Nurses' and Care Workers' Perception of Care Quality in Japanese Long-Term Care Wards: A Qualitative Descriptive Study

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Abstract

Despite the growing importance of long-term care for older adults, there has been limited attention to its quality assurance issues in Japan. To start planning the initiation of continuous quality improvement in long-term care hospitals, we explored how nurses and care workers themselves perceived current approaches to quality assurance and improvement on their ward. We interviewed 16 licensed nurses and nine care workers, transcribed and analyzed data using qualitative content analysis techniques, and derived six categories: *keeping clients alive is barely possible, the absence of a long-term care practice model, the lack of quality indicators, long-term care hospitals as places for castaways, client quality of life as a source of satisfaction*, and *conflict between staff and client well-being*. To develop continuous quality improvement in Japanese long-term care hospitals, it may be first necessary to introduce a practice model of long-term care and mechanisms to evaluate quality.

Keywords

nursing, long-term care, geriatrics, qualitative research

Introduction

The increase in the elderly population is a global phenomenon. In Japan, the percentage of people who are 80 years old or above is expected to increase from 8.6% in 2017 to 21.9% in 2065 (National Institute of Population and Social Security Research, 2017). Increasing numbers of elderly people need assistance with daily living. For this reason, providing quality long-term care for older people approaching the final stages of life is an issue of international interest and importance, especially in Japan.

Few studies have examined quality assurance and improvement in Japanese residential long-term care. This may reflect the recent emphasis on community/home care for older adults. It strongly contrasts with an extensive history of research on quality assurance and improvement over long-term care in countries such as the United States and Canada. The United States has a long history of promoting quality improvement at nursing homes (Rahman & Schnelle, 2008). Many approaches have been attempted, with various target outcomes; these include re-hospitalization (Kane et al., 2017; Rantz et al., 2017), the reduced use of antipsychotic medications (Simmons et al., 2017), and improved resident satisfaction (Poey et al., 2017).

As mechanisms for quality assurance and improvement, there have been multiple quality indicators (QIs) for long-term care in the United States endorsed by the National Quality Forum (2011) and Center for Medicare & Medicaid Services (2017), among others. The U.S. federal government has established quality measures for various settings, including long-term hospitals, nursing homes, and centers that provide palliative care (Center for Medicare & Medicaid Services, 2017). Similar quality improvement mechanisms have also been promoted in Canada, with an additional emphasis on the impact of staff well-being on care quality (Chamberlain et al., 2017). Development of quality improvement interventions has been attempted in other countries such as Italy (Barsanti, Walker, Seghieri, Rosa, & Wodchis, 2017) and Brazil (Fonseca de Oliveira, Saturno Hernandez, de Meneses Sousa, da Silva, & da Silva Gama, 2017).

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In Japan, there are various types of elderly residential care facilities, including nursing homes with limited capacity for medical treatment, convalescent facilities, and group homes for people with dementia (Ministry of Health, Labour, and Welfare, 2015). Another option for those requiring both long-term care and medical interventions is long-term care hospitals (Igarashi et al., 2013). Currently, in most long-term care hospitals, quality assurance and improvement has been largely the responsibility of individual agencies, which may opt to only provide simple educational programs for staff. These facilities have limited access to information to evaluate care quality, while actual quality assurance and improvement interventions have been scarce, apart from some research-based trials (Ikezaki, Mori, & Ikegami, 2010; Kanehira, Sakamoto, & Kato, 2004; Kaneko, 2015; Kawamura, 2004; Kitakami, 2004).

Nurse managers, staff licensed nurses, and care workers are the main care providers in long-term care hospitals. Care quality is largely dependent on how much effort these individuals put into their daily work. Existing research on the caregiving workforce has mainly focused on burnout and turnover; the research has uncovered a high burnout rate and low levels of job satisfaction among these care providers (Chamberlain, Hoben, Squires, & Estabrooks, 2016; Kandelman, Mazars, & Levy, 2018; Saito, Igarashi, Noguchi-Watanabe, Takai, & Yamamoto-Mitani, 2018). On the contrary, few studies have explored the way in which caregivers themselves perceive care quality assurance and improvement at work. Given that they are the main actors of care quality management, it is necessary first to understand how *they* perceive care quality assurance and improvement on their ward.

Aims of the Study

In this study, we have explored the ways in which professional caregivers at long-term care hospitals, namely, directors of nursing, supervisor nurses, staff licensed nurses, and care workers, perceive care quality and improvement on their ward. The research questions were as follows:

> **Research Question 1:** How do nurses and care workers at long-term care hospitals in Japan perceive the quality of the care they provide, and why?
> **Research Question 2:** Do they try to improve care quality and, if so, how? How do they perceive their efforts?

