

## Original article

# Conflicts and coping strategies among nursing and care staff in the daily life management of heart failure in elderly patients with dementia in long-term care facilities in Japan

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**Abstract:** Previous studies have suggested that efforts to improve awareness, including ingenuity in communication and conflict management, are necessary for cooperation and collaboration between nursing and care staff. However, few studies have examined the problems and countermeasures that arise in daily life management for the prevention of heart failure deterioration in elderly individuals with dementia through multi-professional collaboration. Moreover, how to deal with conflicts with non-medical care workers has not yet been clarified. This study aimed to clarify the conflicts and coping strategies that arise between nursing and care staff in the daily life management of heart failure in elderly patients with dementia in long-term care insurance facilities. A self-administered questionnaire survey was provided to facility staff, nurses, and care workers. Responses were gathered over a period of two months, from the end of December 2021 to the end of February 2022. Responses were collected from 320 participants (recovery rate, 16.0%). There were 311 (15.6%) valid responses from 157 nursing and 154 care staff. From the description of the specific conflict, it seems that the nursing staff expected the care staff to focus on the prevention of worsening heart failure by sharing information and cooperating closely, rather than on the early detection of worsening heart failure. On the other hand, although care staff were responsible for the early detection of worsening heart failure, they struggled with not being able to fulfil their responsibilities. Regarding coping strategies about “active,” the nursing staff scored significantly higher than the care staff ( $p < 0.05$ ), and among the care staff, the more experienced group scored significantly higher than the less experienced group ( $p < 0.05$ ). Sharing the content of the conflicts between nursing and care staff would lead to improvements in the quality of care for older adults with dementia and heart failure by proactively involving nursing and long-term care staff with many years of experience.

**Keywords:** heart failure, elderly with dementia, conflict, coping strategies, multi-professional collaboration

## 1. Introduction

In Japan, efforts are being made to shorten the length of hospital stays to moderate medical costs<sup>1)</sup>. However, there are issues with discharge support at local general hospitals, such as the absence of caregivers for home care and families' unwillingness to permit home care<sup>2)</sup>. Long-term care insurance facilities are expected to play a role as discharge destinations for older adults in the construction of an “Integrated Community Care System” in Japan. However, in medical and nursing care settings, conflicts, such as difficulties with cooperation between multiple professionals<sup>3)</sup> and differences of opinion<sup>4)</sup> may occur. It is said that the factors made it difficult for home care workers to cooperate with medical providers include a “feeling of not being respected” and a “communication barrier”<sup>3)</sup>. In addition, the nursing administrators who supervise nursing wards in hospitals for patients requiring long-term care recognize that conflict management and communication with ward staff are necessary for nursing staff to build collaborative relationships with care providers<sup>5)</sup>. From these previous studies, it was concluded that efforts to improve awareness, including

innovation in communication and conflict management, were necessary for cooperation and collaboration between nursing and care staff.

According to a 2016 survey report on hospital discharge coordination and support<sup>6)</sup>, cardiovascular disease, including heart failure, was the most common type of issue (18.9%) among those who were discharged to a different destination before hospitalization. In addition, 51.1% of the patients had worsened dementia symptoms at the time of discharge, and it has been predicted that many elderly people with heart failure and dementia will be discharged to a place of residence other than their own home. One of the most common primary living places other than the home is long-term care insurance facilities, and research on the disease progression and daily life management of elderly people with dementia and heart failure has illuminated the current state of disease and daily life management among elderly patients<sup>7,8)</sup> and those is difficult situations<sup>9,10)</sup>. However, few researchers have examined the problems and countermeasures that arise in the daily life management of measures to prevent heart failure and deterioration in elderly individuals with dementia through multi-professional collaboration. By clarifying the specifics of the conflicts that arise between nursing and care staff and the characteristics of the coping strategies of the professionals, it will be possible to facilitate multidisciplinary care for the

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elderly with heart failure and dementia and contribute to improvements in the quality of care.

Conflicts can arise between individuals and others, with the former attempting to resolve them by satisfying the needs of the individual and the latter arising by attempts to satisfy the needs of both individuals and others<sup>11)</sup>. Health, medical, and welfare professionals who are responsible for the care of the elderly must cooperate with each other; therefore, strategies to avoid conflicts between professionals and resolve conflicts quickly are necessary. Labrague et al.<sup>12)</sup> analyzed nurses' conflict management strategies in 25 articles. As a result, it was found that the most common style of dealing with conflicts was using "integration," followed by "accommodation." "Competition" and "avoidance" strategies were the least frequently used styles. However, these results concern how to deal with conflicts with colleagues and physicians, and how to deal with conflicts with non-medical care workers has not been clarified. In addition, previous research<sup>13)</sup> has shown that nurse managers experience role conflict more significantly than staff members, suggesting that their position and years of experience affect it. Therefore, it is necessary to consider differences in professional experience.

