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ORIGINAL ARTICLE

Perception of Dementia by Different Professionals When Discharging

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ABSTRACT

In order to reduce the difficulty of communication between occupations in supporting dementia patients from discharge, we investigated the perception of dementia in the profession involved in the discharge of dementia patients. Interviews were conducted with 18 professionals including doctors, nurses, medical social workers, care managers, and visiting nurses. The data were analyzed using content analysis. The results indicated that the perceptions regarding patients with dementia, their families, and symptoms of dementia could be classified into eight categories consisting 19 subcategories, which included 79 codes; [hospitalized patients have dementia], [patients with dementia are increasing], [dementia gets worse by hospitalization], [symptoms different from dementia are diagnosed as dementia at hospitals], [family's perception is different], [lack of ability to provide care by family members], [discharge coordination is not provided to patients with dementia], and [differences in discharge because of having dementia]. In some subcategories, a code was extracted from different professionals, or, from a specific professional. The results suggested differences regarding the perception of patients with dementia and symptoms of dementia in different professionals.

<Key-words>

patients with dementia, discharge coordination, interprofessional collaboration, communication, perception of dementia

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I. Introduction

It is predicted that the number of people with dementia will gradually increase, and managing people with dementia is an international issue. In 2016, the Ministry of Health, Labour and Welfare (MHLW) published the “Comprehensive strategies to promote measures for managing dementia: developing friendly communities for elderly with dementia (New Orange Plan)”. This plan proposed developing a circular system for providing appropriate treatment and rehabilitation to people showing Behavioral and Psychological Symptoms of Dementia (BPSD). The plan included the provision of appropriate services in suitable places for physical complications in medical institutions and care facilities, as well as after discharge.

Usually, people with dementia having different illnesses including cerebral infarction, pneumonia, fractures, and external injuries, heart failure, urinary tract infection, and hemiplegia, among others are hospitalized in general wards. For example, patients with dementia with Level II or higher levels of daily life independence account for approximately 20% of the patients in general hospital wards, and 60% or higher of the patients in long-term care hospital wards having a patient-to-nurse ratio of only 7:1 or 10:1 (MHLW, 2016). Therefore, many patients hospitalized in general wards also have dementia. These patients are discharged when treatment for the illness that caused hospitalization is completed, and they return to their homes or facilities. However, it is necessary to provide comprehensive and continuous home health and nursing care for such patients, especially after they return home. Therefore, it is important to develop a system of interprofessional collaboration among medical and welfare professionals to provide discharge coordination and appropriate services.

MHLW (2012) suggested that the following factors are necessary for patient discharge coordination: (1) treatment and support for stabilizing the medical conditions (medication treatment, psychiatric occupational therapy, among others.), (2) liaison and coordination with care managers for daily life support after discharge, and (3) support for family members and caregivers. However, Kinbara, Okada, and Shirasawa (2012) indicated there is role stress associated with collaboration between care managers and nurses working at elderly care facilities. Moreover, Harada and Yamane (2013) reported that it is difficult to share information among team members and collaborate among different professionals because of hesitation, among other reasons. Furthermore, Naruse and Uda (2018) indicated the following difficulties in interprofessional collaboration in home health care provision: (1) Communication difficulties with other professionals, including “lack of time for communicating,” “hesitating to contact other professionals because they might be busy,” “not being recognized by other professionals,” and “lack of knowledge about utilizing local resources.” (2) Difficulties in providing services, including “different perspectives and role expectations depending on the occupation” and “difficulties in sharing information about users.” (3) Difficulties in functioning as a team, including the “lack of information about

the abilities of others’, “difficulties in talking honestly,” and “walls between different professionals.” These difficulties are considered to be caused by the communication gap between different professionals. The communication gap is a gap in communication resulting from differences in understanding and values, as well as the lack of information (Matsumura, 2012). There are two types of communication gaps: the information gap resulting from the lack of information, and perception gap, resulting from differences in cultural backgrounds, the sense of values, experience, and problem consciousness, among others (Japan Contact Center Educational Testing Association, 2014). Differences in perceptions regarding patients and symptoms of dementia based on the occupation might cause a “perception gap” when discharging patients with dementia, leading to communication problems in interprofessional collaboration. Therefore, filling the gaps in perceptions among different professionals is expected to reduce communication difficulties, which is expected to lead to better coordination during discharge and the provision of support.

This study investigated the perceptions regarding patients with dementia, their families, and symptoms of dementia by different professionals involved in interprofessional collaboration. Moreover, the content of the communication gap and methods of reducing the gap was addressed in this study.

II. Objectives

The perceptions regarding patients with dementia, their families, and symptoms of dementia by different professionals involved in the discharge of patients with dementia was investigated in this study.

III. Methodology

1. Research design

Content analysis of semi-structured interviews.

2. Participants

Participants (N = 25) included 5 physicians, 5 discharge support nurses (nurses), 5 medical social workers (MSW), 5 care managers, and 5 visiting nurses with five or more years of experience. The participants were selected through snowball sampling.