Background: Long-Term Care Hospitals in Japan

Hospital long-term care beds were introduced in Japan in 2000, with the revision of the medical care law (Konuma, 2007). There are two national insurance systems in Japan: the health insurance system and long-term care insurance. Long-term care insurance covers caregiving (social care), while health insurance covers medical care (Nagasawa,

2015). In hospitals, there are beds that are designated as long-term care beds, some of which are reimbursed under long-term care insurance, while others are met through health insurance. Approximately 45% (3,793/8,414) of hospitals have beds for long-term care, which are called long-term care hospitals (Ministry of Health, Labour, and Welfare, 2017). In wards with long-term care beds, the ratios of nurses and care workers to clients were much lower (by approximately half to one third) than those in general acute-care wards. The average length of hospital stay of persons who used long-term care beds is 326.9 days for beds with long-term care insurance and 150.9 for beds with health insurance. Among long-term care beds, 40.1% of hospital discharges occur through death (Ministry of Health, Labour, and Welfare, 2017). Hence, long-term care hospitals in Japan virtually function as residential care facilities for those with high medical care needs.

In 2014, a new integrated community-care system was introduced in Japan (Tsutsui, 2014). This model aims to promote community care of elderly people, from prevention to end-of-life, integrating health and long-term care. Here, "integration" of health and long-term care means smooth and frequent admission and discharge between hospitals and home or residential care facilities. It also includes an effective combination of medical care and caregiving (social care) (Arai et al., 2015; Nagasawa, 2015). In this system, long-term care hospitals (as well as other hospitals) have been given financial incentives to send clients home whenever possible. Another major change in this new model is the introduction of community integrated care beds, where a higher nurse–client ratio is available, with strict limits on the average inpatient hospital stay and a minimum rate of discharging clients home. That model provides incentives for long-term care hospitals to admit more clients with subacute conditions, provide rehabilitation, and then send them home, even though a number of those clients continue to require long-term care and end-of-life care. This study was carried out after the introduction of this new system.

One characteristic of long-term care hospitals in Japan is that many nursing assistants are licensed under the title, "care workers" (*"kaigo fukushi shi"*). Licensed care workers constitute a new profession, introduced in 1986. They provide direct, hands-on care for elderly individuals in their daily lives (Yamada & Sekiya, 2003). Licensed care workers are different from licensed nurses (i.e., registered nurses and licensed practical nurses) in that they do not provide health assessments or medical procedures. There are currently 1.4 million licensed care workers in Japan, as compared with 1.6 million employed licensed nurses. Most licensed care workers are based at long-term care facilities for older adults (Nihon Kaigo Fukushishi Kai, 2017). Although care workers at long-term care hospitals are designated "nurse assistants" by law, most long-term care hospitals do not use the term "nurse assistant," preferring to use "care worker," regardless

of whether or not the individual is licensed, to emphasize the equal partnership between nurses and care workers.

Method

The design of this research is a qualitative descriptive study based on the naturalistic paradigm and accompanying axioms (Lincoln & Guba, 1985). According to Sandelowski (2000, 2010), qualitative descriptive studies "offer a comprehensive summary of an event in the everyday terms of those events" (Sandelowski, 2000, p. 336).

Participants

Data were collected at three long-term care hospitals (health insurance–based) within the Tokyo metropolitan area. We intentionally chose three long-term care hospitals; two were owned by private medical organizations, while the third was administered by a non-profit foundation and owned by the local municipal government. We felt that these different forms of ownership might influence the experience of care quality among caregivers. We came to know these hospitals in various venues; in the case of one hospital, the first author met the director at a conference. In the case of the other hospitals, some of the authors met the directors of nursing at a meeting. It seems likely that these directors were more motivated than others to improve or manage quality because they chose to attend this conference and meeting.

Staff patient ratio in these hospitals were government-regulated one to four or six, depending on the ward, although one hospital had slightly higher ratio (i.e., more staff) due to the patients' higher medical care needs (e.g., higher number of ventilator use). The average length of hospital stay ranged from 95 to 420 days. Nursing care was provided on the functional nursing system, while in some wards where more staff was available, the team nursing system was partly used.

The participants were directors of nursing, supervisor nurses, staff nurses (registered nurses and licensed practical nurses), and care workers (licensed and non-licensed care workers). We included not only staff nurses and care workers but also nurses in management positions in our study because they determine how staff nurses and care workers work on the ward, and their policy and direction largely affect care quality assurance and improvement. Therefore, we thought it important to assess their perceptions along with those of staff nurses and care workers.

For recruiting the participants, we used convenience sampling. Directors of nursing conducted actual recruitment based on our request to recruit staff with diverse backgrounds in terms of age, gender, work experience, the type of license (registered nurse or licensed practical nurse), and whether they had care worker licenses or not. The directors of nursing approached supervisors and staff members, explained the research aims, asked them to participate, and obtained participant consent. The researchers were not allowed to know how many staff members were approached or how many declined participation.

Interview Procedure

After explaining the purpose and content of the study and gaining written informed consent, we interviewed some participants individually (minimally structured individual interviews) and others in group interviews (focus groups). The decision about whether to use individual or group interviews was up to the directors of nursing in each hospital; they preferred group interviews in cases where participants were considered too shy or busy to talk about their own experiences in individual interviews.

