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ORIGINAL ARTICLE

A Current Status of Care Plans for Independent Excretion in Japan's Long-term Care Insurance Services

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ABSTRACT

To clarify the current status of care plans for independent excretion in Japan's long-term care insurance services, a self-administered, anonymous questionnaire survey was conducted, involving care planners working regularly in long-term care/welfare facilities or home care support offices throughout Japan. The questionnaire consisted of questions regarding care plans to achieve/maintain independent excretion. The rate of creating excretion care plans for facility users was significantly higher in long-term care/welfare facilities compared with home care support offices ($p < 0.01$). Among the contents of information collected to create care plans for independent excretion, <the frequency of urinary incontinence>, <bowel movements>, and <purgative use> were examined significantly less frequently in home care support offices ($p < 0.01$), while <discharge destination> was confirmed significantly more frequently in long-term care facilities ($p < 0.01$). The rate of considering <discharge destination> as an important factor for independent excretion was significantly higher in long-term care facilities ($p < 0.01$). Thus, the status of care plans for independent excretion and contents of information collected on such plans varied according to the type of service. The results indicate the necessity of enhancing care planners' awareness, educating them focusing on functional recovery as part of practical skill education, and incorporating the learning of care management methods, covering support for independent excretion, into senior CM training to promote independent excretion care in Japan's long-term care insurance services.

<Key-words>

independent excretion care, care plan, long-term care insurance service

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I. Introduction

Aging is progressing more rapidly in Japan compared with other advanced countries, and its measures to address aging issues are drawing global attention. Among the aging issues faced by Japan, growing social insurance payments are especially serious, and support for older persons to lead an independent life is regarded as a challenge. The government emphasizes the necessity of promptly shifting the site of long-term care from facility to home, and establishing community-based integrated care systems to help older persons continue to live in their communities and maintain their dignity. Toward the achievement of these goals, “independent excretion” is key to maintain older persons’ home lives. According to a previous survey examining the status of support for the resumption of home life in long-term care facilities, “the need for excretion assistance” was a factor associated with difficulty in discharging facility users to home (Social Security Council nursing care payment Subcommittee article, 2017). Excretion assistance increases caregiving burdens, and negatively affects the resumption of home life.

Concerning care to achieve/maintain independent excretion, medical institutions began to calculate independent excretion guidance fees with a revision of medical fees in FY2016. As part of this new category, comprehensive urination care through multi-professional team approaches also started. However, in previous studies, acute care ward nurses provided care to promote independent excretion as a routine procedure due to their busy post and insufficient manpower. Furthermore, in acute care hospitals, shortened hospital stays made it difficult to help patients achieve/maintain independent excretion only through primary care, and nurses experienced mental conflicts in such a situation. They also noted the necessity of continuously providing independent excretion care after transfer as a challenge (Kurokawa, Fujio, Kodaira et al., 2017).

In Japan’s long-term care insurance services, excretion support fees were added when medical fees were revised again in 2018. These fees are based on analysis of factors leading to the necessity of excretion assistance, the creation of individualized support plans, and provision of excretion support. In fact, users of facilities with a lower diaper use rate have been reported to be more independent in all activities of daily living (ADL) (Kodaira, Fujio & Takeuchi, 2014). These facilities individually created care plans (Kodaira, Nomura & Inoue, 2010), confirming the importance of creating individualized support plans to promote independent excretion.

On the other hand, care management focusing on functional recovery remains insufficient even after 20 years from the establishment of the long-term care insurance system. In order to provide sufficient functional recovery care in this system, it is necessary for care managers (CMs) to share the idea of such care, and acquire an appropriate sense of value, knowledge, and skills (Shirasawa, 2015). Among care management procedures, care plans are thought to be especially important, as it determines care policies (Shirasawa, Hashimoto & Takeuchi, 2000). Thus, care plans may

play an important role in promoting functional recovery care as part of long-term care insurance services. However, the rate of focusing on functional recovery when creating care plans is still low, and promoting care plans from the perspective of multi-professional collaboration may be another challenge (Morishita, 2005).

Under these circumstances, the present study examined the status of care plans for independent excretion in Japan's long-term care insurance services.

II. Definition of term

The operational definition of terms used in this study is as follows.