3. Period of the study

December 2016 to March 2017

4. Content of the survey

Perceptions regarding patients with dementia and symptoms of dementia were investigated in professional workers at the point of discharging patients.

5. Data collection

Semi-structured interviews were conducted based on an interview guide.

Semi-structured interviews are easy to encourage free thinking and speech by study participants, and researchers can find issues to pursue during interviews and develop questions, by making effective use of interview guides. There is an advantage that it is easy to collect data according to the research purpose (Yatsu, 2000).

Requests for conducting the study was submitted to facility directors. Professionals that agreed to cooperate in this study were selected to take part in the study. Participants were interviewed for approximately 60 minutes after agreeing with the conditions of a written and oral explanation of the research. Each participant introduced the next participant until there were no more remaining people to introduce.

6. Analysis

Verbatim transcripts were developed based on IC recordings and analyzed for their content. Transcripts included only the data that participants consented for the analysis. Data was chunked while preserving meaning and then coded, divided into similar themes and then categorized according to the advice of the research director. Division of data was spread out over time to maintain the validity and reliability and repeated until categories were fixed.

7. Ethical considerations

A letter of request was distributed to facility directors and participants in the study stating the purpose of the study. The letter included a summary explaining that interview data would be used only for this study and would be destroyed five years after the conclusion of the study, or 3 years from the final research presentation. The letter also explained that results might be presented at symposiums or academic journals, but only in such a way that individual information would not be unidentifiable. The letter further explained that participation in the study was voluntary, that there would be no unfavorable consequences if participants did not respond. Moreover, it was explained that participants were free to withdraw from interviews at any time even after granting consent. None of the authors have any conflicts of interest associated with this research. This study has been approved by the International University of Health and Welfare IRB (Approval Number: 16-Ig-84).

IV. Results

1. Participants

Participants (N = 18) including 3 doctors, 3 nurses, 4 MSWs, 5 care managers, and 3 visiting nurses took part in the study (Table 1).

<Table 1> Basic attributes

Basic license	Age	Sex	Duty place		Length of service (years)	
Doctor	1	40s	Male	University hospital	Physician	21
	2	60s	Male	hospital	Surgeon	41
	3	40s	Male	General hospital	Physician	21
Nurse	1	60s	Female	hospital	Discharge support room	30<
	2	40s	Female	hospital	Discharge support room	8
	3	40s	Female	hospital	Discharge adjustment	17
Medical social worker	1	40s	Female	hospital		15
	2	40s	Female	hospital		16
	3	40s	Female	hospital		17
	4	30s	Female	hospital		7
Care manager	1	40s	Female	Home care support establishment	Care job	9
	2	50s	Female	Visit care support	Counselor	17
	3	40s	Female	Home care support establishment	Medical social worker	5
	4	50s	Female	Home care support establishment	Welfare job	5<
	5	50s	Female	Home care support establishment	Care job	11
Health visitor	1	50s	Female	Home nursing station		18
	2	40s	Female	Home nursing station		20
	3	40s	Female	Home nursing station		5<

2. Perceptions about dementia patients, their families, and dementia

We analyzed the content of the interviews. The results indicated the following eight categories consisting of 19 subcategories that included 79 codes: [hospitalized patients have dementia], [patients with dementia are increasing], [dementia gets worse by hospitalization], [symptoms different from dementia are diagnosed as dementia at hospitals], [family's perception is different], [lack of ability to provide care by family members], [discharge coordination is not provided to patients with dementia], and [differences in discharge because of having dementia].

Categories are indicated by [], subcategories are indicated by { }, and codes are indicated by < >. Letters after codes indicate Doctors (Dr), Nurses (Ns), Medical social workers (MSW; M), Care managers (C), and Visiting nurses (V).

1) Perceptions regarding patients with dementia

Among the eight categories that were extracted, [hospitalized patients have dementia] and [patients with dementia are increasing] were categories representing perceptions regarding patients with dementia. [Hospitalized patients have dementia] consisted of the two following subcategories and 11 codes; {dementia exists in the base of patients

hospitalized because of physical diseases} and {hospitalized patients have dementia}. [Patients with dementia are increasing] consisted of the two following subcategories and seven codes: {patients with dementia are increasing} and {there have been patients with dementia before} (Table 2). The codes, {dementia exists in the base of patients hospitalized because of physical diseases} included <many patients have dementia as well as other diseases, and are often hospitalized again> (V/1), and <some patients repeatedly have aspiration pneumonia and leave the hospital> (V/1) among others, which were extracted from visiting nurses. The codes, {hospitalized patients have dementia} were <most of the hospitalized patients have dementia> (Ns/1) and <most of the patients with diseases have mild dementia> (C/2), which were extracted from professionals other than MSW.

Moreover, the codes, {patients with dementia are increasing} included <I feel patients with dementia are rapidly increasing> (Dr/2) among others, which these codes were often extracted from doctors. The codes, {there have been patients with dementia from before} included <there is no impression that patients with dementia have suddenly increased> (M/3) and <the number of home care patients with dementia is larger than that of hospitalized patients> (V/3), which were extracted from MSW, care managers, and visiting nurses.

