CNS Role and Practice in Germany

11

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Abstract

This chapter presents an overview about advanced nursing practice in Germany, which is an emerging concept in the healthcare service. Currently the spheres of work of the majority of advanced practice nurses are comparable to clinical nurse specialists. They provide direct clinical care to patients, support and empower nurses and/or other healthcare staff as well as strive towards changes within the organisation. Widely used are Hamric's Integrative Model of Advanced Practice Nursing and the PEPPA framework to provide guidance regarding the competencies and implementation of ANP. Missing regulation within nursing poses a big hinderance in this process. As an example of ANP practice in Germany serves the implementation of delirium management. Also described are education and professional developments with regard to ANP. An outlook finishes this chapter.

Keywords

Clinical nurse specialist · Advanced practice nurse · Delirium management Emerging ANP practice · Germany · Hamric's Integrative Model of Advanced Practice Nursing

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This chapter describes the role and practices of advanced practice nurses (APNs) in Germany. It outlines common notions regarding advanced nursing practice (ANP), looks at issues such as evaluation and education, provides an example of ANP practice and presents professional issues regarding ANP as well as an outlook.

The vast majority of APNs currently practising in Germany are comparable to clinical nurse specialists (CNS) (Mendel and Feuchtinger 2009; Feuchtinger 2016) as they are covering the three spheres of CNS practice: direct patient care, nursing and nursing staff and the organisation (Chan and Cartwright 2014: 359).

As described in previous monographs of this series (Schober 2016, 2017), ANP in Germany is still at an early stage (Maier et al. 2017). The first publications regarding ANP appeared in the 2000s (Sachs 2007; Advisory Council on the Assessment of Developments in the Health Care System (SVR) 2007; Mendel and Feuchtinger 2009). A decade later, one still finds phrases like "cultural lag" (Schaeffer 2017: 27) or words like exotic (Teigeler 2014: 12). In the mid-1990s the university hospital in Freiburg employed the first academically qualified nurse in a clinical setting (Feuchtinger 2016). In the new millennium, increasingly more and more APN roles were implemented, particularly within hospital settings (Teigeler 2014; Boeckler and Dorgerloh 2014; Weskamm 2017; Feuchtinger 2016). As role models, they open clinical settings as a possible career pathway for academically qualified nurses, next to management, education or science. However, clinical careers remain rare.

For many within the German nursing community, the term "expert" is firmly connected to Benner's "From Novice to Expert" (Benner 2001). An in-depth discussion about commonalities and differences, and consequently a clear distinction between basic, expert and advanced level (Spross 2014: 29), is still pending. However, in conjunction with international notions, there are common understandings regarding APN roles:

- That advanced practice is synonymous with clinical expertise (Dowling et al. 2013: 132).
- That they need to have a clinical focus, working with patients and/or their families. Direct patient care is understood to be there where the patient is (Spirig and DeGeest 2004: 233).
- That ANP should be an extension and expansion of the original nursing field of action (Gaidys 2011: 17; DBfK 2017: 1).
- That these roles require further training and education beyond the basic nursing training and that these roles possess additional competencies and responsibilities (Spross 2014).
- That nursing development across wards or departments remains an important feature of APN roles (Kaden et al. 2012; Schmitte et al. 2014; Hock et al. 2017).
- That successful implementation needs managerial support and a regular exchange between the APN and the nursing management. To ensure that APNs are implemented in accordance with the strategic development and objectives of the organisation, it is pivotal that the director of nursing is part of the board (Sniatecki et al. 2017: 280).

The position paper of the three German-speaking professional organisations (Germany, Austria and Switzerland) in 2013 was an important milestone as it provided a definition of an APN as well as with "Pflegeexperte APN" (translated: nursing expert APN) a possible title for these roles (DBfK et al. 2013: 2). While this title is not protected by law, the addition of the letters "APN" distinguishes it from other, not academically qualified, nursing experts and connects it to the international concept of advanced practice. However, this title does not differ between APN roles such as nurse practitioner (NP)[1] or CNS.

11.1 Utilised ANP Models in Germany

Fitting with the general developmental stage of ANP in Germany, the discussion regarding differing ANP models and concepts is much in their infancy. The most widely known and utilised models are Hamric's "Integrative Model of Advanced Practice Nursing" (Hamric et al. 2014), which is relevant for the discussion regarding competencies (DBfK et al. 2013: 1), and the PEPPA framework[2] of Bryant-Lukosius and DiCenso (2004), which guides the implementation of APN roles in Germany (Feuchtinger 2016).

Most APNs describe their tasks and competencies along Hamric's model (Teigeler 2014; Drexler and Weidlich 2016; Naegele et al. 2016; Schmitte 2016; Weskamm 2017). While all emphasise the importance of working in a clinical setting with patients and/or their families, the other competencies from Hamric's model[3] are present to varying degrees according to the setting and job description of the individual APN. It is apparent; some of these roles have a more general and some a more specialist focus in their daily routines. In the latter the emphasis lies on supporting the patient, while in the former the emphasis lies on supporting nurses and other staff caring for a specialised group of patients (Drexler et al. 2017: 266).