Independent excretion care:

Similarly, 'independent excretion care' is defined as part of functional recovery care and 'supporting excretion using general or portable toilets, rather than defecating/urinating using diapers', based on the terminology used for caregiver workshops held by the Japanese Council of Senior Citizens Welfare Service. These workshops aim to help caregivers learn functional recovery care skills. Since 2003, when the first workshop was held, 100 to 150 special nursing homes for the elderly have participated each year. As an index to conveniently measure outcomes, the council recommends the diaper use rate.

III. Subjects and Methods

1. Subjects and Procedures

Using a system to search for care facilities/daily life-related information organized by the Ministry of Health, Labour, and Welfare, and adopting the cluster sampling method, 500 long-term care facilities, 500 long-term welfare facilities, and 500 home care support offices throughout Japan were selected, and 1 care planner who worked regularly in each of these facilities/offices was included (a total of 1,500 care planners). First, 20 prefectures were selected through complex stratification, and then offices and facilities based in these prefectures were extracted as simple random samples, asking their managers, who consented to cooperate, to select appropriate regular care planners for the study based on their own criteria.

2. Data Collection

As part of this cross-sectional study, a self-administered, anonymous questionnaire survey was used, involving the care planners, and their responses were collected by mail. The period of data collection was between September and October 2018. The study items were as follows:

1) Basic attributes: The sex, age, affiliation, last education degree, basic qualifications,

and total length of care plans experience.

2) Excretion care plan-related items: The statuses of collecting excretion-related information, creating excretion care plans, and care plans when excretion assistance is required. The questions to examine these items were answered on a 4-point scale. Additionally, the detailed contents of excretion care plans and related challenges were answered in a free-description space.

3) Contents of information collected for care plans to achieve/maintain independent excretion: Among the items listed on a comprehensive assessment sheet used by the Japanese Council of Senior Citizens Welfare Service for workshops to improve caregiving skills, 4 related to independent excretion were adopted: <the desire to defecate/urinate>, <frequency of urinary incontinence>, <bowel movements>, and <purgative use>. Subsequently, 15 factors influencing elderly patients' ADL and resumption of home life were extracted from the findings of previous studies: <nutritional condition>, <eating behavior>, <activity level>, <dementia symptoms>, <symptomatic stability>, <content of treatment>, <ability to maintain a sitting position>, <ability to maintain a standing position >, <wheelchair use>, <independent wheelchair manipulation>, <walking assistance>, <independent walking>, <dressing>, <being cared for by a single nurse>, and <experience-based senses>. Furthermore, <patients' own desires>, <respect for their dignity>, <discharge destination>, and <others> were originally added as excretion-related ethical perspectives. Thus, there were a total of 22 contents, and the questions to examine these contents were answered on a 2-point scale.

4) Important factors for independent excretion from the perspective of care planners: There were 22 items, similar to the case of 3). The questions to examine these items were answered on a 4-point scale.

3. Statistics analysis

After obtaining descriptive statistics for each item, the study offices and facilities were divided into 3 groups based on their types of long-term care insurance service: long-term care facilities, long-term welfare facilities, and home care support offices. To examine associations in each case, the chi-square, Fisher's exact test, or Kruskal-Wallis test was used for inter-group comparison. Multiple comparison (Mann-Whitney U-test, adopting the Bonferroni correction method) was also performed to examine differences among the groups. The significance level was set at 0.05, and IBM SPSS Statistics 24 was used for statistical analysis.

4. Ethical considerations

Written explanations of ethical considerations for the study facilities/offices and participants, such as voluntary cooperation and anonymity maintenance, were provided. A returned consent form and returned response to the questionnaire were regarded as consent to cooperate with the study from a study facility/office and participant,

respectively. This research was conducted with approval of the ethics committee of the Faculty of Health Science and Nursing, Juntendo University (Approval No. 30-03).

IV. Results

1. Subject Characteristics

Among the 1,500 care planners engaged in long-term care insurance services, 160 responded (response rate: 10.7%), and 159 valid responses from them were analyzed (valid response rate: 10.6%). The number of those belonging to each group based on the type of long-term care insurance service was as follows: long-term care facilities: 48 (30.2%), long-term welfare facilities: 43 (27.0%), and home care support offices: 68 (42.8%).