<Table 2> Perceptions regarding patients with dementia

Categories	Subcategories	Codes (Basic license/the person number)
Hospitalized patients have dementia.	Dementia exists in the base of patients hospitalized because of physical diseases.	Many patients have dementia as well as other diseases and are often hospitalized again. (V/1)
		Some patients repeat aspiration pneumonia and leave the hospital. (V/1)
		Many people having dementia get cancer, hospitalized and discharged. (V/1)
	Hospitalized patients have dementia.	There are many users having dementia. (V/2)
		The percentage of patients with dementia is rather high. (V/1)
		Approximately half of the elderly have dementia. (V/2)
		Most of the hospitalized patients have dementia. (Ns/1)
		Although not having diagnosed, most of the patients have mild dementia. (V/3)
		Many people are classified into I or II stages of dementia, and not severely demented. (V/1)
		People that are diagnosed and not diagnosed as dementia are increasing. (Dr/3)
Most of the patients with diseases have mild dementia. (C/2)		
Patients with dementia are increasing.	Patients with dementia are increasing.	Patients with dementia are increasing. (Dr/1.2.3, C/3, V/1)
		People with dementia are increasing with aging. (Dr/1)
		I feel patients with dementia are rapidly increasing. (Dr/2)
	There have been patients with dementia from before.	Not many patients with dementia are discharged from the hospital. (C/4)
		There is no impression that patients with dementia have suddenly increased. (M/3)
		Although I have an impression that there are people with dementia, but don't know whether they are increasing. (C/4)
		The number of home care patients with dementia is larger than that of hospitalized patients. (V/3)

*(Dr):Doctors, (Ns) :Nurses, (M):Medical social workers , (C):Care managers, (V) :Visiting nurses

2) Perceptions regarding dementia symptoms

Two categories were extracted: [dementia gets worse by hospitalization] and [symptoms different from dementia are diagnosed as dementia at hospitals]. The former consisted of the following subcategories that included 13 codes; {when getting hospitalized, dementia gets worse} and {the pace of hospital life and restriction worsen dementia}. The latter consisted of the two following subcategories that included four codes; {the symptoms that are not regarded as dementia at home are diagnosed as dementia at hospitals and considered a problem} and {symptoms that are not dementia are diagnosed as dementia} (Table 3).

The codes {when getting hospitalized, dementia gets worse} were as follows; <physical levels rather decline, depending on the hospitalization period> (C/2), <although physical conditions improved, it is difficult to live at home because of dementia> (Dr/3), and <in many cases, cognitive functions further decline through hospitalization and it is impossible for the family to accept the patient> (Dr/3), among others, were extracted from doctors, care managers, and visiting nurses. The codes, {the pace of hospital life and restriction worsen dementia} were as follows; <especially people with dementia feel as if they are tortured. When resisting hospital staff because they did what the patient disliked, including bed-baths or perineal care, the patient is considered heavily demented and physically restrained> (Dr/2) and <patients are not accustomed to the hospital environment. Moreover, different types of care are provided automatically for treatment without patients' consent, getting patients with dementia confused> (C/5), which were extracted from doctors and care managers.

The codes, {the symptoms that are not regarded as dementia at home are diagnosed as dementia in the hospital and considered a problem} were as follows; <symptoms that are not regarded as dementia at home are perceived as dementia when hospitalized> (Dr/2) and <dementia symptoms that did not stand out at home become highlighted by hospitalization> (Ns/1), among others, which were extracted from doctors and nurses. The code of {symptoms that are not dementia are diagnosed as dementia} was <depression, schizophrenia, among others are included in dementia. Patients with such symptoms are discharged from the hospital diagnosed as dementia> (C/2), extracted from a care manager.

<Table 3> Perceptions regarding symptoms of dementia

Categories	Subcategories	Codes (Basic license/the person number)
Dementia gets worse by hospitalization.	When getting hospitalized, dementia gets worse.	Dementia gets worse in nine in ten patients. (C/2)
		Dementia in people having had surgery and returned home gets heavier compared to those without having surgery. (C/2)
		In patients with Alzheimer's disease, the symptoms develop gradually. In patients with cerebrovascular diseases, the symptoms develop slowly to some extent, if not having an attack. Few patients can maintain the condition and gets worse. (V/2)
		Cognitive abilities in people that are hospitalized and need medical treatment for complications rapidly decline. Early discharge is desirable. (V/3)
		Physical levels rather decline, depending on the hospitalization period. (C/2)
		Although physical conditions improved, it is difficult to live at home because of dementia. (Dr/3)
		In many cases, cognitive functions further decline through hospitalization and it is impossible for the family to accept the patient> (Dr/3)
		Family members know that dementia develops by hospitalization. Therefore, some members do not want the patient hospitalized if in-home care is available. (C/5)
		The patient had a compression fracture and hospitalized. If there are no differences between hospital care and in-home care, early discharge is desirable before developing delirium. (V/2)
		The pace of hospital life and restriction worsen dementia.
Especially people with dementia feel as if they are tortured. When resisting hospital staff because they did what the patient disliked, such as bed bath or perineal care, the patient is considered heavily demented and physically restrained. (Dr/2)		
In the surgical ward and gastrointestinal ward, patients are sometimes restrained for treatment. (C/5)		
Patients are not accustomed to the hospital environment. Moreover, various types of care are provided automatically for treatment without patients' consent, getting patients with dementia confused. (C/5)		
Symptoms different from dementia are diagnosed as dementia at hospitals.	The symptoms that are not regarded as dementia at home are diagnosed as dementia at hospitals and considered a problem.	Symptoms that are not regarded as delirium at home are regarded as delirium when hospitalized. (Dr/2)
		The cases in which slightly forgetful conditions are diagnosed as dementia are increasing. (Dr/1)
		Dementia symptoms that did not stand out at home become highlighted by hospitalization. (Ns/1)
	Symptoms that are not dementia are diagnosed as	Depression, schizophrenia, among others are included in dementia. Patients with such symptoms are discharged from the hospital diagnosed as dementia. (C/2)

