

		<i>n</i> = 9	
		<i>n</i>	(%)
Sex	male	0	(0.0)
	female	9	(100.0)
Age 1)	51.7±8.8 [42--70]		
Age distribution	40–49	5	(55.6)
	50–59	3	(33.3)
	over 70	1	(11.1)
Experience of bedside nursing	15 years and 2 months (2 years and 0 months to 30 years and 0 months)		
Experience of GH nursing 2)	4 years and 10 months (one year and 0 months to 11 years and 2 months)		
Acquired qualifications (multiple answers allowed)	Public health nurse	0	(0.0)
	Midwife	0	(0.0)
	Nurse	9	(100.0)
	Assistant nurse	0	(0.0)
	Certified nurse	0	(0.0)
	Nurse specialist (Dementia care)	1 (1)	(11.1)
Career of nursing education (Multiple responses allowed)	Nurse school	7	(77.8)
	Nursing junior college	2	(22.2)

1) Mean ±standard deviation (minimum value – maximum value)

2) Mean (minimum value – maximum value)

the points for them to do a death watch, and their opinions and views about it. After we carefully read what they freely described, we extracted the smallest units of description expressing their reasons and views on respiratory arrest confirmation to encode them and make categories based on similarities of meanings. To secure strictness and truth, they were conducted by three educational researchers specializing in the geriatric nursing field. The categories are put in square brackets and code in angled brackets.

4. Ethical considerations

We presented participants with documents related to ethical considerations, which stipulated the research idea, the object, the method, protection of personal data, freedom to refuse cooperation, and how to publish the results. Furthermore, we explained to them that we considered their return of the questionnaire as representing their consent. This research was conducted with the approval of the ethics committee of the Tohoku University School of Medicine.

IV. Results

1. Outline of participants

Nine nurses returned questionnaires with responses (collection rate is 6%). We treated them as participants for our analysis.

Their basic attributes are presented in Table 1. They are nine female nurses with average age of 51.7 ± 8.8 yr (42-70 yr), with an average of 15 years and 2 months experiencing bedside nursing and of 4 years and 10 months experiencing GH nursing. In addition, one participant had certification as a dementia care nurse specialist. Those with career nursing education were seven nursing school graduates and two nursing junior college graduates. No difference was found between those who received nursing education and for whom “respiratory arrest confirmation” was conducted at their GHs and whether they agreed with it or not.

2. Whether respiratory arrest confirmation by a nurse was conducted at their GHs and whether they agreed

Table 2: Benefits and shortcomings and reasons of nurses conducting “respiratory arrest confirmation”

(Number of codes, 3; number of responding nurses, 2)

Pros and cons (Number of responding nurses)	Category (Number of codes)	Code
a. (n=1) Agree	Because a physician comes late, a nurse can take steps. (1)	When a physician comes late, a nurse may do it under a physician's supervision.
	Nurses have ability to explain it to a patient's family. (1)	It is necessary to explain it sufficiently to the family; some nurses can do it.
b. (n=1) Yes and no	Given the situation, it is unavoidable. (1)	A physician does not reside there. Therefore, I have no option but to do it.

Table 3: Pros and cons and reasons by nurses not conducting “respiratory arrest confirmation”

(Number of codes, 5; number of responding nurses, 5)

Pros and cons (Number of responding nurses)	Category (Number of codes)	Code
a. (n=2) Disagree	Death certificate is up to the physician. (2)	<ul style="list-style-type: none"> • I think that a physician can write a death certificate because of qualifications. • I think it is the doctor's work.
b. (n=3) Yes and no	I have no idea because I have never experienced it. (1)	• I cannot judge it because I have never experienced a death watch.
	I lack confidence. (1)	• I will need to do so, but I have no confidence.
	It varies depending on the place to do it. (1)	• Though the procedure should be followed in a large hospital, it is on a case-by-case basis in home based care. It varies depending on the place.

with it or not

Two nurses had experienced respiratory arrest confirmation: (1) no one “thought that a nurse should do it”; (2) one “thought that a nurse agree to it”; (3) one selected “yes and no.” Five nurses had not experienced respiratory arrest confirmation: (1) no one “thought that a nurse should do it”; (2) no one “thought a nurse may do it if conditions are met”; (3) two “disagreed with it”; and (4) three selected “yes and no.”

Additionally, two nurses did not respond whether they had conducted respiratory arrest confirmation or not.

3. From the viewpoint of whether a nurse has conducted respiratory arrest confirmation, the participants' preferences, reasons, and points to be aware of when doing it

Table 2 shows whether the nurses conducting respiratory arrest confirmation agreed to it or not, and their reasons. Table 3 shows whether nurses not conducting it agreed to it or not, and their reasons.