This study clarifies the conflicts and coping strategies that arise between nursing and care staff in the daily life management of elderly individuals with dementia with heart failure in long-term care insurance facilities. Subsequently, we provide suggestions for useful cooperation and collaboration methods.

## 2. Methods

### 2.1 Operational definition of the term

"Daily life management" in this study refers to daily life support and health management to prevent worsening of heart failure. For example, it includes providing assistance with eating, toileting, hygiene, and other activities to prevent heart failure from worsening and early detection and response when heart failure worsens.

### 2.2 Participants

The participants were 1,000 nursing and 1,000 care staff from 500 welfare facilities for the elderly requiring long-term care (special nursing homes for the elderly) and 500 healthcare facilities for the elderly requiring long-term care (health service facilities for the elderly) in Japan. The facility manager was informed in writing and voluntarily asked to select participants who had experience caring for elderly people with dementia and heart failure and who were aware of conflicts between nursing staff and care staff.

### 2.3 Survey method

A self-administered questionnaire was mailed to the participants. Responses were collected during a period of two months, from the end of December 2021 to the end of February 2022.

### 2.4 Survey content

#### 2.4.1 Subjects' background

We investigated the type of care facility, sex, profession type

(nursing/care staff), number of years of experience as a nurse/care worker, number of years of experience caring for older adults with dementia and heart failure, and current position (manager/staff).

#### 2.4.2 Receiving support from colleagues in the same or another profession, superiors, and family members or friends

Here, someone providing support refers to someone who allows the participant to feel free to talk, is dependable, and provides consultation. The degree of support provided was measured using a 4-point scale ranging from 4 points ("very much") to 1 point ("not at all").

#### 2.4.3 Conflict and coping strategies

A section for free description was provided to assess the specific content of the conflict that occurred between nursing and care staff in managing the daily lives of elderly people with dementia and heart failure. In addition, with the author's permission, the following scales were used to assess the ability to cope with conflict: coping strategies and competency in multidisciplinary collaboration.

##### 2.4.3.1 Intragroup conflict coping scale

Murayama et al.<sup>14)</sup> created this scale to measure the cognition related to coping with conflicts that occur within a group. The subordinate concept consisted of seven active and seven agreeable items. The former measures active and assertive conflict-related coping behaviors, while the latter measures cooperative and empathetic conflict-related coping behaviors. The answer is given using a 7-point system from 7 ("use a lot") to 1 ("do not use at all"). The evaluation used the average response value for each subordinate concept. Higher numbers were considered more active and agreeable. The total score for each question ranged from 7 to 49 points.

##### 2.4.3.2 Kato's<sup>15)</sup> interpersonal conflict strategy styles scale

This scale consists of 20 questions that measure the style of behavior in interpersonal conflict. The subordinate concepts are (1) the integration style factor (negotiating to satisfy the interests of the executor of the strategy and the conflict partner), (2) the avoidance style factor (trying to avoid direct conflict), (3) the coercive style factor (trying to satisfy the executor's demands regardless of the interests of the conflicting partner), (4) the self-concession style factor (restraining the executor's opinions and demands and complying with the conflicting partner's demands), and (5) the mutual compromise style factor (executor and conflicting partner make concessions to each other), which are classified into 4 items each. Responses are given on a 4-point scale ranging from 3 points ("very applicable") to 0 points ("doesn't apply"). The higher the score, the more frequently the strategy is used. Each question item's value was totalled, and the results were compared using the mean and median values. The scores ranged from 0 to 12 points.

##### 2.4.3.3 Interprofessional work competency (IPW) (OIPCS-R24)<sup>16)</sup>

This scale was developed by Kunisawa et al.<sup>16)</sup> to measure competency in interprofessional collaborative practice. It is composed of 6 factors and consists of 2-7 items for each factor, for a total of 24 items. Each factor consisted of (1) mutually

exchanging facts and assessments, (2) managing team activities, (3) facilitating dialogue and discussion, (4) coordinating integrated care, (5) understanding others and giving respect, and (6) sharing and giving meaning to emotions. The answer is given on a 4-point scale from 4 points (“doing”) to 1 point (“not doing”). The average total score is evaluated for each of the 6 subordinate concepts for each professional. Higher scores indicate higher competency. Scores ranged from 2 to 28 points.

**2.5 Analysis**

Descriptive statistics were used to determine the participants’ backgrounds. Responses regarding the status regarding receiving support from people in the same or another profession at the facility, superiors, family members, and friends were scored on a scale of 4 points (“very much”) to 1 point (“not at all”). Nursing and care staff were divided into two groups, and trends in the number of respondents on a four-level scale were analyzed using the chi-square test.

In addition, the Kolmogorov-Smirnov test was performed on the results of each scale related to conflict coping, coping strategies, and competency in multidisciplinary collaboration. They were then classified into two groups based on the average number of years of experience for each professional, and the Mann-Whitney U test was performed. It has been suggested that role conflict may be influenced by job position and years of experience.<sup>13)</sup> Therefore, we analyzed the differences in job positions and years of experience as covariates. IBM SPSS Statistics ver. 25 was used as the analysis software, and the significance level was set at less than 5%.