Table 1 outlines their basic attributes. The largest age group was those aged 40-49 (57; 36.1%). Females were a majority (104; 65.8%). The most frequent last education degree was vocational school graduate (47; 29.6%), followed by senior high school graduate (44; 27.7%); they totally accounted for the majority. The most frequent basic qualification was care worker (128; 81.5%). When limiting to qualifications for CMs, the numbers of those only qualified as a certified CM (55; 35.7%) and those with no CM qualification (48; 31.2%) were the largest and second largest, respectively. The most frequent length of care plans experience was 1-5 years (48; 32.0%). The last education degree ($p < 0.05$) and CM qualification ($p < 0.01$) significantly varied according to the type of service. Adjusted residual analysis revealed that there were significantly fewer vocational school graduates in long-term welfare facilities, and significantly fewer junior college graduates in long-term care facilities. With regard to CM qualifications, the rates of being qualified as both a senior CM and certified CM and those only qualified as a senior CM were significantly higher in home care support offices, while that of being only qualified as a certified CM was significantly higher in long-term care/welfare facilities.

<Table 1> Subject Characteristics

item	total	Type of service						p value			
		① Long-term care facilities		② Long-term welfare facilities		③ Home care support offices					
Age ※2											
(N=158)	20-29	3 (1.9)	1 (2.1)	2 (4.7)	0 (0.0)	14 (20.6)	22 (32.4)	18 (26.5)	13 (19.1)	1 (1.5)	0.201
	30-39	32 (20.3)	10 (21.3)	8 (18.6)	14 (20.6)	22 (32.4)	18 (26.5)	13 (19.1)	1 (1.5)		
	40-49	57 (36.1)	19 (40.4)	16 (37.2)	22 (32.4)	18 (26.5)	13 (19.1)	1 (1.5)			
	50-59	47 (29.7)	16 (34.0)	13 (30.2)	18 (26.5)	13 (19.1)	1 (1.5)				
	60-69	18 (11.4)	1 (2.1)	4 (9.3)	13 (19.1)	1 (1.5)					
	70-79	1 (0.6)	0 (0.0)	0 (0.0)	1 (1.5)						
Sex ※1											
(N=158)	Female	104 (65.8)	31 (64.6)	25 (59.5)	48 (70.6)						0.482
	Male	54 (34.2)	17 (35.4)	17 (40.5)	20 (29.4)						
Educational background ※2											
(N=159)	Senior high school	44 (27.7)	12 (25.0)	16 (37.2)	16 (23.5)						0.047 *
	Vocational school	47 (29.6)	19 (39.6)	7 (16.3)	21 (30.9)						
	Junior college	26 (16.4)	2 (4.2)	11 (25.6)	13 (19.1)						
	University	40 (25.2)	14 (29.2)	8 (18.6)	18 (26.5)						
	Graduate school	2 (1.3)	1 (2.1)	1 (2.3)	0 (0.0)						
Type of profession ※1											
(N=157)	Medical profession	29 (18.5)	11 (23.4)	4 (9.5)	14 (20.6)						0.202
	Welfare profession	128 (81.5)	36 (76.6)	38 (90.5)	54 (79.4)						
Type of care managers ※1											
(N=154)	Senior and certified	14 (9.1)	1 (2.2)	0 (0.0)	13 (19.1)						<0.001 **
	Senior only	37 (24.0)	6 (13.0)	5 (12.5)	26 (38.2)						
	Certified only	55 (35.7)	22 (47.8)	20 (50.0)	13 (19.1)						
	No CM	48 (31.2)	17 (37.0)	15 (37.5)	16 (23.5)						
Years of experience ※1											
(N=150)	1-5	48 (32.0)	17 (37.8)	12 (32.4)	19 (27.9)						0.851
	6-10	42 (28.0)	11 (24.4)	12 (32.4)	19 (27.9)						
	11-15	43 (28.7)	13 (28.9)	8 (21.6)	22 (32.4)						
	>16	17 (11.3)	4 (8.9)	5 (13.5)	8 (11.8)						

※1 χ^2 test, ※2 Fisher's exact test *:P<0.05, **:P<0.01

2. Relationship between the type of service and status of excretion care plans

Table 2 explains the relationship between the type of service and status of excretion care plans. The latter markedly varied according to the former, as excretion care plans were created by care planners more frequently in long-term care/welfare facilities compared with home care support offices.