The following reason categories were extracted from responses by nurses who had conducted respiratory arrest confirmation and agreed to it: [Even if a physician comes late, a nurse can deal with it] and [Nurses have the ability to explain it to the patient's family]. From the nurse who conducted it and who had selected “yes and now,” [Given the situation, it is unavoidable] was extracted. However, the following reason category for why the nurses without conducting respiratory arrest confirmation disagreed to it was extracted: [Physicians are up to conducting death certification]. The following reason categories of why the nurses who had not conducted respiratory arrest confirmation chose “yes and no” were extracted: [I have no idea about it because I have no object and experience], [I have no confidence], and [It varies depending on the place where the death watch is done]. Hereinafter categories are put in square brackets and code in angled brackets.

1) Preferences and reasons reported by nurses who had conducted respiratory arrest confirmation

The nurses who had conducted respiratory arrest

Table 4: Points to be aware of in doing “respiratory arrest confirmation”

(Number of codes, 6; number of responding nurses, 2)

Category (Number of codes)	Code
1. To share common recognition among a team including the family to deepen cooperation. (3)	<ul style="list-style-type: none"> • A nurse should confirm with a physician that their patient is in the terminal phase, decide what is expected and how to deal with it, and inform the family of it. • It is necessary to have a key-person of a patient’s family confirm what all family members think and unite them. • It is important to have the family understand that a physician cannot be in time at the death bedside.
2. Considering when a physician comes, to take steps so that the family can accept the patient’s death. (3)	<ul style="list-style-type: none"> • I have a physician do death confirmation as early as possible, just as the physician arrives at the bedside. • I see whether the family can accept and understand the death. • If the family says that they will wait for death confirmation until a physician comes, I wait for it.

confirmation and who had agreed to it were one, who thought that < when a physician comes late, a nurse may conduct it under the direction of the physician > and [a physician arrives at the bedside late, but a nurse can deal with it]. Furthermore, she recognized that because < the family must be given sufficient explanation and a nurse can explain it to them >, [nurses have the ability to explain it to the patient’s family]. However, the nurses who had conducted respiratory arrest confirmation and who had responded “yes and no” were one. That nurse recognized that, because < a physician is not always present and a nurse has no choice but to do it >, [given the situation, it is unavoidable].

2) Preferences and reasons reported by nurses who had not conducted respiratory arrest confirmation

Two nurses did not conduct respiratory arrest confirmation and disagreed to it. They reported that < I think that a physician can provide death certification because a physician is qualified as a doctor > and < it is the work of a doctor >, [death certification is up to a physician]. However, three nurses responded “yes and no”; they recognized that < I have never experienced a case of death watch, so I cannot judge it > and [I have no idea because I have no experience and object], that < though I think it will become necessary, I feel unsure >, [I have no confidence], and that < though the procedure should be followed in a large hospital, it is on a case-by-case basis in home-based care and it

varies depending on places >, [it varies depending on the places to do death watch].

3) Points to be aware of when a nurse is in charge of respiratory arrest confirmation

Related to points to be aware of when a nurse is in charge of respiratory arrest confirmation, the following categories by two nurses who conducted it were extracted: [Common recognition is shared in a team including a patient’s family to deepen the cooperation] and [Considering the time when a physician arrives at the bedside, a nurse should take steps to help the family accept it] (Table 4).

(1) [Common recognition is shared in a team, including a patient’s family, to enhance cooperation]

As points to be aware of when a nurse is in charge of doing respiratory arrest confirmation, they referred to the following: keeping < it is important to have the family understand that a physician might not come in time > in mind, < a nurse should confirm with a physician that the patient is in the terminal phase, decide what is expected and how to address it, and inform the patient’s family of it >, and < it is necessary to have a key person of a patient’s family confirm what all family members think and unite them.>

(2) [Considering the time when a physician comes to the bedside, take steps so that a patient’s family can accept death]

As points for a nurse in charge of dealing with respiratory arrest confirmation to be aware of, the

Table 5: GH nurse opinions and views on death watch by nurses

(Number of codes, 12; number of responding nurses, 7)