*(Dr):Doctors, (Ns):Nurses, (M):Medical social workers, (C):Care managers, (V):Visiting nurses

3) Perceptions regarding families of patients with dementia

Two categories were extracted below; [family's perception is different] and [lack of ability to provide care by family members]. The former consisted of the following two subcategories that included five codes; {insufficient understanding from family} and {family members have different recognition}. The latter consisted of the following three subcategories and 13 codes; {sometimes family members have dementia}, {it is difficult to decide on a place to live because of lack of ability to care}, and {returning home rather

than entering facilities}. See Table 4.

One of the codes {insufficient understanding from family} was as follows: <although family members think the patient still needs treatment, the patient needs care rather than treatment. Family members think the patient cannot leave the hospital without the ability to walk. Some people do not understand that a person cannot enter the hospital without the ability to walk> (M/2). The codes, {family members have different recognition} were extracted from MSW and nurses, including <family members say that the patient does not have dementia because he/she behaved properly at home> (Ns/1), among others.

The codes, {sometimes family members have dementia} were extracted from MSW, including <the head of the family, i.e., the key person, or his wife, has mild dementia> (M/2) and <the person living with the patient has dementia. In some cases, the person that has been taken care of the patient gets sick> (M/2), among others. The codes for {it is difficult to decide on a place to live because of lack of ability to care} were extracted from doctors, MSW, and visiting nurse, including <caregivers do not have sufficient ability to care, or, family members are working during the daytime and cannot take care of the patient> (V/1), <many patients live alone or live with another person at home. It is difficult for them to live daily life by themselves, including drug and toilet management, among others.> (V/1), and <family members released from caring for the patient by hospitalization cannot return to their previous life, and want the patient to stay in hospital> (Dr/2), among others. The codes, {returning home rather than entering facilities} were extracted from care managers, including <although looking for care facilities, the facilities did not accept the patient and there was no choice but to return home> (C/5) and <in many cases, patients return home rather than entering a facility> (C/1), among others.

<Table 4> Perceptions regarding families of patients with dementia

Categories	Subcategories	Codes (Basic license/the person number)
Family's perceptions are different.	Insufficient understanding from family.	Although family members think the patient still needs treatment, the patient needs care rather than treatment. Family members think the patient cannot leave the hospital without the ability to walk. Some people do not understand that a person cannot enter the hospital without the ability to walk. (M/2)
		It is difficult to decide how much asking for understanding from family. (M/2)
	Family members have different perceptions.	The patient him/herself does not recognize that he/she has dementia. Family neither. (M/2)
		Sometimes family members refuse to receive service and support. It is difficult to let them accept the service and support. (M/2)
		Family members say that the patient does not have dementia because he/she behaved properly at home. (Ns/1)
Lack of ability to provide care by family members.	Sometimes family members have dementia.	Often family members have dementia. (M/2)
		The head of the family, i.e., the key person, or his wife, has mild dementia. (M/2)
		The person living with the patient has dementia. In some cases, the person that has been taken care of the patient gets sick. (M/2)
	It is difficult to decide the place to live because of the lack of ability to care.	It is difficult to take care of the patient at home. For example, people that had been living alone cannot live by themselves anymore, or, the old husband is taking care of his old wife, and vice versa. Even if children live together, it is difficult for them to take care of their demented parents. (Dr/3)
		Caregivers do not have enough ability to care, or, family members are working during the daytime and cannot take care of the patient. (V/1)
		Many patients live alone or live with the other person at home. It is difficult for them to live daily life by themselves, including drug management and excretion management, etc. (V/1)
		There are various cases. It is difficult to deal with patients with dementia living alone. (M/2)
		Family members that were released from taking care of the patient by hospitalization cannot return to the previous life and want the patient to stay in the hospital. (Dr/2)
		It takes time to decide the place to live. There are facilities that do not accept the demented patients. (Dr/3)
		Those that have not diagnosed as dementia, but might have dementia, often return home. (C/1)
Returning home rather than entering facilities.	In many cases, patients return home rather than entering a facility. (C/1)	
	Although looking for care facilities, the facilities did not accept the patient and there was no choice but to return home. (C/5)	
	The mean number of the case of returning home is approximately 10 a year. (C/1)	