The free response descriptions were classified based on the similarity of the content, and the assistance scenes and number of responses are summarized in a table. The results of the free-response descriptions were analyzed repeatedly until the researchers reached consensus. In addition, we asked a researcher familiar with qualitative research who had no conflicts of interest to provide suggestions to ensure objective evaluation.

**2.6 Ethical considerations**

The purpose and methods of this study were explained to the participants using documents, and responses were obtained when consent was provided voluntarily. Approval was obtained from the Ethics Committee of Hirosaki University Graduate School of Health Sciences (reference number:2019-048).

**3. Results**

Responses were collected from 320 participants (response rate: 16.0%). A total of 311 valid responses (15.6%) were obtained.

**3.1 Participant overview**

**3.1.1 Nursing staff (n=157)**

Seventy-eight participants (49.7%) were in special nursing homes for the elderly, and 79 participants (50.3%) were in health service facilities for the elderly. This study included 14 men (8.9%) and 143 women (91.1%). The average number of years of nursing experience was 24.5±10.1 years, and the

average number of years of experience caring for the elderly with heart failure and dementia was 13.0±8.1 years.

There were 24 head nurses (15.3%), one deputy head nurse (0.6%), 33 chiefs (21.1%), 4 deputy chiefs (2.5%), 2 leaders/unit leaders (1.3%), 1 sub-leader (0.6%), and 92 staff members (58.6%).

**3.1.2 Care staff (n=154)**

The type of facility was a special nursing home for the elderly for 80 (51.9%) and a health service facility for the aged for 74 (48.1%). The study included 69 men (44.8%) and 85 women (55.2%). The average number of years of experience as a care worker was 15.2±6.4 years, and the average number of years of experience caring for elderly people with dementia with heart failure was 12.8±7.0 years.

There were 2 managers (1.3%), 1 acting manager (0.6%), 1 assistant manager (0.6%), 12 chief care workers (7.8%), 1 deputy chief care worker (0.6%), 44 chiefs (28.7%), 11 deputy chiefs (7.2%), 35 leaders/unit leaders (22.7%), 1 unit subleader (0.6%), and 46 staff members (29.9%).

**3.2 Receiving support from colleagues in the same or another profession, superiors, and family members or friends**

Table 1 shows the situations in which nursing and care staff might receive support. Both the nursing and care staff felt that they had received the most support from among the same type of professionals at the facility. The result of the chi-square test showed that care staff felt that it had received support from other professionals at the facility more than the nursing staff.

Table 1 Receiving support from colleagues in the same or another profession, superiors, and family members or friends

	Number of responses (%)				p-value
	very much	so-so	not much	not at all	
<b>same professionals</b>					
nursing staff	84 (53.5)	68 (43.3)	5 (3.2)	0 (0)	0.267
care staff	67 (43.6)	80 (51.9)	6 (3.9)	1 (0.6)	
<b>other professionals</b>					
nursing staff	28 (17.8)	106 (67.5)	22 (14.0)	1 (0.6)	0.031*
care staff	47 (30.5)	82 (53.2)	22 (14.3)	3 (1.9)	
<b>superiors</b>					
nursing staff	43 (27.4)	87 (55.4)	22 (14.0)	5 (3.2)	0.981
care staff	40 (26.0)	86 (55.8)	22 (14.3)	6 (3.9)	
<b>family members or friends</b>					
nursing staff	49 (31.2)	64 (40.8)	35 (22.3)	9 (5.7)	0.317
care staff	46 (29.9)	77 (50.0)	25 (16.2)	6 (3.9)	

chi-square test \*p<0.05  
 Adjusted residual by residual analysis -2.0 or higher, significantly less frequent than others  
 Significantly more frequent than others with an adjusted residual of 2.0 or more by residual

**3.3 Concrete content of conflicts between nursing and care staff in daily life management of elderly with dementia and heart failure**

**3.3.1 Nursing staff answers**

Table 2 shows the specific content of conflicts recognized by the nursing staff. We obtained responses from 59 staff members. The most common answer, “conflict arose in terms of awareness of deterioration prevention and lack of support and care,” was

Table 2 Concrete content of conflicts between nursing and care staff in daily life management of elderly patients with dementia and heart failure based on the nursing staff's responses (n=59)