Category (Number of codes)	Code
1. Death watch by a nurse with knowledge and skills is required. (5)	<ul style="list-style-type: none"> • After a physician judges that a patient is in the terminal phase, it is important to relieve the patient's pain, keep the patient in a clean state, and devote close attention to the environment. • For nurses to expand their field from death watch to death certificate, they must have a solid grasp of knowledge and skills. • Qualified people should perform tasks with social cooperation with people including a doctor. • I think nurses will have no alternative but to do a death watch. • With support such as advice and instruction to caregivers, it is necessary to lessen their anxiety.
2. I want to provide end-of-life care with common recognition among a team including the family. (4)	<ul style="list-style-type: none"> • When an older adult enters the terminal phase, a physician, the family, and caregivers talk about it to have common recognition. Under the circumstances, I'd like to send my patient quietly and without confusion. • I will be happy when I can hold hands with the family at the bedside of my parent who has passed away, reassuring them that "We have done our best." • Cooperation with medical facilities and physicians enables nurses and caregivers to do end-of-life care without anxiety. • It is necessary to make a manual and for all workers to work together.
3. It is expected that physicians will be less likely to be in time at the death bedside. (2)	<ul style="list-style-type: none"> • A physician does not reside at a patient's home and a small facility. Therefore, it is more likely that a physician cannot arrive in time at the bedside when a patient passes away. • In the future, it is expected that older adults' death will be provided with end-of-life care. Then, sometimes a doctor cannot be in time at their death bed.
4. It is difficult for nurses to do a death watch under time pressure. (1)	<ul style="list-style-type: none"> • End-of-life care by a nurse detains the nurse at work for more hours. Therefore, I can never do it.

following were referred: < a nurse should have a physician do death confirmation as early as possible, immediately when arriving at the bedside >, < if the family says that they will wait for death confirmation until a physician comes, then a nurse should wait for it >, and < see whether they have received and understood it.>

4. Nurse opinions and views on death watch duties

Seven respondents freely described their opinions and views on death watch by a nurse, with the following categories extracted: [nurses with knowledge and skills are required to do death watch duties], [I want to have common recognition among a team including a patient's family], [it is expected that physicians will be less likely to be in time at the death bedside], and [it is difficult for a nurse to do death watch duties under time pressure].

Hereinafter, the categories are put in square brackets and code in angled brackets. The categories are described in descending order of description number.

1) [Nurses with knowledge and skills must do death watch duties]

Thinking that < nurses will have no option but to do a death watch by themselves > and < people such as physicians who are socially respected should do it >, the participant reported that < for nurses to expand their field from death watch to death certification, they must have a solid grasp of knowledge and skills >. She also thought that < after a physician judges that a patient is in the terminal phase, it is fundamentally important to relieve the person's pain, keep the person in a clean state, and devote close attention to the person's environment >, and that nurses < must give advice or instructions to caregivers and to lessen their anxiety >.

2) [I want to provide end-of-life care with common recognition among a team including the patient's family]

The participant thought that when an older adult < enters the terminal phase, a physician, the family, and a facility's workers should talk about items to confirm

and share them carefully to care for the person without confusion at the bedside when death occurs > and that < I will be happy to join hands with the family at the bedside saying, “we’ve done our best”>. Furthermore, < without cooperation with medical facilities and physicians, caregivers cannot do death watch duties free from anxiety > and < it is necessary to make a manual and for a facility’s workers to work together >. 3) [It is expected that physicians will be less likely to be in time at the death bedside]

The participant expected the following: < because a physician is not always by a patient’s bedside in home-based or small-facility-based care, it is more likely that a physician cannot arrive in time at the bedside when a patient dies >; < in the future, it is expected that more older adults’ death will be provided with end-of-life care at home. Therefore, sometimes a physician cannot arrive in time at their death bedside.>

4) [it is difficult for a nurse to do death watch duties under time pressure]

One respondent reported that because the death watch by a nurse < detains the nurse at work for more hours, she could never do it >.

V. Discussion

1. Subject background and the current situation of respiratory arrest confirmation by nurses

Responses from only nine participants were analyzed in this study, but two respondents had conducted “respiratory arrest confirmation.” Additionally, their average age was 51.7 ± 8.8 yr (42-70 yr), which underscores the result that death watch duties in long-term care health facilities for elderly people or welfare facilities for elderly people are supported by middle-aged nurses⁸⁾. However, even if nurses working at GHs are presumed to have more experience with terminal care¹⁵⁾ as a participant’s background, it remains unknown whether employment status, medical cooperation system addition, and end-of-life care systems have been consolidated in GHs in which nurses responding to our questionnaire worked. Moreover, it is uncertain whether a death watch occurred there on a daily basis.