*(Dr):Doctors, (Ns):Nurses, (M):Medical social workers, (C):Care managers, (V):Visiting nurses

4) Perceptions regarding discharging patients with dementia

Two categories were extracted: [discharge coordination is not provided to patients with dementia] and [differences in discharge because of dementia]. The former consisted of the following three subcategories that included 14 codes: {there are no problems in the discharge of patients with dementia}, {home-visit nursing for patients with dementia is not accepted when the original disease has been cured}, and {professionals involved in discharge differ depending on the symptoms}. The latter consisted of the three following subcategories that included 12 codes: {patients are discharged because of having dementia

symptoms}, {there is no rapid discharge from the hospital because of dementia}, and {certain conditions are required for hospital discharge}. See Table 5.

The codes, {there are no problems in the discharge of patients with dementia} were extracted from doctors, care managers, and visiting nurses, including <coordination of discharge date is not necessary for patients with dementia because they rarely prepare welfare goods> (V/1), <patients with dementia do not need any discharge coordination> (C/4), and <there are no problems in the discharge of patients with dementia> (Dr/3). The codes, {home-visit nursing for patients with dementia is not accepted when the original disease has been cured} were extracted from visiting nurses, including <it is very important to understand the physical conditions by home-visit nursing because patients with dementia cannot tell their medical conditions by themselves. However, when physical conditions are stable, home-visit nursing is hardly accepted> (V/2) and <when the original disease has been cured even having dementia, requests for home-visit nursing are very few> (V/2). The codes, {professionals involved in discharge coordination differ depending on the symptoms} were extracted from visiting nurses and care managers, including <when patients have dementia, they refuse to receive nursing> (C/5) and <discharge of terminal cancer patients is supported by the visiting care system through collaboration among doctors, nurses, patients' family, visiting nurses, and home caregivers> (C/5).

The codes, {patients are discharged because of having dementia symptoms} were extracted from care managers and nurses, including <some patients often return home the next morning because of dementia> (C/5), <some patients ask the discharge date when intravenous drips finish> (Ns/2), and <it is difficult to provide treatment because of dementia> (C/5), among others. The codes, {there is no rapid discharge from the hospital because of dementia} were extracted from care managers, including <there has been no discharge because of dementia, although sometimes patients with dementia have been discharged suddenly because there was another patient that needed immediate hospitalization> (C/4). One of the codes, {certain conditions are required for hospital discharge} was extracted from a doctor; <firstly, the previous support system should be confirmed. When the patient had a care manager or received home-visit nursing, and home-visit medical treatment, the patient's current conditions should be explained to the staff, necessary care and nursing are coordinated, and then the patient returns home> (Dr/2).

<Table 5> Perceptions about discharging patients with dementia

Categories	Subcategories	Codes (Basic license/the person number)
Discharge coordination is not provided to patients with dementia.	There are no problems in the discharge of patients with dementia.	When the dementia level and ADL do not change through hospitalization, patients return home without having a conference. (Dr/2)
		Patients with dementia were returned home without having a discharge conference. Now, they have a conference before discharge. (C/1)
		Coordination of discharge date is not necessary for patients with dementia because they rarely prepare welfare goods. (V/1)
		Patients with dementia do not need discharge coordination. (C/4)
		There are no problems in the discharge of patients with dementia. (Dr/3)
		There is no discharge coordination for patients with dementia. (C/4)
	Home-visit nursing for patients with dementia is not accepted when the original disease has been cured.	When having a conference, it is difficult to ask the patient's intention because he/she is demented. (C/4)
		We rarely participate in discharge coordination for home-visit nursing for patients with dementia. (V/2)
		When the original disease has been cured even having dementia, requests for home-visit nursing are very few. (V/2)
		It is very important to understand the physical conditions by home-visit nursing because patients with dementia cannot tell their medical conditions by themselves. However, when physical conditions are stable, home-visit nursing is hardly accepted. (V/2)
Professionals involved in discharge coordination differ depending on the symptoms.	Responding to the request from a care manager, a visiting nurse participated in discharge coordination. (V/2)	
	When patients have dementia, they refuse nursing. (C/5)	
	There is no chance to talk with a doctor in a big hospital. (C/5)	
	Discharge of terminal cancer patients is supported by the visiting care system through collaboration among doctors, nurses, patients' family, visiting nurses, and home caregivers. (C/5)	
Differences in discharge because of having dementia.	Patients are discharged because of having dementia symptoms.	Patients living home return home as soon as possible even when they are hospitalized. (C/5)
		Some patients often return home the next morning because of delirium. (C/5)
		Treatment is the first priority at a hospital. When delirium occurs, or medical restraint is required, I sometimes picked up the patient because treatment was impossible. (C/5)
		Some patients ask the discharge date when intravenous drops finish. (Ns/2)
		It is difficult to provide treatment because of dementia. (C/5)
	There is no rapid discharge from the hospital because of dementia.	Patients with dementia do not positively receive treatment. They received outpatient service more often than hospitalization. (Ns/3)
		Some patients with dementia are discharged because of a decline in swallowing functions. (V/1)
		There is no rapid discharge because of dementia. (C/4)
		There has been no discharge because of dementia, although sometimes patients with dementia were suddenly discharged because there was another patient that needs to be hospitalized immediately. (C/4)
		Admission is decided based on the policies of the facility, not whether having dementia or not. (M/3)
Certain conditions are required for hospital discharge.	Firstly, the previous support system should be confirmed. When the patient had a care manager or received home-visit nursing and home-visit medical treatment, the patient's current conditions should be explained to the staff, necessary care and nursing are coordinated, and then the patient returns home. (Dr/2)	
	After a certain period of hospitalization, the patient should return home. (V/2)	