<Table 2> Relationship between the type of service and status of excretion care plans

	Type of service										p value※2		
	① Long-term care facilities			② Long-term welfare facilities			③ Home care support offices			p value※1	①vs②	①vs③	②vs③
	n	Average value	Standard deviation	n	Average value	Standard deviation	n	Average value	Standard deviation				
Collecting excretion information	48	3.9	0.4	43	3.7	0.5	68	3.7	0.4	0.124	0.143	0.127	0.492
Creating excretion care plans	48	3.3	0.5	42	3.2	0.6	65	3.0	0.4	<0.001 **	0.830	<0.001 **	0.002 **
Care plans when excretion assistance is required	48	3.2	0.6	41	3.0	0.5	68	3.1	0.5	0.275	0.149	0.220	0.633

4 methods : 1. Not at all 2. Not much 3. When necessary 4. Be sure to do (Calculate average value and standard deviation)

※1 Kruskal Wallis-test, ※2 Mann-Whitney U-test (Bonferroni) *:P<0.05, **:P<0.01

3. Relationship between the type of service and contents of information collected to create care plans for independent excretion

Table 3 outlines the relationship between the type of service and contents of information collected to create care plans independent excretion. The rates of collecting information regarding <the frequency of urinary incontinence>, <purgative use>, <walking assistance>, <independent walking> ($p < 0.05$ in all cases), <bowel movements>, <dressing>, <being cared for by a single nurse>, and <discharge destination> ($p < 0.01$ in all cases) significantly varied according to the type of service. Adjusted residual analysis revealed significantly higher and lower rates for <the frequency of urinary incontinence> in long-term care facilities and home care support offices, respectively. Similarly, the rates for <bowel movements> and <purgative use> were markedly lower in home care support offices. The rates for <walking assistance> and <independent walking> were significantly lower in long-term welfare facilities. The rate for <dressing> was markedly higher in home care support offices and lower in long-term welfare facilities. The rate for <being cared for by a single nurse> was significantly higher in long-term care facilities and lower in home care support offices. The rate for <discharge destination> was markedly higher in long-term care facilities and home care support offices, and lower in long-term welfare facilities.

<Table 3> Relationship between the type of service and contents of information collected to create care plans for independent excretion