Conflict specifics	Description	Care scenario	Number of responses
Conflict arising in relation to awareness of deterioration prevention and lack of support and care	Inability to provide the necessary observations and support to prevent worsening of heart failure	Activity, meal/fluid intake, hygiene, excretion, overall daily living support, pain relief, early detection of deterioration	18
	Ability to entrust nursing staff with general support when an elderly person with dementia became unwell	Meal intake, overall daily living support	2
	Lack of individualized care	Meal/fluid intake,	2
	Opinions and responses differed depending on the care staff	Fluid intake, pain relief, early detection of deterioration	2
Conflict arising due to insufficient information sharing and coordination in daily life management	Poor reporting	Meal/fluid intake, excretion, early detection of deterioration	9
	Insufficient information sharing and cooperation	Fluid intake, early detection of deterioration	5
	Lack of prior consultation	Fluid intake, activity	2
	Inability to unify care	Overall daily living support, early detection of deterioration	2
Trouble with correspondence and conflicting opinions	Opinions on care that differed depending on the occupation	Meal/fluid intake, hygiene, early detection of deterioration	3
	Lack of consideration for the elderly with dementia when caregiving	Activity, meal intake	3
	Worries about being asked to respond	Early detection of deterioration, infection prevention measures	2
	Trouble deciding on the appropriate response	Activity, pain relief	2
Shortage of care staff affected the elderly with dementia and nursing staff	Shortage of care staff, which affected nursing staff	Activity, fluid intake, excretion, pain relief	4
	Shortage of care staff, which caused a risk of delay in response and worsening of heart failure in elderly with dementia	Activity, early detection of deterioration	3

Table 3 Concrete content of conflicts between care and nursing staff in daily life management of elderly patients with dementia and heart failure based on the care staff's responses (n=57)

Conflict specifics	Description	Care scenario	Number of responses
Conflict arising due to differences in thinking about care methods and conflicts of opinion	Conflict due to differences in care methods considering the elderly with dementia	Meal/fluid intake, excretion, activity, hygiene, early detection of deterioration	24
	differences in opinions among nursing staff make it difficult to respond	meal/fluid intake,	6
	conflicting opinions on care methods	meal/fluid intake,	5
	Differences in attitudes toward care	Meal/fluid intake,	4
Conflict with not being able to respond appropriately to medical instructions from nursing staff	Inability to provide satisfactory assistance without specific predictive instructions	Psychological relationship, pain relief, early detection of deterioration, first aid	6
	Failure to provide care as instructed by nursing staff	Activity, early detection of deterioration	3
	Inability to perform work without being able to cooperate with the nursing staff	Hygiene, early detection of deterioration	2
Conflict due to differences in positions between nursing and care staff	Unfair treatment	Fluid intake, early detection of deterioration	3
	Conflict arising over the division of work between nursing and care staff	Meal intake, early detection of deterioration	3
	Failure to share information from nursing staff	Early detection of deterioration	1

obtained from 24 staff. In descending order, the others included 18 staff who reported that “conflict arose due to insufficient information sharing and coordination in daily life management,” 10 staff who were “troubled with correspondence and conflicting opinions,” and 7 staff who noted that a “shortage of care staff affected the elderly with dementia and nursing staff.”

**3.3.2 Care staff’s answers**

Table 3 shows the specific content of conflicts recognized by

the care staff. We obtained responses from 57 staff members. The most common answer, “conflict arose due to differences in thinking about care methods and conflicts of opinion,” was obtained from 39 people. In descending order, 11 staff reported “conflicts with not being able to respond appropriately to medical instructions from nursing staff” and 7 staff reported “conflicts due to differences in positions between nursing and care staff.”

Table 4 Results of each scale for nursing and care staff

	Score range	Nursing staff n=157		Care staff n=154		p value
		Median (interquartile range)	Mean value(SD)	Median (interquartile range)	Mean value(SD)	
<b>Intragroup conflict coping scale</b>						
Active	7~49	30.0 (32.0)	30.3±6.1	29.0 (36.0)	28.4±6.1	*0.042
Agreeable	7~49	34.0 (32.0)	35.5±5.9	36.0 (38.0)	36.6±5.6	*0.030
<b>Interpersonal conflict strategy styles scale</b>						
Integration style	0~12	8.0 (12.0)	7.6±2.3	8.0 (12.0)	7.3±2.5	0.571
Avoidance style	0~12	7.0 (12.0)	7.2±2.8	8.0 (12.0)	7.5±2.7	0.367
Coercive style	0~12	2.0 (12.0)	2.4±2.6	1.0 (12.0)	2.0±2.5	0.083
Self-concession style	0~12	5.0 (12.0)	4.6±2.0	5.0 (12.0)	5.1±2.5	0.055
Mutual compromise style	0~12	5.0 (12.0)	5.3±2.4	5.0 (12.0)	5.1±2.2	0.341
<b>OIPCS-R24</b>						
Mutual exchange of facts and assessments	4~16	16.0 (7.0)	14.7±1.6	15.0 (12.0)	14.4±2.1	0.372
Management of team activities	4~16	7.0 (12.0)	7.2±2.8	8.0 (12.0)	7.5±2.7	0.367
Facilitation of dialogue and discussion	4~16	11.0 (12.0)	11.0±2.7	11.0 (12.0)	10.9±2.8	0.707
Coordination for integrated care	4~16	5.0 (12.0)	4.6±2.1	5.0 (12.0)	5.1±2.5	0.055
Understanding of others and respect	6~24	13.0 (9.0)	13.4±2.1	13.0(9.0)	13.1±2.2	0.206
Sharing and giving meaning to emotions	2~8	5.0 (12.0)	5.3±2.4	5.0 (12.0)	5.1±2.2	0.341