The nurses referred to the following as reasons why a nurse would do respiratory arrest confirmation: [because a physician comes late, nurses can deal with it] and [nurses have the ability to explain it to a patient’s family]. The responses suggest that nurses thought of it positively and that nurses have confidence in the ability to do death confirmation. However, results show that because a physician does not reside with the patient, nurses reported that [given the situation, it is unavoidable]: a nurse has no alternative but to do respiratory arrest confirmation. Given that nurses had ambivalent feelings related to respiratory arrest confirmation, the result is the same as a result of a study about respiratory arrest confirmation targeting nurses working at long-term care health facilities for elderly people and at welfare facilities for elderly people^{8,10)}. However, the reasons for “opposition” or “yes and no” described by the nurses who did not conduct respiratory arrest confirmation, including [death certification is a physician’s responsibility], [I have no idea because I have no experience or patients], [I lack confidence], and [it varies depending on the place to do it] revealed that nurses were exposed to severe pressure from their anxiety and responsibility about how to address an older adult and a family in cases of respiratory arrest confirmation.

Currently, because only physicians can write a death certificate in Japan (Article 20 of the Medical Law), “death confirmation” has been presumed to be an act that affects the human body if conducted without the medical judgment and skills of a physician. Therefore, nurses are not allowed to do it alone. Moreover, in nursing education, nursing students are taught not to touch the body of a patient facing immediate death before a physician arrives at the bedside¹⁶⁾, which might underlie the nurses’ recognition that [death confirmation is up to a physician]. Furthermore, it seems consistent with the results of earlier studies^{8,10)}. In addition, although the average age of the participants is not so different from that of studies targeting home-care nurses, and nurses of long-term care health facilities for elderly people or welfare facilities for elderly people^{8,10)}, their average years of experiencing bedside nursing and GH nursing were 15

years and 2 months and 4 years and 10 months, respectively, which were shorter than the average years of experiencing bedside nursing of 19 years and 3 months and average years of experiencing home-care nursing of 9 years and 3 months by home-care nurses and average years of experiencing bedside nursing of 19 years and 8 months and nursing at long-term care health facilities for elderly people of 9 years and 5 months by nurses working there, which might explain their anxiety about dealing with older adults and their families. The results are the same as those of earlier research^{8,10}: no difference was found between nurses who received education and nurses for whom "respiratory arrest confirmation" was conducted at a GH. Nevertheless, the present study included few participants. For that reason, future verification of results will be necessary.

2. Characteristics and problems of respiratory arrest confirmation and death watch by nurses in GHs

That nurses conduct respiratory arrest confirmation in long-term care health facilities for elderly people and welfare facilities for elderly people has been supported by older adults' families, who appreciate it^{8,9}. Furthermore, in home-care scenes, it has been maintained by recognition and attitudes of nurses that they respect better death watch duties¹⁰. However, respiratory arrest confirmation conducted at GHs in this study has been supported by unavoidable or uncontrollable conditions: a physician does not reside with the patient; a physician will usually come late to the bedside of a dying older adult; and nurses' self-confidence in their ability to explain respiratory arrest to the family and do death confirmation. Because GHs are presumably domestic, caregivers at GHs are often not required to have any qualification. Additionally, similarly to special elderly nursing homes as nursing homes for elderly people, full-time medical doctors are characteristically not required to be deployed. The fact that it is an unavoidable situation is also regarded as influencing the recognition of the nurses for working GHs. Furthermore, in terms of the nurses' confidence in their abilities to confirm a patient's death and to explain it to the family, the survey's method of

selecting participants might make it highly probable that nurses who are more interested in respiratory arrest confirmation and more confident might respond to it. In fact, GH nurses often experience a death watch whether they like it or not, although they are not in a person's final home⁶. As described above, a lack of human resources has been reported in medical professions⁴, suggesting that nurses in the present situation should be reluctantly engaged in respiratory arrest confirmation at GHs in which nurses are deployed.

The points to be aware of in doing respiratory arrest confirmation referred to by the nurses are the following: [to share common recognition among a team including a patient's family and deepen their cooperation] and [to consider when a physician arrives at the bedside and then to take steps to help the family accept the patient's death]. These are the same as results of an earlier study targeting home-care nurses¹⁰. It might be true because it is influenced by their intimate relation to the family like that of home-care nurses supporting home-based care because of GHs' concept of providing a domestic place for life as a part of community-based service. However, the category [to share a common recognition among a team including a patient's family and to enhance cooperation] was the same as results of a study targeting home-care nurses and nurses working for long-term care health facilities for elderly people and welfare facilities for elderly people⁸⁻¹⁰, which suggests that the category [to share common recognition among a team including and to deepen their cooperation] should be characteristic of nurses at an older adult's home as a scene of home-care and a facility for elderly people as scenes of an older adult's life. In other words, the character by which a home-care nurse cares for an older adult is represented by consideration that the person and the family are one unit. Making cooperative systems between GHs and home-care nurse stations and other professionals of other facilities to make medical decisions or take medical steps and meeting the needs of the older adult and the family⁴ is necessary because medical workers are not legally required to be deployed at GHs.