Most of the interviews were held in the afternoon, after the day shift. In some cases, nurses were interviewed earlier in the afternoon, in a small hospital meeting room. In individual interviews, the interviewers took notes. Three group interviews with three participants each were led by one facilitator and one co-facilitator. Each group consisted of staff in the same roles from the same hospital, with one group for supervisor nurses, a second for staff nurses, and a third for care workers. For this reason, the researchers had no need to accommodate any power imbalances in the group interviews. The facilitator conducted most of the interviews, while the co-facilitator observed the participants' non-verbal communications and kept notes on which participants talked about which topics. Interviews were conducted in Japanese, the native language of all participants and researchers. Individual interviews lasted approximately 1 hour and group interviews approximately 2 hours.

To collect data on the participants' own perceptions with regard to their care quality assurance and improvement in their ward (Hsieh & Shannon, 2005; Sandelowski, 2000), we asked participants to freely describe their perceptions. Sample initial questions included the following: "How do you perceive the quality of care you and your team provide on the ward, and why do you think you perceive it in this way?" "What are the challenges in maintaining/improving care quality?" and "What would be necessary to maintain/improve care quality?" We added some alternative, probe questions during the interviews (e.g., "How do you *feel* about the care provided to clients?" and "Why do you think that?"). All of the data were audio-recorded and transcribed.

Data Analysis

We followed the analytic logic of a conventional qualitative content analysis (Hsieh & Shannon, 2005), in which "codes are defined during data analysis" (p. 1286). Codes were generated and used to sort the interview data in the way that best summarized, integrated, and represented its content. Researchers read through the data repeatedly, immersing themselves to "obtain the sense of the whole" (p. 1279). They then coded the data according to meaning chunks,

grouping similar codes into 32 subcategories to provide insight into larger themes. The subcategories were analyzed again to identify similarities and differences and then grouped into six categories. The final category scheme was presented in the form of a tree diagram with data belonging to each category. The four formal caregiving roles—directors of nursing, supervisor nurses, staff nurses, and care workers—were first analyzed separately and then combined to reveal the similarities and differences across roles. In the same way, hospital data were initially analyzed separately and then combined. There were some limited differences across roles and hospitals.

All the analyses were conducted in Japanese, our native language, and English translation was conducted when we started writing the article. The first author has had multiple experiences of doing qualitative research in Japanese and wrote manuscripts in English, and she first translated the research findings into English, beginning with the categories and relevant data. A literal translation was attempted, although it was necessary to replace a few colloquial terms with equivalent expressions. The initial translations were reviewed by the research team with some outside consultation, including a professional English editor. Some of the professional editor's corrections were re-examined by the authors to ensure a good English–Japanese fit.

Examining Rigor

We used the framework developed by Lincoln and Guba (1985) to ensure trustworthiness. Some of the authors (N.Y.M., Y.S., M.T.) had several years of experience working as staff nurses in long-term care hospitals and were therefore familiar with the working conditions in these institutions. After analyzing the data, the authors shared a summary report with the participants and gained their feedback, which was used to refine the overall structure of the analyses. Although there is some debate about the effectiveness of member checking as a method of pursuing rigor in qualitative research (Morse, 2015), in this case, we considered that it was valuable to have additional information from participants. Because the purpose of this study was to explore the participants' own perceptions of care quality assurance and improvement, we considered that their additional comments enhanced the credibility of these analyses.

Descriptions were added to explain background information and detailed hospital conditions as much as possible to enhance transferability. The researchers had a series of meetings to discuss the analysis and to develop codes and categories. When researchers disagreed about the coding, they discussed the issues until consensus was reached. The coding process was recorded in an Excel file to enable tracking of the analysis and provide an overview of the process to ensure confirmability and dependability.

Ethical Considerations

The study was approved by the internal review board of the university to which the authors belonged (10521) and also by the institutional review board (IRB) of each participating hospital. Written informed consent was received from all participants. To protect the participants' confidentiality, an audio-record of the interview data was erased after transcription. The transcribed interview data were made anonymous by substituting numbers for individual names. All of the data files were locked, using passwords.

Results

Participants

We interviewed 25 caregivers with varying qualifications and positions, working at three long-term care hospitals (Table 1). From the interviews, six categories were identified to describe the caregivers' overall experience of care quality: *keeping clients alive is barely possible, the absence of a long-term care practice model, the lack of QIs, long-term care hospitals as places for castaways, client quality of life as a source of satisfaction*, and *conflicts between staff and client well-being*. The main data are described in the text and additional data are listed in Table 2.