*(Dr):Doctors, (Ns):Nurses, (M):Medical social workers, (C):Care managers, (V):Visiting nurses

V. Discussion

1. Perceptions regarding patients with dementia and symptoms of dementia

Professional workers involved in the discharge of patients with dementia recognized that {in the base of patients hospitalized because of physical diseases, dementia exists}. or {hospitalized patients have dementia}. As reported by MHLW (2016) patients with dementia accounted for approximately 20%, and in long-term care hospitals, patients with dementia accounted for 60% or higher in wards with a patient-to-nurse ratio of 7:1 or 10:1. The results indicated that professionals working in hospitals perceived that many inpatients have dementia. Moreover, doctors recognized that {patients with dementia are increasing}, MSW, care managers, and visiting nurses perceived {there have been patients with dementia from before}. These perceptions might be the result of such professionals interacting with many patients with dementia to date when conducting discharge duties and support activities.

Doctors, care managers and visiting nurses recognized the following: {when getting hospitalized, dementia gets worse} and {the pace of hospital life and medical restriction worsen dementia}. Miyoshi (2017) suggested that people with dementia are people that could not adapt to aging. When such people experience environmental changes, it is possible that the symptoms get serious and problem behaviors increase. Moreover, older adults feel much stress with lifestyle changes. It is suggested that patients and older adults with dementia cannot adapt themselves to environmental and lifestyle changes caused by hospitalization, which leads to the deterioration or the onset of dementia symptoms. MHLW (2015) reported that both early responses to physical complications and appropriate measures for dealing with dementia among others, are required in acute care hospitals. However, it is sometimes difficult to individually manage each patient with dementia appropriately, which result in the rapid worsening of dementia symptoms. This situation might lead to perceptions including {patients with dementia are increasing} and {when getting hospitalized, dementia gets worse}. Moreover, perceptions including {the symptoms that are not regarded as dementia at home are diagnosed as dementia in the hospital and considered a problem} (<symptoms that are not regarded as dementia at home are regarded as dementia when hospitalized> (Dr/2) and <dementia symptoms that did not stand out at home become highlighted by hospitalization> (Ns/1)), or, {symptoms that are not dementia are diagnosed as dementia} (<depression, schizophrenia, among others are included in dementia. Discharging such patients with these symptoms from the hospital, with a diagnosis of dementia> (C/2)) might lead to the recognition, {patients with dementia are increasing}.

2. Perceptions regarding families of patients with dementia and discharge from hospital

Families of patients with dementia were recognized mainly by MSW as follows; <although family members think the patient still needs treatment, the patient needs care

rather than treatment. Family members think the patient cannot leave the hospital without being able to walk. Some people do not understand that a person cannot enter a hospital without being able to walk> (M/2) ({insufficient understanding from family}), or, <family members say that the patient does not have dementia because he/she behaved properly at home> (Ns/1) ({family members have different recognition}).

The Japan Medical Association (2016) has stated; “patients and their families tend to think that patients are discharged from hospital when they recover to a state that is similar to the condition before entering the hospital. However, in many cases, patients still need medical support, or, might be in a state in which different functions have declined. Therefore, patients and their families tend to be anxious about life after discharge.

Moreover, families have got accustomed to the condition of patients that had mild dementia before entering the hospital and might have doubts about being diagnosed with dementia, or, find it difficult to accept the diagnosis. Therefore, especially MSW who must conduct the discharge procedures with families first might have recognized that {family members do not have sufficient understanding} or {family members have different perceptions}. Moreover, medical workers might express all the symptoms of a patient, including dementia symptoms and temporary confusion as dementia. Both medical workers and families might not correctly understand dementia symptoms, leading to perceptions such as {insufficient understanding from family} or {family members have different recognition}.