As opinions and views about death watch duties by nurses, [I want to do death watch duties with a common recognition shared among a team including the family] was presented. The GH personnel often consist of more caregivers, including workers, lacking professional qualifications. Kimura¹¹⁾ reported that because nurses regard cooperation between nurses and physicians as a nurse role in doing death watch duties at a GH, they are likely to think that if they have better cooperation, they have successfully accomplished a death watch. It is considered that nurses working for GHs to share a common recognition among their team and enhancing their cooperation were the most important concerns when they were engaged in end-of-life care for elderly people. It is also considered that the nurses themselves recognized the importance of cooperation in doing death watch duties as in long-term care health facilities for elderly people and welfare facilities for elderly people. Additionally, because [death watch conducted by nurses with knowledge and skills is required] and [it is expected that situations in which a physician cannot be in time at the bedside will increase] were reported, one can infer that they well recognized the roles and skills necessary for nurses working for GHs. However, [it is expected that situations in which a physician cannot be in time at the death bedside will increase] and [it is difficult for a nurse to do death watch duties under time pressure] were presented as opinions, suggesting a current situation that is still difficult in actual situations, although nurses recognize the necessity for death watch duties. Although earlier reports describe that caregivers of GHs feel anxiety and difficulty in doing a death watch without medical workers deployed¹⁷⁾, the results of this study demonstrate that not only caregivers but also nurses feel anxiety and difficulty.

3. Limitations and difficulties of this study

This study has limitations affecting the generalization of its results because it targeted only nurses working at some GHs. Moreover, the collection rate of questionnaires used for this study was very low, with only nine respondents from a targeted population of 150 questionnaire recipients.

Actually, the collection rates in earlier studies targeting nurses of GHs were also very low¹⁸⁾. That low rate might be attributable to the possibility that nurses were absent at our targeted GHs because nurses need not be employed at GHs. Furthermore, because the typography and text of the questionnaire survey and expressions of the questionnaire items were not unified, the possibility exists that the nurses' interests in respiratory arrest confirmation might not be fully reflected. It is also possible that nurses who were highly concerned with respiratory arrest confirmation and who had confidence in it might have responded to this study. Nevertheless, the results hold some importance: they demonstrate the present state of respiratory arrest confirmation by nurses working for GHs in cases of the expected death of an older adult, which had not been elucidated in earlier reports of the relevant literature. At the Section Committee of Nursing Care Benefits meeting held on November 15, 2017, the Health, Labour, and Welfare Ministry announced a policy to establish new classifications for additional medical cooperation for GHs and to evaluate careful nursing systems. Those changes are expected to start after system reform in fiscal 2018. From these reforms, issues such as requirements to employ nurses and enhancement of full-time nurses, which have been pointed out in reports of earlier studies⁴⁾, are expected to be resolved. Nevertheless, we must continue to examine nursing system improvement and quality enhancement associated with increased opportunities of nurses performing death watch duties. A challenge for future research is to examine an increased number of participants.

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要 旨

高齢者の「予想される死」の援助場面における「呼吸停止確認」の現状についてグループホーム（認知症高齢者グループホーム；以下 GH とする）の看護師に郵送質問紙調査を実施し、9 人から回答を得た（回答率 6%）。自由記載について質的分析を行った。

「呼吸停止確認」をしている看護師は 2 人、していない看護師は 5 人であった。「呼吸停止確認」をしている看護師の看護師による「呼吸停止確認」に「賛成である」理由のカテゴリは【医師の到着時間が遅く、看護師が対応できる】【看護師が家族に説明できる能力がある】が抽出され、「どちらともいえない」理由のカテゴリは【状況を考えるとやむを得ない】が抽出された。一方、「呼吸停止確認」をしていない看護師の「反対である」理由のカテゴリは【死亡確認は医師の責務である】が抽出され、「どちらともいえない」理由のカテゴリは【経験や対象がいないので分からない】【自信がない】【看取りを行う場所による】が抽出された。

GH の「呼吸停止確認」の実施は、医師が常駐していないことや医師の到着時間が遅いことによる、やむを得ない状況と看護師自身の家族への説明や死亡確認の能力に対する自信によって支えられていたことが示唆された。

キーワード：「予想される死」 呼吸停止確認 グループホーム 看護師 高齢者