Mann-Whitney U test \*p<0.05

Table 5 Results of each scale according to the nursing staff’s number of years of experience

	Score range	Group with fewer than average years of experience (n = 91)		Group with greater than average years of experience (n = 66)		p value
		Median (interquartile range)	Mean value(SD)	Median (interquartile range)	Mean value(SD)	
		<b>Intragroup conflict coping scale</b>				
Active	7~49	30.0 (6.0)	29.8±5.3	31.0 (8.0)	31.0±6.9	0.361
Agreeable	7~49	34.0 (9.0)	35.3±5.6	35.0 (9.0)	35.7±6.2	0.543
<b>Interpersonal conflict strategy styles scale</b>						
Integration style	0~12	7.6(2.0)	7.6±2.3	8.0 (3.0)	7.7±2.4	0.523
Avoidance style	0~12	8.0 (4.0)	7.4±2.8	7.0 (4.0)	6.9±3.0	0.347
Coercive style	0~12	2.0 (4.0)	2.6±2.5	1.0 (3.0)	2.2±2.7	0.179
Self-concession style	0~12	5.0 (3.0)	4.9±2.2	4.0 (2.0)	4.2±1.7	*0.034
Mutual compromise style	0~12	6.0 (3.0)	5.4±2.5	5.0 (4.0)	5.1±2.3	0.322
<b>OIPCS-R24</b>						
Mutual exchange of facts and assessments	4~16	15.0 (3.0)	14.5±1.7	16.0 (2.0)	15.1±1.3	0.083
Management of team activities	4~16	8.0 (4.0)	7.4±2.8	7.0 (4.0)	6.9±3.0	0.347
Facilitation of dialogue and discussion	4~16	11.0 (4.0)	10.9±2.7	12.0 (3.0)	11.2±2.8	0.293
Coordination for integrated care	4~16	5.0 (3.0)	4.9±2.2	4.0 (2.0)	4.2±1.7	*0.034
Understanding of others and respect	6~24	13.0 (4.0)	13.2±2.2	14.0(4.0)	13.7±2.0	0.139
Sharing and giving meaning to emotions	2~8	6.0 (3.0)	5.4±2.5	5.0 (4.0)	5.1±2.3	0.322

Mann-Whitney U test \*p<0.05

### 3.4 Results of each scale

#### 3.4.1 Comparison of results between nursing and care staff

Table 4 shows the results for each scale for nursing and care staff. Regarding the intragroup conflict coping scale, nursing staff were significantly more “active” than care staff and care staff were significantly more “agreeable” than nursing staff ( $p < 0.05$ ). There were no significant differences between each item of the interpersonal conflict strategy styles scale or the OIPCS-R24. On the interpersonal conflict strategy styles scale, the scores for “coercive style” and “avoidance style” in both groups were around the 7-point range, slightly higher than the middle value of the score range. On the other hand, “integration style” was ranked the lowest, around the 2-point range, and a similar tendency was observed for both groups.

#### 3.4.2 Comparison according to years of nursing staff experience

Table 5 shows the results of the comparison of each scale according to the years of nursing staff experience. Regarding the interpersonal conflict strategy styles scale, the average value of “self-concession style” was significantly higher among the nursing staff with fewer than average years of experience than among those with greater experience ( $p < 0.05$ ). In terms of the OIPCS-R24, the nursing staff with fewer than average years of experience had a significantly higher average score of “coordination for integrated care” than the nursing staff with more years of experience ( $p < 0.05$ ). No differences were observed in intragroup conflict-coping scale scores.

#### 3.4.3 Comparison by years of care staff experience

Table 6 shows the results of the comparison of each scale according to the number of years of care staff experience. The mean values for each scale were significantly higher for care

staff with more years of experience than for care staff with fewer years of experience: “active” on the intragroup conflict coping scale ( $p < 0.05$ ) and “facilitation of dialogue and discussion” ( $p < 0.01$ ) and “understanding of others and respect” on the OIPCS-R24 ( $p < 0.05$ ). There was no difference in terms of the interpersonal conflict strategy-style scale.