Keeping Clients Alive Is Barely Possible

When asked to describe their perceptions with regard to the quality of care they provided, some participants stated that their care met the required level in terms of sustaining the physical lives of clients. However, many participants expressed a general sense of dissatisfaction with the quality of care they provided, although the levels of frustration varied across different wards and roles. For these participants, current levels of care were not sufficient to maintain and promote clients' quality of life, even if they did succeed in physically keeping clients alive. This frustrated the participants, who were willing to provide a better quality of life for their clients. They might not have been as frustrated if they were not concerned about quality of life of the clients; they would simply get things done in the given time and would not mind things that could not be completed. However, the frustration of these participants was significant because they cared about their clients and wanted them to have a better quality of life. As one participant commented,

> I do not think we visit bedsides often enough. There must be more things we should provide. We do this for this client—this and this—and just let go of others. Now we just follow routines. We cannot do anything except work by the clock. (Staff Nurse 10)

Many staff members were pressed for time, with numerous tasks to accomplish. As a result, they had to limit their activities to a minimal level that was barely enough to sustain the

Table 1. Participants of Research.

ID	Title	License	Sex (F: Female; M: Male)	Age	Experience in the Hospital (Years)	Experience Caring for the Aged (Years)	Individual (I)/Group (G) Interviews
1	Director of nursing	RN	F	51	1.3	8.3	I
2	(n = 3)	RN	F	45	1	1	I
3		RN	F	55	5	5	I
			Mean	50.3	2.4	4.8	
			Median	51	1.3	5	
4	Supervisor nurse	RN	F	46	5.5	21	I
5	(n = 5)	RN	F	39	10	15	G
6		RN	F	36	6	16	G
7		RN	M	37	3	8	G
8		RN	M	35	2	2	I
			Mean	38.6	5.3	12.4	
			Median	37	5.5	15	
9	Staff nurse (n = 8)	RN	F	39	4	4	I
10		RN	F	45	2.3	13	I
11		RN	F	52	9	15	I
12		RN	F	42	1	10	G
13		RN	F	30	1	8.5	G
14		RN	F	28	1	5	G
15		RN	F	43	3.8	7.8	I
16		LPN	F	53	3	13	I
			Mean	41.5	2.1	9.5	
			Median	42.5	1.6	9.3	
17	Care workers (n = 9)	LCW	F	51	6	12	I
18		LCW	F	32	1.8	11	I
19		LCW	F	51	3	6	I
20		LCW	F	40	5	5	G
21		LCW	F	55	12.5	12.5	G
22		LCW	M	31	7	7	G
23		LCW	F	36	5	14	I
24		Unlicensed	M	35	3.5	3.5	I
25		LCW	F	53	4	4	I
			Mean	42.7	5.3	8.3	
			Median	40	5	7	
		Total	Mean	42.4	3.9	9.1	

Note. RN = registered nurse; LPN = licensed practical nurse; LCW = licensed care worker.

physical lives of clients. For nurses, the minimum level meant medical treatment and activities such as sponge-baths—just wiping the body down. For care workers, it included only routine bathing and changing diapers. Nurses reported that they wished they could spend more time on careful and comfortable bathing and cleansing; care workers wanted to offer more recreational activities, such as taking a walk or having small gatherings: "We can provide only minimum basic care, such as checking vital signs or other critical issues; we have to leave behind everything that can be left behind, and those care activities are never done" (Supervisor Nurse 5).

In such a hectic daily schedule, assessing clients carefully to provide physical comfort, spending time on each service, or providing timely care were considered beyond the capacity of care providers. Several reported feeling resentful that they could not provide the sort of care they wished to provide:

> No, there is no time to respond to a client's pain. The only thing we can do is to ask the doctor to give them medication, and that's it. The reality is that we don't have any time left for such things. (Staff Nurse 11)

Absence of a Long-Term Care Practice Model

When asked how they perceive the quality of care, some participants said that they did not know how to answer about the quality of care they provided or how well they felt they were doing (good or bad); this was also true of directors of nursing. It seemed that some had not even thought about

Table 2. Categories and Subcategories.