According to Matsuo (2011) when communication with older adults with dementia is difficult, or their behavior is unpredictable, nurses tend to be abrupt without finding a permanent solution to their problems, because of their lack of experience or prejudices. This is because nurses are unaware of appropriate methods for managing these patients. As a result, it is necessary for medical professionals to acquire appropriate knowledge for assessing patients with dementia during acute medical care. Moreover, there are few nurses in hospital wards that have the experience of being a visiting nurse or doing welfare-related work. Therefore, it is difficult to share the experiences or an image of patients' life at-home among nurses (Kawashima et al., 2015). Not only nurses but also doctors and MSW cannot imagine patients' life at-home, which result in differences in perceptions about discharge and the coordination of discharge.

Matsuoka (2011) stated that most patients with dementia are older adults having various chronic diseases and a decline in physical functions. Therefore, an interprofessional team approach is required for managing their physical and various psychological and social care needs, including problems related to nursing care. However, the results of this study indicate that staff involved in discharging patients with dementia recognized that [discharge coordination is not provided to patients with dementia] including subcategories such as, {there are no problems in the discharge of patients with dementia} and {home-visit nursing for patients with dementia is not accepted when the

original disease has been cured}.

In terminal care for cancer patients, among others, it is possible to listen to patients' and their families' opinions and set goals based on their opinions. On the other hand, in the case of patients with dementia, it is difficult for them to express their desires, which might lead to the perception that [discharge coordination is not provided to patients with dementia]. Ozawa et al. (2014) stated that when patients maintain verbal abilities, medical workers can use language to communicate with them. However, when patients have language impairments, communication tends to be with patients' families or caregivers, instead of the patients themselves. Moreover, in many cases when elderly patients with dementia are discharged from the hospital, their husband or wife also tend to have dementia. Furthermore, the number of older adults living alone has been increasing recently, which might lead to difficulties in discharge coordination for patients with dementia.

MHLW (2012) reported that there are families hoping for in-home care, but hesitate about discharge because of the heavy load imposed on them. Patients with dementia often need medical support, or, have a decline in various functions compared to before hospitalization. Therefore, patients and their families tend to feel anxious about life after discharge (Japan Medical Association, 2016). It is necessary to have a conference for developing interprofessional collaboration before a discharge, through which patients, their families, and members supporting home care can directly meet one another, decide the future care system, and thereby reduce anxiety associated with being discharged (Japan Medical Association, 2016). However, MHLW (2015) reported that only under 50% of dementia patients were discharged after taking measures including "a conference to discuss methods of providing home care," "taking manual based preventive measures," and "dealing with the patients depending on the conditions according to nursing plans."

At the conference, medical and welfare professionals can discuss the common topics and based on their specialty, strong or weak points, and limitations, among others. Through collaboration, they can experience synergistic effects, leading to an improvement in service quality. Having a conference is a simulation having a sense of reality. Accumulating such experiences can lead to team formation (Shinoda, 2011). It is necessary to have a conference not only at the discharge of patients with dementia but also during hospitalization. However, there are difficulties in functioning as a care team. According to Naruse and Uda (2018), medical professionals responded that "the abilities of other professions are unknown. Therefore, it is difficult to decide the level at which we should talk to them," and nurses responded, "we cannot honestly talk with other professionals," and welfare workers responded, "there is a wall between other professionals and us." Especially they felt a distance from medical professionals. Moreover, Kikuchi (2000) indicated that a unique structure (positions and roles) in the team approach is formed during interprofessional collaboration, which causes consistent or inconsistent problems with the organizational structure (positions and roles). Furthermore, Kamiyama and

Sasaki (2011) reported that there are communication gaps between care workers and medical professionals because their knowledge bases are different, and filling this gap is an urgent issue.

This study examined perceptions regarding patients with dementia and their families, as well as dementia symptoms in different professionals involved in the discharge of patients. Moreover, a code was extracted for certain subcategories from different types of professionals or from a specific type of professional. It was suggested that the perception of patients with dementia and dementia symptoms might differ depending on the occupation. That said, this study was limited by a small number of interviewees, and coding may have been biased due to a semi-structured interview format. In the future, effective measures for reducing the communication gap among professionals should be developed for improving discharge coordination and support after discharge.

VI. Conclusions

Eight categories of perceptions regarding patients with dementia, their families, and symptoms of dementia in professionals involved in the discharge of patients were extracted in this study. These included: [hospitalized patients have dementia], [patients with dementia are increasing], [dementia gets worse by hospitalization], [Symptoms different from dementia are diagnosed as dementia at hospitals], [family's perception is different], [lack of ability to provide care by family members], [discharge coordination is not provided to patients with dementia], and [differences in discharge because of having dementia]. A code was extracted for some subcategories from different types of professionals or a specific type of professional. Results suggested that the perception of patients with dementia and dementia symptoms differ depending on the occupation.