## 4. Discussion

### 4.1 Conflicts between nursing and care staff in the daily life management of elderly patients with heart failure and dementia in long-term care insurance facilities

“Conflict” refers to the confrontation, clash, or conflict that occurs between individuals or organizations<sup>11</sup>). Conflicts include task conflicts that arise from conflicts of ideas and opinions with others; relationship conflicts that arise from conflicts in human relationships, such as disagreements in feelings, thoughts, and attitudes with others; and process conflicts that arise from conflicts such as discretionary authority<sup>17,18</sup>). From the results of this study, it can be seen that the specific details of the conflicts recognized by the nursing and care staff were that “conflict arose in awareness of deterioration prevention and lack of support and care,” “conflict arose due to insufficient information sharing and coordination in daily life management,” and a “shortage of care staff affected the elderly with dementia and nursing staff.” In addition, the care staff recognized that there was “conflict with not being able to respond appropriately to medical instructions from nursing staff” and “conflict due to differences in positions between nursing and care staff.” These conflicts are presumed to be process conflicts arising from the positions of medical and non-medical workers<sup>17,18</sup>). Moreover, “troubled with correspondence and conflicting opinions” was

Table 6 Results according to the care staff’s number of years of experience

	Score range	Group with fewer than average years of experience (n = 85)		Group with greater than average years of experience (n = 69)		p value
		Median (interquartile range)	Mean value(SD)	Median (interquartile range)	Mean value(SD)	
<b>Intragroup conflict coping scale</b>						
Active	7~49	28.0 (9.0)	27.3±6.4	30.0 (6.0)	29.8±5.3	*0.023
Agreeable	7~49	37.0 (9.0)	36.9±5.7	36.0 (8.0)	36.3±5.5	0.657
<b>Interpersonal conflict strategy styles scale</b>						
Integration style	0~12	8.0(4.0)	7.3±2.7	8.0 (3.0)	7.4±2.3	0.988
Avoidance style	0~12	8.0 (4.0)	7.5±2.9	8.0 (3.0)	7.4±2.6	0.742
Coercive style	0~12	1.0 (3.0)	1.8±2.5	1.0 (3.0)	2.1±2.5	0.219
Self-concession style	0~12	5.0 (4.0)	5.3±2.6	5.0 (3.0)	4.8±2.3	0.198
Mutual compromise style	0~12	5.0 (3.0)	4.9±2.5	5.0 (3.0)	5.3±2.0	0.382
<b>OIPCS-R24</b>						
Mutual exchange of facts and assessments	4~16	15.0 (4.0)	14.2±2.2	15.0 (2.0)	14.7±1.9	0.259
Management of team activities	4~16	8.0 (4.0)	7.5±2.9	8.0 (3.0)	7.4±2.6	0.742
Facilitation of dialogue and discussion	4~16	10.0 (3.0)	10.2±2.9	12.0 (3.0)	11.7±2.6	**0.001
Coordination for integrated care	4~16	5.0 (4.0)	5.3±2.6	5.0 (3.0)	4.8±2.3	0.198
Understanding of others and respect	6~24	12.0 (4.0)	12.7±2.2	14.0(4.0)	13.7±2.2	*0.005
Sharing and giving meaning to emotions	2~8	5.0 (3.0)	4.9±2.4	5.0 (3.0)	5.3±2.0	0.382

Mann-Whitney U test \*\* $p < 0.01$  \* $p < 0.05$

recognized by nursing staff and “conflict arose due to differences in thinking about care methods and conflicts of opinion” was recognized by care staff, a situation that arises from differences in opinions and ways of thinking about assistance and care, which was regarded as a task conflict<sup>17,18</sup>).

The results of this study did not show anything like “relationship conflict.” In addition, on the interpersonal conflict strategy styles scale, the scores for “integration style” and “avoidance style” tended to be slightly higher than the middle values of the score range for both types of professionals, and the score for “coercive style” tended to be the lowest. Both types of professionals were thought to have coping strategies meant to avoid direct conflict and negotiate mutual interests. This may have prevented tension and interpersonal conflicts.

Regarding the answers of the care staff, “conflict with not being able to respond appropriately to medical instructions from nursing staff” and “conflict due to differences in positions between nursing and care staff” were commonly seen in situations during early detection of deterioration in patients. Although care staff are non-medical workers, they have a responsibility to respond to the early detection of deterioration and were conflicted when they could not fulfil it. On the other hand, the nursing staff answered that “conflict arose in awareness of deterioration prevention and lack of support and care” and “conflict arose due to insufficient information sharing and coordination in daily life management.” It is thought that the nursing staff expected the care workers to be more involved in preventative care by sharing information and coordinating closely when assisting in daily life activities, rather than through early detection of worsening heart failure. It is speculated that the conflict in the daily life management of the elderly with dementia and heart failure was caused by nursing and care staff aiming to provide appropriate support, such as prevention of worsening heart failure and early detection. Therefore, sharing the content of such conflicts would lead to an improvement in the quality of care. The nursing staff’s most common answer, “conflict arose in terms of awareness of deterioration prevention and lack of support and care,” may have been biased against care staff because the early detection of deterioration regarding the care scenario may have included monitoring for weight gain and assisting with comfortable breathing positions. In some cases, the nursing staff may have considered it to be unexpected care, even though the care staff had provided sufficient care. Therefore, interpretation of the results is limited.