item		total	Type of service						p value
			① Long-term care facilities	② Long-term welfare facilities	③ Home care support offices	n (%)			
The desire to defecate/urinate ^{※1}	Yes	151 (96.8)	47 (100.0)	40 (95.2)	64 (95.5)			0.327	
	No	5 (3.2)	0 (0.0)	2 (4.8)	3 (4.5)				
Incontinence frequency	Yes	105 (67.7)	39 (83.0)	28 (66.7)	38 (57.6)			0.017 *	
	No	50 (32.3)	8 (17.0)	14 (33.3)	28 (42.4)				
Bowel movements	Yes	87 (56.5)	30 (65.2)	29 (69.0)	28 (42.4)			0.009 **	
	No	67 (43.5)	16 (34.8)	13 (31.0)	38 (57.6)				
Purabative use	Yes	119 (76.3)	39 (83.0)	36 (85.7)	44 (65.7)			0.025 *	
	No	37 (23.7)	8 (17.0)	6 (14.3)	23 (34.3)				
Nutritional condition	Yes	89 (57.4)	30 (63.8)	23 (56.1)	36 (53.7)			0.551	
	No	66 (42.6)	17 (36.2)	18 (43.9)	31 (46.3)				
Eating behavior	Yes	121 (78.6)	41 (85.4)	27 (67.5)	53 (80.3)			0.113	
	No	33 (21.4)	7 (14.6)	13 (32.5)	13 (19.7)				
Activity level	Yes	95 (61.7)	34 (72.3)	25 (62.5)	36 (53.7)			0.131	
	No	59 (38.3)	13 (27.7)	15 (37.5)	31 (46.3)				
Dementia symptoms ^{※1}	Yes	140 (90.9)	45 (95.7)	33 (82.5)	62 (92.5)			0.083	
	No	14 (9.1)	2 (4.3)	7 (17.5)	5 (7.5)				
Symptom stability	Yes	116 (76.3)	40 (85.1)	30 (75.0)	46 (70.8)			0.207	
	No	36 (23.7)	7 (14.9)	10 (25.0)	19 (29.2)				
Content of treatment	Yes	96 (61.9)	33 (68.8)	21 (52.5)	42 (62.7)			0.291	
	No	59 (38.1)	15 (31.3)	19 (47.5)	25 (37.3)				
Sitting position holdable	Yes	148 (94.9)	46 (95.8)	38 (92.7)	64 (95.5)			0.758	
	No	8 (5.1)	2 (4.2)	3 (7.3)	3 (4.5)				
Standing position holdable ^{※1}	Yes	147 (94.2)	47 (97.9)	37 (90.2)	63 (94.0)			0.301	
	No	9 (5.8)	1 (2.1)	4 (9.8)	4 (6.0)				
Wheelchair use ^{※1}	Yes	146 (93.6)	47 (97.9)	37 (90.2)	62 (92.5)			0.303	
	No	10 (6.4)	1 (2.1)	4 (9.8)	5 (7.5)				
Independent wheelchair	Yes	131 (84.0)	41 (85.4)	32 (78.0)	58 (86.6)			0.477	
	No	25 (16.0)	7 (14.6)	9 (22.0)	9 (13.4)				
Walking assistance ^{※1}	Yes	140 (89.7)	45 (93.8)	32 (78.0)	63 (94.0)			0.016 *	
	No	16 (10.3)	3 (6.3)	9 (22.0)	4 (6.0)				
Independent walking	Yes	135 (86.5)	44 (91.7)	30 (73.2)	61 (91.0)			0.014 *	
	No	21 (13.5)	4 (8.3)	11 (26.8)	6 (9.1)				
Dressing	Yes	139 (89.7)	44 (91.7)	29 (72.5)	66 (98.5)			<0.001 **	
	No	16 (10.3)	4 (8.3)	11 (27.5)	1 (1.5)				
Nurse assistance by one person	Yes	78 (51.7)	33 (73.3)	17 (42.5)	28 (42.4)			0.002 **	
	No	73 (48.3)	12 (26.7)	23 (57.5)	38 (57.6)				
Experience-based senses	Yes	37 (24.3)	13 (28.3)	8 (20.0)	16 (24.2)			0.673	
	No	115 (75.7)	33 (71.7)	32 (80.0)	50 (75.8)				
Desires	Yes	140 (90.9)	41 (87.2)	35 (87.5)	64 (95.5)			0.217	
	No	14 (9.1)	6 (12.8)	5 (12.5)	3 (4.5)				
Respect of their dignity	Yes	104 (68.0)	30 (63.8)	28 (70.0)	46 (69.7)			0.765	
	No	49 (32.0)	17 (36.2)	12 (30.0)	20 (30.3)				
Discharge destination	Yes	111 (74.0)	41 (87.2)	16 (42.1)	54 (83.1)			<0.001 **	
	No	39 (26.0)	6 (12.8)	22 (57.9)	11 (16.9)				

※1 Fisher's exact test, Other χ^2 test*: P<0.05, **: P<0.01

4. Relationship between the type of service and important factors for independent excretion from the perspective of care planners

Table 4 represents the relationship between the type of service and important factors for independent excretion from the perspective of care planners. The care planners' opinions regarding the <content of treatment>, <independent wheelchair manipulation>, <independent walking>, <being cared for by a single nurse> (p<0.05 in all cases), <dressing>, and <discharge destination> (p<0.01 in all cases) significantly varied according to the type of service. For example, the rate of regarding the <content of treatment> as important was markedly higher in long-term care than in welfare facilities (p<0.05). The rate for <dressing> was significantly higher in long-term care facilities and home care support offices compared with long-term welfare facilities (P<0.01). The rate for <being cared for by a single nurse> was markedly higher in long-term care facilities compared with home care support offices (p<0.05), and that for <discharge destination> was significantly higher in long-term care facilities compared with long-term welfare facilities and home care support offices (P<0.01).

<Table 4> Relationship between the type of service and important factors for independent excretion from the perspective of care planners