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References

- 1) Akira MATSUMURA ed. (2012) *Daijisen dai ni han* [Major Japanese dictionary, Second ed.]. Shogakukan Inc., Tokyo.
- 2) Chiyo MATSUOKA (2011) *Chīmu apurōch ni motomerareru komyunikēshon sukiru* [Communication skills required for team approach]. *Case journal of dementia care*. 3(4), 401-408.
- 3) Haruki MIYOSHI (2017) *Ninchishō kea no nana dai gensoku* [Seven major principles of dementia care]. Nagomi care Saitama Ageo home-visit nursing office. Retrieved October 29, 2017. <http://www.nagomi-care.net/article/13957705.html>
- 4) Japan Contact Center Educational Testing Association. (2014) *Kontakuto sentā sūpābaizā kanzen manyuaru* [Contact center supervisor complete manual]. FOM Direct, Tokyo.
- 5) Japan Medical Association (2016) *Chiiki houkatsu kea to tashokushu renkei-Gakushūyou wākubukku* [Comprehensive community care and interprofessional collaboration: workbook for learning]. Tokyo: Japan Medical Association, 8.
- 6) Kana MATSUO (2011) *Ippan byoutou ni oite kangoshi ga taiken shita ninchishō kanja eno taiou no konnansa* [Difficulties in dealing with patients with dementia experienced by general ward nurses]. *Bulletin of the Japanese Red Cross College of Nursing*, No. 25, 106-109.
- 7) Kazuko NARUSE & Midori UDA (2018) *Zaitaku kea ni okeru tashokushu renkei no konnan to kadai* [Difficulties and problems in interprofessional collaboration for in-home care]. *Bulletin of Kobe City College of Nursing*, Vol.22, 12.
- 8) Kazunori KIKUCHI (2000) *Tashokushu chīmu no kouzou to kinou-Tashokushu chīmu kenkyū no kihonteki wakugumi* [The structure and functions of interprofessional teams: Basic frameworks of studies on interprofessional teams]. *Japanese journal of social welfare*, 41 (1), 13-25. Doi:10.24469/jssw.41.1_13
- 9) Kyoko KINBARA, Shinichi OKADA, & Masakazu SHIRASAWA (2012) *Kaigo roujin fukushi shisetsu no kaigoshoku tonno renkei ni okeru "yakuwari sutoresu" no kouzou* [The structure of "role stress" in collaboration with care workers in nursing care facilities]. *Research journal of care and welfare*, 19, 42-50.
- 10) Michiko SHINODA (2011) *Tashokushu renkei wo takameru chīmu manejimento no chishiki to sukiru* [Knowledge and skills of team management for improving interprofessional collaboration]. Igaku-Shoin Ltd., Tokyo.
- 11) Ministry of Health, Labour and Welfare (2012) *Ninchishō kanja eno taiin shien* [Discharge support for patients with dementia]. Retrieved July 1, 2016 <http://www.mhlw.go.jp/topics/2012/01/dl/tp0118-1-40.pdf>
- 12) Ministry of Health, Labour and Welfare (2015) Nyūin iryou (6) [Hospitalization for medical care (6)]. Retrieved July 1, 2016. <http://www.mhlw.go.jp/file/05-Shingikai-12404000-Hokenkyoku-Iryouka/00001050>

- 13) Ministry of Health, Labour and Welfare (2016) *Ninchishō shisaku* [Dementia strategies]. Retrieved July 1, 2016
<http://www.mhlw.go.jp/stf/seisakunitsuite/bunya/0000076236.html>
- 14) Miwa OZAWA, Masahiro KODAMA & Yutaka MATSUI ed. (2014) *Shougai hattatsu no naka no kaunseringu IV-Kango genba de ikiru kaunseringu* [Counseling in life-span development IV: Counseling utilized for nursing care]. Saiensu sha Co., Ltd., Tokyo.
- 15) Motoko KAWASHIMA, Masami MORI, Ai MATSUMIYA, & Atsuko ISOBE (2015) *Byoutou kangoshi no taiin shien no genjō to kadai-Kanja ga chiiki e anshin shite modoru tamenī* [The state and problems in discharge support provided by ward nurses; supporting patients in returning to local communities at ease]. *Seisen journal of nursing studies*, 4, 29-38.
- 16) Motoyuki KAMIYAMA & Yoshie SASAKI (2011) *Iryōteki kea ni okeru kaigoshoku no fuan to kattō ni taisuru ichikōsatsu-Koureisha kea shisetsu ni okeru iryōteki kea no jittai oyobi fuan, kattō ni kansuru chousa kara* [Anxiety and conflicts in care workers working at nursing care facilities in providing medical care-Based on the survey on the state of medical care, anxiety, and conflicts at nursing care facilities]. *Oral presentation at the 19th annual meeting of the Japanese Association of Research on Care and Welfare*.
- 17) Sayo HARADA & Hiroshi YAMANE (2013) *Kourei seishin shougaiisha no zaitaku seikatsu shien ni okeru hōmu herupā no kea konnankan to tashokushu renkei no kadai* [Home-care workers' difficulties in providing in-home care to elderly people with mental disabilities and problems in interprofessional collaboration]. *Japanese Journal of Psychiatric Rehabilitation*, 17(1), 50-59.
- 18) Hiroko YATSU (2010) *Start Up Shitsuteki kango kenkyu* [Start Up Qualitative nursing research]. Gakken medical syuujyunsha, Tokyo.



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