## **4.2 Strategies for coping with conflicts between nursing and care staff in the daily life management of heart failure in the elderly with dementia in long-term care insurance facilities**

### **4.2.1 Characteristics of coping strategies for each type of professional**

Regarding the intragroup conflict coping scale scores, the nursing staff were significantly more active than the care staff, and the care staff were significantly more agreeable than the nursing staff ( $p<0.05$ ). This background was thought to be related to the fact that nursing staff are medical professionals. Nursing staff in special nursing homes for older persons are the

only medical personnel in the facility. Therefore, it felt the need to be actively involved in preventing the worsening of heart failure in older people with dementia and were thought to play a role in leading the care staff.

Regarding positions, 58.6% of the nursing staff were staff members and 41.4% were managers, such as head nurses and leaders, while 29.9% of the care staff were staff members and 70.1% were managers, such as section chiefs and leaders. In addition, the care staff felt that they received more support from other professionals at the facility than from the nursing staff. Based on these findings, it was inferred that the care staff, regardless of their position, tend to seek support from and make requests of other professionals, such as nursing staff, and have a cooperative style.

The standard number of nursing staff per 100 admissions at special nursing homes and health service facilities for the elderly is three for the former and nine for the latter, while 31 for the former and 25 for the latter are the standard number of care staff per 100 admissions in Japan. Nursing staff are required to make individual judgments as medical professionals daily, with fewer staff than the care workers. Therefore, it is possible that nursing staff, even if they are staff members, may engage in proactive behavior. The results of this study are considered valuable because no previous study has discussed the relationship between placement standards for elderly facilities overseas.

### **4.2.2 Characteristics of coping strategies by number of years of nursing and caregiving experience**

In terms of differences in the respondents’ years of nursing experience, the nursing staff with fewer than average years of experience had a significantly higher mean value for “self-concession style” on the interpersonal conflict strategy styles scale than the nursing staff with greater than average years of experience ( $p<0.05$ ). Takada<sup>19</sup>) stated that the degree to which post-employment nurses make decisions regarding their own responsibility during their early careers may affect the development of their autonomy. Compared to nurses with many years of experience, it was inferred that the lack of self-confidence resulting from the lack of experience in autonomous clinical diagnosis led to the coping behavior of obeying others. Therefore, it was inferred that the average value of “self-concession style” of nurses with fewer years of experience was significantly higher. In terms of the OIPCS-R24, the nursing staff with fewer than average years of experience had a significantly higher average score for “coordination for integrated care” than the nursing staff with greater experience ( $p<0.05$ ). The nursing staff with only a few years of experience were more likely to participate in conferences to discuss care plans because they individually took care of residents in their day-to-day care more than those with more experience in managerial positions.

The care staff with greater than average years of experience also showed significantly higher mean values for “active” on the intragroup conflict coping scale than those with fewer than average years of experience ( $p<0.05$ ). Although no findings were discovered regarding the factors that could affect the

“active” score of the care staff, it was speculated that, like the results of the nursing staff, more years of practical experience led to greater self-confidence and the ability to think and act independently. Nursing staff in long-term care insurance facilities in Japan is staffed less than care staff. In facilities where multidisciplinary collaboration is well established, nursing staff provides care staff with advice and knowledge on the daily life management of heart failure in older people with dementia.<sup>20</sup> Therefore, if the heart failure of an older person with dementia worsens, care staff with practical experience may be able to proactively lead care staff with fewer years of experience and confidently respond to the situation.

Regarding the results of the OIPCS-R24, the care staff with greater than average years of experience were more likely to engage in “facilitation of dialogue and discussion” ( $p<0.01$ ) and their score for “understanding of others and respect” ( $p<0.05$ ) was significantly higher. In a survey<sup>21</sup>, targeting care staff working at long-term care insurance facilities, the most common answer was “communication” as their specialty in daily practice, regardless of their number of years of experience. On the other hand, the issue raised was “preserving dignity”<sup>21</sup>. It was inferred that the more years of caregiving experience a person had, the better their communication skills and attitude toward and respect for the elderly with dementia would be.

#### **4.3 Investigation of useful collaboration and cooperation methods in daily life management of heart failure in elderly people with dementia in long-term care insurance facilities**

The mean intragroup conflict coping scale score was significantly higher for nursing staff than for care staff, and the group with more experience had significantly higher scores than the group with less experience ( $p<0.05$ ). In addition, the average score on the interpersonal conflict strategy styles scale was significantly higher for nursing staff with fewer years of experience than for “self-concession style” ( $p<0.05$ ). Professionals with more years of experience tended to act independently, without waiting for help from others. Nursing staff with many years of experience tended to do so. Hatou<sup>22</sup> stated that activeness is essential for the attitude and stance of a leader and that activeness includes not worrying about trifles, being problem-solving-oriented, and acting first. However, according to Matsubara<sup>23</sup>, leadership behavior that enhances job autonomy and expertise is perceived as an extraneous interference that can hurt self-esteem. Senior staff members are in a position to exercise leadership, but they should not interfere too much, regardless of their professional experience. Nursing staff, who comprises medical professionals, has knowledge of the daily management of heart failure in older people with dementia. However, it is also important for nursing staff not to exert too much leadership and respect the professionalism of the care staff in caring for older people with heart failure and dementia.