Categories	Representative Quotes
Keeping clients alive is barely possible	I want to let the client stay in the bathtub longer, but things are so hectic, and we rarely can do this. Changing diapers also takes time, and last clients are left behind for a long time after they probably wet the diaper; I imagine it must be uncomfortable for them—especially those who cannot use nursing calls. (Care Worker 21)
	We used to have things like monthly birthday parties before, but we have not done such things at all recently. On such occasions, we used to bring those who usually couldn't leave bed to the dining hall, but we can't do it anymore. . . . We used to invite family members (but now we can't). (Care Worker 22)
	If you go to another type of elderly facility, you can participate in much more rehabilitation, but here, within the time of 3 months, the client's ADL goes down (instead of improving). (Care Worker 18)
	I wish we had more staff. I know I shouldn't say the number matters, but rather than doing many things with a limited number of staff, we could provide careful and good care for sure with a sufficient number of staff. If you have to give baths to 20 clients, you know, things are so hectic. Adding just one person would make a difference. I know it is not only a matter of the number of persons, but I always wish we could have more staff. (Staff Nurse 9)
Absence of a long-term care practice model	I cannot get used to this ward where clients die sooner or later. I used to work in the ward where clients got better as we provided care and they went home. Here, clients die whatever we do. (Care Worker 17)
Lack of quality indicators	It takes a lot of muscle energy even for a wheelchair transfer. We would like to have (a device for transfer), but we do not know how we could ask administrators for them; nothing has happened concretely (to improve the situation). (Care Worker 21)
	We have a case conference once a month (for quality improvement purpose), but client conditions do not visibly improve here, and we just maintain the status quo. So, we rarely go into heated discussion. (Staff Nurse 7)
Long-term care hospital as a place of castaway	Nobody would choose to be a care worker unless there is some particular reason, because it is a hard, dirty job. I have never worked outside the home in my life. Suddenly, I must work and earn some money, and I came here because there was nowhere else I could find a job. (Care Worker 19)
Client's quality of life as a source of satisfaction	I am happy when the client is pleased with what I do. It is the only important thing. If I could get enough salary, I would be even happier. Some clients cannot express themselves, but if I can see how happy and comfortable they are, I am happy enough. (Care Worker 24)
	I want clients' families to feel good. I can work more if somebody thanks me for what I do. (Care Worker 19)
Staff well-being conflicting with that of clients	We know how busy we are, but at the same time, we need to protect our own health. It is hard to find the balance. (Care Worker 20)
	Physically, it is hard. Some are taking sick leave. We are absent from work one after another; it seems many are sick due to overwork. Many catch colds so easily. I hope we do not collapse altogether. (Care Worker 19)
	After our (nurses and care workers) work schedule is developed, work schedules for child care workers are set. Now, a caregiver can go home when her kid has a fever, mostly. I used to be allowed to go home, so I would like to return the favor so I will let the young mothers go home. We have been helping one another. There are many nurses with small kids, even some babies. I guess this is a good place to work for them. (Supervisor Nurse 7)
	[Those who can sustain motivation and continue working] seem to enjoy their work even when they say they are tired. Even when things are busy, they can carefully find what they have to do. Many of them are like this. Those with high motivation have the willingness to find things to do and to think how they would like to take care of them from their side. (Supervisor Nurse 6)
	There are many nurses from acute hospitals who come to us, expecting that the work is not busy here. But we are busier than they expected, and many leave us soon. I don't know what to do with them. I wish we could create a work environment where we can work in less busy conditions, but we cannot reduce things we do when we have to take care of the clients. No, there are things we have to do more, not less. So, individual motivation is important. (Supervisor Nurse 7)

considering their own performance in terms of care quality: "The term 'care quality' does not ring a bell to me. I don't have anything to say about it" (Staff Nurse 11). One of the reasons the term "care quality" did not resonate with some caregivers seemed to be that they did not have a clear frame of reference for considering what constituted care quality in an long-term care setting, other than some intuitive, general impressions about clients' physical condition and quality of life. Some of the nurses derived their idea of nursing from

acute care settings, where nurses assist clients to recover from disease and regain independence. In long-term care settings, most clients are not expected to recover; at best, they aim to maintain their daily quality of life with assistance from the hospital staff. In this situation, nurses seemed to be at a loss regarding what efforts they should make to enhance quality of care: "Acute-care hospitals are for saving lives. To survive, clients endure the inconvenience of staying in the hospital. But this place is different. Nursing is invisible; I

cannot see what goals are placed in nursing care" (Director of Nursing 3).

For care workers, the conditions of clients in long-term care hospitals were also difficult to accept because they were used to helping elderly people without symptoms enjoy their daily lives. In reality, most long-term clients are bedbound, with limited levels of communication. Many are in the end-of-life stage; what care workers would normally consider quality care, such as small gatherings or activities, were impossible in their busy daily routines. As a result, neither nurses nor care workers had an effective framework for providing good care or any ideal against which to evaluate their own practice. This situation seemed to have created some conceptual difficulties among the nurses and care workers who participated in this study.

Lack of QIs

As a natural result of the absence of an effective frame of reference, the participants had no visible milestones to reflect on their practice, let alone any strategies to improve quality. If they had been working in an acute-care setting, it would have been possible to reflect on their work using references such as recovery rates or a lack of complications among clients. However, in their eyes, just maintaining life without visible recovery or with inevitable gradual deterioration, common conditions in a long-term care setting, can hardly have any quality criteria. The new community integrated–care system may suggest that successful discharge home is a key reference point, but it only applies to a small group of inpatients. As a result, given their basic orientation toward an acute care model and the changing climate of elderly long-term care, staff members are left alone to wonder what care quality means and how they could possibly improve it: "Everyone wants to improve care quality, but we don't know how" (Staff Nurse 5).