item	Type of service									p value ^{※2}			
	① Long-term care facilities			② Long-term welfare facilities			③ Home care support offices			①vs②	①vs③	②vs③	
	n	Average value	Standard deviation	n	Average value	Standard deviation	n	Average value	Standard deviation				
The desire to defecate/uninate	47	4.8	0.5	43	4.7	0.7	68	4.7	0.8	0.420	0.614	0.843	1.000
Incontinence frequency	47	4.2	0.9	43	4.2	0.9	68	4.1	1.0	0.709	1.000	1.000	1.000
Bowel movements	48	4.4	1.0	42	4.3	0.9	68	4.4	0.9	0.940	1.000	1.000	1.000
Purabative use	48	3.9	1.1	43	4.0	1.0	68	3.8	1.1	0.722	1.000	1.000	1.000
Nutritional condition	47	3.9	0.9	42	3.9	1.0	68	4.1	1.0	0.496	1.000	0.830	1.000
Eating behavior	47	3.6	1.0	43	3.5	1.0	68	3.6	1.0	0.742	1.000	1.000	1.000
Activity level	48	4.4	0.8	43	4.2	0.8	68	4.5	0.7	0.092	0.249	1.000	0.121
Dementia symptoms	48	4.1	0.9	43	3.7	1.3	68	4.2	1.0	0.202	0.599	1.000	0.254
Symptom stability	48	4.3	0.9	42	3.9	1.0	68	4.2	0.8	0.263	0.356	1.000	0.715
Content of treatment	47	4.2	1.0	43	3.7	0.9	68	3.8	1.1	0.014 *	0.012 *	0.118	0.950
Sitting position holdable	48	4.7	0.7	42	4.5	0.9	67	4.5	0.7	0.062	0.248	0.060	1.000
Standing position holdable	48	4.6	0.8	43	4.3	0.9	68	4.4	0.8	0.118	0.168	0.228	1.000
Wheelchair use	47	4.0	1.1	43	3.6	1.1	68	4.0	1.0	0.099	0.208	1.000	0.152
Independent wheelchair	48	4.1	1.0	43	3.6	1.2	68	4.1	0.9	0.042 *	0.117	1.000	0.060
Walking assistance	47	3.9	1.2	43	3.5	1.3	67	4.0	1.0	0.091	0.252	1.000	0.113
Independent walking	47	4.1	1.2	42	3.5	1.2	68	4.0	1.1	0.041 *	0.056	1.000	0.131
Dressing	48	4.3	1.0	43	3.6	1.2	68	4.2	1.0	<0.001 **	0.002 **	1.000	0.005 **
Nurse assistance by one person	47	3.9	1.0	42	3.4	1.2	68	3.3	1.2	0.015 *	0.091	0.017 *	1.000
Esperience-based senses	47	3.3	1.0	42	3.2	0.9	68	3.1	1.0	0.861	1.000	1.000	1.000
Desires	48	4.8	0.5	43	4.7	0.7	68	4.6	0.8	0.273	1.000	0.342	1.000
Respect of their dignity	48	4.6	0.8	43	4.6	0.6	68	4.5	0.8	0.668	1.000	1.000	1.000
Discharge destination	48	4.7	0.5	40	3.9	0.9	68	4.2	0.9	<0.001 **	<0.001 **	0.005 **	0.398

5methods : 1. Not think at all 2. Not think so much 3. Neither 4. Somewhat agree 5. Very likely (Calculate average value and standard deviation)

※1 Kruskal Wallis-test, ※2 Mann-Whitney U-test (Bonferroni) *:P<0.05, **:P<0.01

V. Discussion

The present study examined the status of care plans for independent excretion in long-term care insurance services through a nationwide survey. This section discusses such a status, dividing the study facilities/offices into 2 groups: facility services: long-term care/welfare facilities; and home services: home care support offices.

1. Status of care plans for independent excretion in facility services

In long-term care/welfare facilities compared with home care support offices, excretion care plans for facility users were created significantly more frequently. This may have been a result of measures to promote functional recovery care as a social trend, such as the addition of excretion support fees in 2018 and establishment of operational standards on diaper use, which have provided facilities with an incentive. The contents of excretion care plans listed in the free-description space aimed to achieve/maintain independent excretion (e.g., <gradually shifting from diaper to portable toilet use> and <participating in exercise programs for independent excretion>) or provide integrated care approaches (<considering excretion assistance methods>). Thus, the contents of excretion care plans markedly varied from those focusing on functional recovery to detailed care approaches.

The contents of information collected to create care plans for independent excretion also varied between long-term care/welfare facilities. For example, long-term care facilities examined <discharge destination> more frequently, while long-term welfare facilities confirmed <walking assistance>, <independent walking>, <dressings>, and <discharge destination> less frequently than the other group. A similar tendency was observed regarding important factors for independent excretion, as many care planners of long-term care facilities regarded <discharge destination> as important, but few of the long-term welfare facilities placed importance on <dressings>.