Based on the specific content of the conflicts between nursing and care staff in this study, it was found that process conflict arose from the standpoints of medical and non-medical staff, and task conflict arose from differences in opinions and ways of

thinking about assistance and care. Matsuo<sup>24</sup> conducted a literature review and summarized the assertion that conflict type enhances group performance. Process and relationship conflicts tend to reduce group performance, whereas task conflict tends to increase performance, although there are disagreements regarding work ideas and opinions. Conflicts arise within a group, regardless of whether they are among the same type of professional or other types of professionals, and it is important to provide opportunities for constructive discussions so that workers from each occupation can collaboratively provide care that demonstrates their expertise.

The answers to the specific content of conflicts among care staff included “conflict with not being able to respond appropriately to medical instructions from nursing staff” and “conflict due to differences in positions between nursing and care staff.” In a survey<sup>21</sup> targeting care workers working in long-term care insurance facilities, emergency response/first aid and medical care were ranked as the fields they most wanted to learn about in their daily caregiving practice. In addition, Otsu et al.<sup>25</sup> conducted research on daily life management for the prevention of exacerbation of physical diseases in the elderly and found that care staff had “knowledge of skills and assistance methods related to daily life management of the elderly” and that they ranked “medical care knowledge and skills” as what they most want to learn about in the future regarding the prevention of exacerbation of physical diseases. The nursing staff in this study felt that “conflict arose in awareness of deterioration prevention and lack of support and care” and “conflict arose due to insufficient information sharing and coordination in daily life management.” It is necessary for healthcare professionals to share information and collaborate closely with each other. As medical professionals, nursing staff must be actively involved so that they can learn about specific daily life support methods to prevent the deterioration of heart failure in elderly people with dementia. It is suggested that such involvement reduces conflicts between nursing and care staff in the daily life management of elderly people with dementia and heart failure.

## **5. Limitations**

In this study, the response rate was low and the number of subjects was limited. In Japan, owing to the spread of COVID-19 during the survey period, each facility was busy responding to the pandemic. Considering this context, it will be necessary to conduct another survey in the future.

## **6. Conclusions**

From the content of the conflict that occurred between the nursing and care staff in managing the daily life of elderly patients with dementia and heart failure, it was found that nursing staff were more interested in information-sharing during normal daily life support than early detection of worsening heart failure. It is thought that they expected the care staff to work closely with each other, preventing their involvement. Although care staff are non-medical workers, they have a responsibility to engage in early detection of deterioration and were conflicted in



that they could not fulfil it. Sharing the content of such conflicts is thought to lead to an improvement in the quality of care. Regarding coping strategies, the nursing staff scored significantly higher than the care staff, and among the care staff, the more experienced group scored significantly higher than the less experienced group in terms of the “active” strategy. Those in a position to exercise leadership must not interfere too much with others, regardless of their professional experience.

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## 8. Conflict of interest

There are no conflicts of interest to declare.

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## 【原著】

# 介護保険施設に入所する認知症高齢者の心不全の日常生活管理において看護職員と介護職員の間で生じるコンフリクトと対処方略

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(2023年9月12日受付, 2023年11月15日受理)

**要旨:** 看護職員と介護職員が連携・協働するためには、コミュニケーションの工夫やコンフリクトマネジメントを含めて相互の意識向上に取り組む必要があるとされる。しかし、認知症高齢者の心不全の悪化を予防するための日常生活管理において生じる問題や課題を多職種間により検討した先行研究は少ない。また、日常生活管理において医療職と非医療職との間に生じるコンフリクトとその対処方略については明らかにされていない。本研究は認知症高齢者の心不全の日常生活管理において、看護職員と介護職員との間に生じるコンフリクトと対処方略を明らかにすることを目的とした。介護保険施設の看護職員及び介護職員を対象に自記式質問紙調査を実施し、有効回答は看護職員157名、介護職員154名から得られた。コンフリクトの内容に関する回答から、看護職員は介護職員に心不全の悪化の早期発見よりも情報共有や緊密な連携により心不全の悪化予防を重視することを期待していた。一方、介護職員は心不全の悪化の早期発見に責任を感じながら、その責任を果たせていないことに葛藤していた。対処方略については、「活動的」対処の得点が看護職員では介護職員よりも有意に高く( $p<0.05$ )、介護職員間では経験年数の長い群が短い群よりも有意に高かった( $p<0.05$ )。看護職員や経験年数の長い介護職員が先導して、職種間に生じたコンフリクトの内容を共有し対処することで、認知症や心不全をもつ高齢者のケアの質向上につながると考えられた。

**キーワード:** 心不全, 認知症高齢者, コンフリクト, 対処方略, 多職種連携

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