It was not surprising that supervisors and staff members who had no conceptual framework of quality care in long-term care (LTC) had equally limited hands-on knowledge of quality improvement and its strategies. As a result, available quality improvement efforts were limited to individual extra attention to quality or the use of tools to assess pressure ulcers, pain, or falls. In some hospitals, even such basic assessment tools were not in use. A strict set of regulations on the space and staffing of nursing homes, which served as a set of structural QIs, was available; however, other process- and outcome-based QIs were largely lacking. It is notable that the participants considered quality an abstract term that was difficult to tangibly evaluate in a long-term care setting:

> Care quality is difficult to measure in long-term care; quality is not something you can buy with money. There are quite a few clients who cannot voice their opinions. We have to rely on their facial expressions, tone of voice, or family members as their proxies. (Director of Nursing 2)

In addition to nursing staff, even a hospital CEO said that he had difficulty evaluating care quality, relying on the tone of voice in which families said "thank you" after end-of-life care. Both administrators and staff keenly recognize the need to visualize the effects of care to draw on experiences of good care for future practice: "We have not been conscious about effect of one's practice on clients, but now I would like to identify such effects, keenly observe them, and make the good use of past learnings" (Director of Nursing 1).

Long-Term Care Hospitals as Places for Castaways

Another issue around care quality reported by the participants was the generally low profile of long-term care hospitals. In the nurses' view, the most prestigious workplace is a critical-care setting, such as emergency or intensive care unit or at least a large acute-care hospital; long-term care hospitals were not a workplace they could be proud of. Most new graduates would begin their careers in large, acute care hospitals, such as university hospitals. Only those who cannot endure the high levels of commitment required in acute care settings move to smaller long-term care hospitals, generally to maintain a work–life balance after starting a family. One supervisor nurse commented that she felt as if working for a long-term care hospital was like being a *miyako-ochi* (exile or castaway). Another supervisor nurse mentioned that he initially hesitated when considering a possible transfer to a long-term care hospital, although he also reported later finding invaluable meaning in the types of care provided in long-term care hospitals:

> Originally, my image of a long-term care hospital was a house for those at the end-of-life. I wanted to do acute care, so I thought for about one year before I came here. I was a supervisor nurse in my previous hospital and it was not easy to quit the job there. I doubted that it was OK to move here at my (young) age. (Supervisor Nurse 8)

Care workers also found it difficult to take pride in their work in long-term care hospitals. Care workers denigrated their own status. For care workers, the most prestigious workplace is a nursing home where care workers can take the initiative in providing care to residents. In long-term care hospitals, they are designated "nursing assistants" under the law. As a result, care workers find it difficult to take pride in their work: "Some care workers just do not care; they complain about additional work" (Care Worker 19).

Client Quality of Life as a Source of Satisfaction

Given the absence of a framework and the scarcity of tangible milestones of quality, participants mentioned relying on subtle signs from clients as sources of satisfaction in providing care. Such altruistic satisfaction was frequently referred

to in the interviews: "We are busy every day. Even though we want to talk more to the clients, the next task is waiting. If we could have even little time to talk with the clients, I would feel satisfied" (Staff Nurse 15).

They seemed to gain satisfaction from the everyday, subtle value in their work:

> Before, the care workers kindly gave a hot-water bath to residents once a week. It's a lot of work; a nurse has to be there and it adds to the workload of care workers. Care workers also need to learn how to assess the physical condition of the clients. Anyway, it is a lot of work, but it is care workers themselves who come to me and say they want to give the clients hot-water baths. (Supervisor Nurse 8)

Managers also encourage this mechanism for gaining satisfaction from the work; they try to respect the willingness of staff members to provide good quality of care and to be satisfied with such practices:

> Rather than leading the staff by controlling them, I would rather help them take care of the clients the way they want to, making it a source of satisfaction. I would like to be a leader in this way. I may not commend them verbally but I acknowledge the good things they do. (Director of Nursing 1)

In one hospital, care workers jointly decided to allow a designated worker to have some spare time to provide better care to a specific resident. They took turns allocating such time. Arrangements such as this was a coping by the care workers to maintain morale and motivation among them to provide good quality care to clients.

Conflict Between Caregiver and Client Well-Being

The relationship between caregiver and client well-being is further complicated by the extremely hard work that caregivers are required to provide. When the demands of care work are excessive, caregivers can damage their own physical well-being if they try to provide extra, high quality care. This situation creates conflicts between client and caregiver well-being. Caregivers often gain altruistic satisfaction at the expense of tireless work and engagement. For example, participants explained that if a caregiver works hard to give baths to clients once a week, this is good quality, desirable care. However, caregivers may not be able to complete their work in time. They may become too tired and exhausted to appreciate the altruistic satisfaction. In such cases, caregivers believed it was challenging to find a balance between wanting to provide more care to clients and avoiding exhaustion. This dilemma was most visible among care workers in this study:

> In some wards, night-shift caregivers also help morning diaper changes; without them, only 2 staff have to change the diapers of 60 clients. One of the caregivers is often a newcomer. When the diaper changes are completed, it is already 9:30 or 10:00 am. It is a common practice. Care workers often ruin their health. Some have backaches and have to go to the hospital, while others use wrist supporters. Experiencing these things gradually made me angry. We all understand [that the number of caregivers is determined by the government], but why do we have to go through this? (Care Worker 22)