APNs are either assigned to a department and work, due to interdepartmental tasks, in a matrix organisation (Boeckler and Dorgerloh 2014: 14) or form a leadership team, in which they take the clinical lead, while another person occupies the managerial lead (Drube et al. 2016: 94).

11.2 Evaluation of ANP in Germany

Evaluation of ANP practice is not optional (Kleinpell 2013: 27). At this early stage of APN roles in Germany, evaluation is pertinent to identify needs of patients, families, teams or healthcare services and to promote role clarity by ensuring a good

[1] Nurse practitioners (NPs) are understood to work foremost in primary care and frequently carry out task traditionally performed by doctors. In Germany NPs are discussed as a possible solution for the lack of medical staff in rural areas (Feuchtinger 2016: 49; Maier 2017: 62).

[2] Participatory, evidence-based, patient-focused process, for guiding the development, implementation and evaluation of advanced practice nursing (PEPPA) (Bryant-Lukosius and DiCenso 2004).

[3] Guidance and coaching, consultation, evidence-based practice, leadership, collaboration, ethical decision-making (Spross 2014: 44).

match between the identified needs and the APN, her role, competencies and scope of practice (Bryant-Lukosius et al. 2016: 37). Expanding on the PEPPA framework (Bryant-Lukosius and DiCenso 2004), PEPPA-Plus guides the development of stage-specific questions for APN-role evaluation (Bryant-Lukosius et al. 2016). It is conceivable that PEPPA-Plus is suitable for and applicable to the German context, but more applications are needed to confirm this.

Evaluation is a complex process as APNs cannot be seen in isolation due to the multifactorial impact of their roles (Schaeffer 2017: 28). A suitable approach to evaluate complex interventions includes qualitative and quantitative methods and builds on formative and summative steps (Höhmann and Bartholomeyczik 2013). Currently the majority of evaluations are formative and encompass descriptive statistical data such as number of training sessions and number of participants (Höhmann and Bartholomeyczik 2013: 308). Lack of regulation and licensing of APN further complicates evaluation of these roles.

11.3 Education of APNs in Germany

There is no doubt that an established nursing science plus academically qualified nurses in clinical settings are essential factors for the successful development and implementation of ANP. However, in Germany academic structures in nursing have been established with great delay. The first academic nursing courses were not established until the 1990s (Robert Bosch Stiftung 1992); initially offered courses were aimed at experienced nurses, who were interested to move into management or teaching. As late as 2004, the first bachelor's degree in nursing, which combined academic training with a nursing exam, was commenced (Friesacher 2014: 35). This late implementation of nursing science and lack of research funding contributes to the difficult data situation in nursing and ANP (Schaeffer 2017: 29).

Presently ANP curricula in Germany are not standardised, the courses on offer vary, and their contents are heterogeneous (Maier 2017: 62). A nationwide curriculum for ANP courses is missing. In 2013 Ullmann and Lehwaldt postulated a demand for more clinically focused and patient-orientated ANP-course content that furthers autonomous (nursing) practice plus the necessary decision-making skills. Pulcini (2014: 142) recommends that faculty members remain embedded in APN practice. In Germany, this is a challenging notion due to little overlap between the differing sectors of education and clinical practice. Course leaders may not possess own personal work experience as an APN.

11.4 An Example of APNs in the Hospital Setting

Exemplary for APN roles in the hospital setting are APNs working with patients with delirium, either in a general hospital setting (Bürger and Kugler 2016) or within the setting of an intensive care unit (ICU) (Krotsetis and Nydahl 2014;

Sniatecki 2016, 2017). APNs are well educated and placed to successfully implement and conduct a structured and interprofessional management of these patients.

The occurrence of a delirium results in significant consequences for the patient with regard to the healing process and treatment outcomes (Arbeitsgemeinschaft der Wissenschaftlichen Medizinischen Fachgesellschaften e.V. (AWMF) 2015: 6).

With published incidence rates from 30% to over 80%, delirium belongs to the most commonly observed syndromes in critical care patients (AWMF 2015: 6). Its signs are an impaired cognitive function or perception and a disturbed consciousness, and it presents with an acute onset and fluctuating course. It is usually reversible (AWMF 2015: 24).

A delirium can present itself in various subforms: hyperactive, hypoactive or as a mixed form. The hyperactive form is more easily recognised as the patients can be restless or agitated; patients with a hypoactive delirium can be sleepy, quiet and withdrawn. As a consequence, it is estimated that two-thirds of patients with delirium syndromes are not recognised during a routine clinical assessment (AWMF 2015: 26). Guidelines therefore recommend a structured screening with a suitable delirium assessment tool on at least 8 hourly basis (AWMF 2015: 13), to ensure that patients with a hypoactive or a mixed delirium are identified. An early delirium management can positively influence the outcome (AWMF 2015: 3). Preventative measures play a particularly pivotal role, especially as non-pharmacological options such as reorientation strategies (e.g. intensive communication or ensuring the use of glasses or hearing aids) take here centre stage (AWMF 2015: 8–9), one of the many opportunities for nurses to directly impact on the patients' wellbeing.