The Ministry of Health, Labour, and Welfare promotes support for the resumption of home life, specifying the basic principle of long-term care facilities as “helping facility users resume their home lives” (Ministry of Health, Labor and Welfare, 2017a). This may explain the higher rate of collecting information regarding <discharge destination> in long-term care facilities when creating care plans for independent excretion as a factor contributing to the resumption of home care.

In contrast, long-term welfare facilities are defined as facilities for older persons requiring care to lead their daily lives. When the Long-Term Care Insurance Act was revised in 2015, users of these facilities were basically limited to older persons with a care grade of 3 or higher. The mean care level in long-term welfare facilities was 3.91 in 2016 (Ministry of Health, Labor and Welfare, 2017b), suggesting the progression of care dependency among their users. Based on this, the necessity of approaches to improve <independent walking>, <dressings>, or other ADL abilities, which tend to be favorably maintained, may have been less noted in long-term welfare facilities, resulting in a lower

rate of collecting information regarding these contents for care plans. In fact, their care planners described: <Most residents of nursing homes for the elderly begin to use diapers on admission. Care plans for them rarely aim at the achievement/maintenance of independence> and <Almost all residents are using diapers and bedridden. They are far from being independent>, revealing their difficulty in creating care plans for independent excretion despite the progression of care dependency among facility users. Compared with most other ADL, excretion may markedly affect one's dignity, and his/her desire to maintain the ability to excrete independently is strong. Takeuchi (Takeuchi & Fujio, 2011) noted: "Their dignity remains impaired if caring for them is changing their diapers. Caregiving is a theory". Even when care dependency is marked, optimal interventional approaches should be provided toward the achievement/maintenance of independent excretion. In this respect, it may be necessary to enhance care planners' awareness of functional recovery care and provide them with related education.

2. Status of care plans for independent excretion in home services

The rate of creating excretion care plans was significantly lower in home care support offices compared with long-term care/welfare facilities. Among the 4 items listed on the comprehensive assessment sheet used for workshops to improve caregiving skills, <the frequency of urinary incontinence>, <bowel movements>, and <purgative use> were examined markedly less frequently in home care support offices when collecting information to create care plans for independent excretion.

As for excretion care as part of home care services, Nishii et al. (Nisihi, Funatani, Kumazawa et al. , 2008)noted that little attention is paid to excretion problems, and care dependency may be progressive in individuals with such problems, unless they are appropriately assessed and treated. Assessment for independent excretion was also insufficient in the present study. Furthermore, the care planners mentioned excretion care-related burdens on family caregivers, such as "Functional recovery care increases family burden. Therefore, in some cases, we use diapers even when independent excretion may be achieved" and "More effective care plans tend to be more burdensome for caregivers", as a challenge of care plans for independent excretion. Facility users' financial problems were another barrier to care plans for independent excretion, as some care planners noted: "It is difficult to use insurance services for sanitary disposal due to a low pension income". Such a situation of excretion care as part of home care services may be associated with complicating social factors, including caregivers and financial conditions. With the facility-to-home transition of long-term care, independent excretion is indispensable for the continuation of home life. It also enables older persons to continue to live in their communities with a sense of security. Therefore, intervention for independent excretion may also be essential in home care.

In the present study, the rates of being qualified as both a senior CM and certified CM and those only qualified as a senior CM were significantly higher in home care support

offices, suggesting that more skilled CMs are in charge of care plans in these offices. However, they did not create care plans for independent excretion due to the following complicating circumstances: Senior CM training is currently being provided to develop human resources who will lead other CMs, and nurture those who will promote community development toward the establishment of community-based integrated care systems. It is a pity that care management for independent excretion is not included in the purposes of this training. Independent excretion care cannot be completed by a single type of profession or institution, but it requires multi-professional team approaches and advanced care management skills. Therefore, it may be necessary to incorporate care management for independent excretion into programs to educate senior CMs in the future.

In summary, the present study revealed significant differences in the status of care plans for independent excretion and contents of information collected for such planning among different types of long-term care insurance service. However, with the response rate limited to 10.7%, the results cannot be fully generalized. As a future perspective, we will analyze the care planners' free descriptions to further clarify the challenges of care plans for independent excretion in Japan's long-term care insurance services. It may also be necessary to identify challenges of multi-professional and -institutional collaboration, in order to continuously provide independent excretion care, regardless of the site of long-term care.

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