Caregivers explore possible solutions to ease the burden of work and provide clients with good quality care, but it is not easy:

> How to (physically) turn the client is important (to avoid backache). You need a certain grip strength to pull up a client who weighs a reasonable amount. This was a topic in the work improvement committee. They say that using a bath towel to turn the client causes pressure ulcers, and so we wondered if there were any other methods. We asked other hospitals in the group, but the only other way was to lift the client without a bath towel, which results in the same workload. Our director of nursing says it is natural that the client slips off gradually, so we don't have to pull them up and turn them during the night. (Care Worker 21)

As methods of maintaining caregiver well-being are limited, hospital administrators provided various worker support systems, which seemed to help preserve caregiver well-being. Child care, maternity leave, and the basic wage are important considerations. A supervisor nurse took pains to maintain mutual support for a good work–life balance.

When the work was so busy that there was a conflict between caregiver and client well-being, caregivers had varying motivations to provide better quality care. Not all caregivers aspired to improve their skills and some were unwilling to work in a busy environment. Caregivers explained that nurses often come to work at long-term care hospitals believing that this environment will not be as busy or high pressure as an acute-care hospital; some nurses come believing that their only work is to distribute medications. However, the reality is that workloads are just as busy as those in acute-care hospitals and sometimes even busier. Caregivers thought that this was one of the reasons for high turnover among nurses:

> There are not as many nurses at long-term care hospitals who are willing to improve their nursing skills. But here in this hospital, the only nurses who are willing to do this stay here: [Some staff say] "Can I also improve my skills? If so, I am interested in trying!" (Director of Nursing 3).

While supervisors understood that caregiver motivations varied, they still made efforts to find the balance between caregiver and client well-being, although it was not easy.

Discussion

Because staff caregivers assume the main role of performing high-quality care in long-term care hospitals, it is essential to incorporate their perceptions of care quality in the care

quality assurance and improvement program. Based on this premise, in this study, we explored how professional caregivers, including directors of nursing, supervisor nurses, staff licensed nurses, and care workers, perceived the current care quality assurance and improvement of their ward in long-term care hospitals in Japan. This is one of the first studies to examine the perceptions of professional caregivers in Japanese long-term care hospitals with regard to care quality issues; our literature review clearly showed that the issue of care quality in these institutions had not been previously explored in Japanese health care research. Our experience might resonate with that found in many other countries where long-term care for older adults is being initiated. In addition, as is discussed, a large part of Japanese caregivers' experiences was similar to those of caregivers from countries with longer histories of long-term care, such as the United States or Australia.

The results showed that, although there was a certain variability, many nurses and care workers considered the care in their ward to be suboptimal and were more or less dissatisfied with situations in which more tasks must be done on an extremely busy schedule. Caregivers aspired to provide what they believed was good quality care to clients and were frustrated at not being able to do so. There was an overall lack of practice models and mechanisms to examine and improve quality in long-term care hospitals, and this problem seemed to make care quality and its improvement activities a rather distant concept for the participants. Although they used subtle signs of client well-being as a limited source of satisfaction in their work, caregiver and client well-being were essentially in conflict. A careful balance between caregiver and client well-being should be sought.

Caregivers' perception on care quality issues in long-term care hospitals showed that sustaining clients' physical lives, a minimum requirement of care quality, was "barely possible"; they aspired to do more despite extremely busy work schedules. This finding resonates with the perceptions of professional caregivers in other countries as well (Brady, 2016; Engle et al., 2017). The current working conditions in Japan made it difficult for caregivers to derive job-related satisfaction from what they do, as exemplified in their struggle for better quality and their frustration and anger at not being able to achieve their aspirations. Although we do not have the specific caregiver turnover statistics for long-term care hospitals, one can easily imagine that this situation could lead to high turnover among caregivers at long-term care hospitals. There is an urgent need to explore ways to provide job satisfaction and prevent turnover. Squires et al. (2015), in their review, reported that empowerment and autonomy, organizational resources, and reduced workload were significant factors affecting the job satisfaction of nursing assistants. We need to introduce mechanisms to promote empowerment and autonomy of caregivers at long-term care hospitals to enable nurses to achieve desired improvements in the quality of care they provide.

Both nurses and care workers hoped for more time to spend on individualized interactions and care, such as more careful and relaxed bathing for nurses, as a feature of better-quality care, while more recreational activities for care workers. Because there were no definite criteria for evaluating their own care quality, they relied on subtle clues from clients (such as smiling) as an important source of satisfaction. Achieving to obtain such satisfaction was not easy. Similarly, in other studies, caregivers focused on small increases in engagement, mainly in the form of active communications, as well as affection and respectful attitudes, as important components of care quality (Chung, 2013; Kusmaul & Bunting, 2017). Understanding caregiver perspectives on care quality is helpful and could be used by hospital managers to recognize these components of care work and provide working environments where these aspects of good care can be carried out. In this way, clients will not only gain higher quality care, but caregivers will gain a sense of pride and job satisfaction in their work. Workplaces might need to promote this approach, especially encouraging caregivers to obtain a certain sense of satisfaction by providing high-quality care. This might be relevant to those caregivers working in long-term care regardless of the countries in which they reside.