Working in direct clinical practice with delirious patients revealed the need for a structured management for these patients regarding assessment, prevention, monitoring, therapy and evaluation (Sniatecki 2016: 278). Having identified the need, the aim was to improve the quality of delivered care and health services. For this, the issue was raised within the management structures within the unit and the hospital, ultimately leading to changes in service provision of the organisation (Sniatecki et al. 2017: 286–287). After the implementation of a structured assessment tool in form of the confusion assessment method for the intensive care unit (CAM-ICU) (Ely et al. 2001), a formative evaluation revealed that the numbers of patients with delirium were higher than prior to the implementation. This confirmed the assumption that particularly patients with hypoactive or mixed form of delirium were not identified earlier and did not receive any support or treatment because of this (Sniatecki et al. 2017: 287).

Spending time in direct clinical practice supports the development of a deepened relationship between patient and the APN that allows for early detection of (mood) changes and empowering staff to act in a timely manner (personal communication with S. Sniatecki 27/04/2018).

While preventative and non-pharmacological treatment options are mainly influenced by nurses (Bürger and Kugler 2016), another pivotal strategy to reduce the risk for developing a delirium is avoiding sedation and its medication (AWMF

2015: 8). Therefore, an interprofessional approach and close collaboration with medical staff is a prerequisite for success (Sniatecki 2016). Consultation with the families of patients with delirium can contribute numerous information about patients' usual behaviour or likes and dislikes; notwithstanding families also need guidance in dealing with the situation (Krotsetis and Nydahl 2014).

APNs provide clinical leadership through utilisation of their advanced skills in the direct patient contact but also by empowering nurses and other staff through mentoring or teaching, in either formal or informal teaching sessions, either in groups or one to one (Sniatecki 2016), or facilitating evidence-based practice through the development of an easy-to-use evidence-based pocket card (Bürger and Kugler 2016). This corresponds with their perception as "change agents" and as an intermediary between nursing science and practice (Mendel and Feuchtinger 2009: 208).

Leadership is also displayed by contributing to the nursing and ANP community through articles or conference presentations, which allowed others to benefit from their strategies and their findings (Krotsetis and Nydahl 2014; Sniatecki 2016; Bürger and Kugler 2016; Sniatecki et al. 2017; Bürger 2017; Nydahl 2018).

11.5 Professional Issues Regarding ANP

Like many countries, the healthcare service in Germany is facing multiple challenges due to the demographic and epidemiological changes. The need for change in the provision of health care has been recognised by politicians as well as professional organisations, such as Deutscher Pflegerat (DPR) and Deutscher Berufsverband für Pflegeberufe (DBfK), who support the development of APN roles (DBfK 2013). However, just transferring tasks between professions will fail; instead processes need to be changed (Wolke 2017: 37).

Specific challenges to the implementation of ANP are due to a lack of registration and self-government in nursing and, as a consequence, not regulated APN roles. This is a major hinderance to push the notion of ANP, as regulation means role clarity (Maier et al. 2017: 34) and contributes to the sustainability of ANP (Schober 2016: 124). Currently, APN roles are implemented in Germany without being clearly defined. There is a lack of funding for education and research into ANP (Schaeffer 2017: 29). Clinical salary structures are just beginning to consider academic qualifications (DBfK 2016: 2).

The central professions within the healthcare services in Germany are, by law, physicians. New professional groups such as physician assistants (PAs) have been discussed and implemented in recent years. In 2017 the Federal Medical Council agreed to support the implementation of delegatory practice of PAs (Bundesärtzekammer 2017: 113), not autonomous practice like APN. While it is possible that PA may pose a suitable career move for some nurses, the nursing association Deutscher Berufsverband für Pflegeberufe (DBfK) emphasises that this is not an extension and expansion of nursing, but rather stands in competition to developments such as ANP (DBfK 2017: 1).

11.6 Outlook

While ANP is getting more known within nursing, it is still not general knowledge in politics or society. Plenty of APNs are professionally and politically engaged to further ANP. By presenting and discussing their roles as well as demonstrating positive patients' experiences to the public, either locally or through liaison with the media, they create an awareness within society regarding APN-supported healthcare services. National and international networking and exchange supports that German APNs benefit from experiences with the implementation of ANP in other countries.

It can be assumed that with an increasing number of academically qualified nurses as well as more role models in clinical practice, the interest in a clinical career will grow and in the midterm/long term enhance the numbers of APNs in Germany.

Future plans for nursing take ANP already into account, as seen in case studies presented on a website regarding the skill mix. There it is shown how APNs contribute to the provision of health care by enhancing the nursing team (Robert Bosch Stiftung 2018).

In the coming years, ANP and APNs will continue to develop into an important building block for the delivery of a patient-focused health care, particularly for patients with complex needs in and across all settings and areas. However, this requires structured implementation, regulation and evaluation of APN roles as well as an education, which is internationally compatible.

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