The participants in this study indicated that they did not have a clear model of long-term care, quality management system, or milestones of care quality. This was especially prominent among caregivers who, without having a long-term care practice model, could not but rely on acute care model for determining how they could perceive their care quality, or did not know what to perceive at all. This has not been reported in other countries, at least not among countries with a certain history of long-term care (Engle et al., 2017; Garcia, Harrison, & Goodwin, 2016; McGilton & Boscart, 2007; Parker et al., 2018). This made it difficult for nurses and care workers to understand how to improve care quality. It seemed to put them *in limbo*, with a general frustrated feeling of not providing good care. Even when they tried harder, they could not tell whether their efforts had been fruitful. Over the long term, caregiver frustration and dissatisfaction could lead to burnout (Hwang, 2018; Schmidt, Dichter, Bartholomeyczik, & Hasselhorn, 2014). The lack of a clear quality assurance and improvement program could also lead to situations where necessary nursing care was missed (Knopp-Sihota, Niehaus, Squires, Norton, & Estabrooks, 2015; Nelson & Flynn, 2015). This situation might also occur in other countries where long-term care nursing has barely started (Glass, Gao, & Luo, 2013; Hsieh & Chen, 2017; Kang, Moyle, & Venturato, 2011). Introducing the concept of long-term care, its practice model, and associated QIs might be an important initial step. To accomplish this, workplaces would need to have a clear vision and practice model of long-term care, and communicate it to their staff caregivers.

It is ironic that pursuing client well-being can be a source of job satisfaction and yet also hazardous to caregiver well-being. Compassion fatigue is considered to be the cost of

caring; it occurs when caregivers are exposed to repeated interactions requiring high levels of empathic engagement with distressed clients (Sorenson, Bolick, Wright, & Hamilton, 2016). As compassion fatigue among caregivers providing long-term care has not been given due attention in the literature, further investigation is necessary. Careful support is needed to avoid caregivers' compassion fatigue reaching the level of burnout, depression, or turnover.

This study has several implications for practice. First, it is vital to develop an effective quality assurance and improvement program based on a conceptual framework for long-term care for elderly people. The system needs valid QIs, not just to improve care quality but also to improve morale and motivation among care professionals. QI for long-term care has been available—one example is InterRAI Long-Term Care Facilities (Guthrie, Declercq, Finne-Soveri, Fries, & Hirdes, 2016)—but they are not used widely in Japan and many other countries, due to the perceived high burden of documentation. Alternative indicators might also be considered and such measures would make care quality visible. A new framework, such as the nursing home culture change (Grabowski et al., 2014), may help, although it must be examined to assess its compatibility with Japanese culture.

Second, we need to promote the value of long-term care in this super-aged society and support caregivers in valuing their work. Among nursing professionals in Japan, there remains a tendency to value acute and tertiary care, as seen in this study. Similar conditions could be expected where the concept of gerontological nursing and long-term care have just been introduced (Hsieh & Chen, 2017). However, the importance of nursing care which allows those with chronic conditions to sustain life should not be neglected. Caregivers may benefit from in-service training that allows them to see the actual value of the care they provide through programs such as reflecting on and debriefing a past case. Third, because caregivers are frustrated about not being able to give enough quality care, they may benefit from being able to give such care, even to a limited extent. The episode of care workers jointly allowing a worker to provide better care to a specific resident that meets with the care worker's satisfaction might be a good example.

There was a limitation in this study. The data were collected in only three hospitals, and this makes the generalizability of the findings rather limited. We tried to recruit different types of hospitals (one public and two private) and participants with diverse backgrounds. There were no observable differences in the types of care quality issues they experienced. On the contrary, the strength of this study is that it is one of the first attempts to collect the voices of care providers in long-term care commenting on their own perceptions regarding care quality. Their voices vividly explain the need to introduce quality improvement mechanisms to maintain caregiver well-being and work motivation.

In this study, we explored the way in which nurses and care workers perceived care quality assurance and improvement in their long-term care ward in Japan. Based on a qualitative content analysis of interview data from 16 licensed nurses (directors of nursing, supervisor nurses, and staff nurses) and nine care workers, we derived categories to describe their struggles to pursue high-quality care in busy long-term care wards. Results revealed that in the overall lack of either a practice model of long-term care or any mechanisms to evaluate and improve care quality, nurses and care workers rely on the subtle signs of client quality of life as QIs gaining satisfaction based on such indicators. Quality assurance and improvement efforts should incorporate and build on caregiver perspective of care quality, and include changes in workplace environments to enable improvements to care quality where these are needed.

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