CNS Role and Practice in Japan

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Abstract

The aim of this chapter is to describe the Certified Nurse Specialist (CNS) role and practice in Japan from the history of the role's development to current challenges and opportunities. The CNS was the first post-RN role in Japan, a developed country with a high proportion of elderly people and a high healthy life expectancy. Included in the chapter is a brief history of modern Japanese nursing since 1874 noting the first CNS practice in hospitals began in the early 1990s. In Japan, laws governing health professional scope of practice are national. National law stipulates the qualifications for licensure of Japanese health care professionals. In the chapter, definition of CNS role and practice is described. A case exemplar described the practice of an expert Japanese CNS. The U.S. CNS was the

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model for the Japanese CNS. Initially the role focused on inpatient hospital care with both direct and indirect care activities. In Japan, practice competencies for CNSs are jointly endorsed among three organizations: the Japanese Nurses Association (JNA), the Japanese Association of Nursing Programs in University (JANPU) and professional nursing specialty organizations. JNA certifies individual CNSs. The JANPU accredits CNS educational programs.

Discussion of research on CNS outcomes includes recommendations for additional research. Psychiatric CNS outcomes research has demonstrated the effectiveness of psychiatric liaison CNSs, influencing health policy. Current issues in advanced practice nursing development are reviewed in relation to challenges and opportunities for the future.

Keywords

Certified nurse specialist (CNS) role · History Japanese CNS · Research on CNS effectiveness · Advanced practice nurse (APN) in Japan · CNS credentialing system · CNS practice competencies · Licensure · Case exemplar

12.1 Introduction

In this chapter, we will describe the certified nurse specialist (CNS) role and practice in Japan from the history of the role's development to current challenges and opportunities. We will also provide a case exemplar to describe the practice of an expert Japanese CNS.

Japan is a developed country that is undergoing many social changes. The proportion of elderly people in the population is increasing, and there is a decline in people under the age of 15. Health-related indicators have constantly improved, and healthy life expectancy is high (Japanese Nursing Association (JNA) 2016). Japan has a universal healthcare insurance system in which all citizens benefit (JNA 2016). Certified nurse specialists are an integral part of the healthcare system to provide expert specialist nursing practice to advance the health of Japanese people.

12.2 Brief History of the CNS Role

Modern Japanese nursing developed with a change from traditional Chinese medicine to western medicine in 1874 after the Meiji Restoration (1868) (JNA 2016). In 1987, the Ministry of Health, Labor, and Welfare published a report about the need for nurse specialists (Komatsu 2010). This was the first reference to the CNS role (Dr. Keiko Okaya, personal communication, 6/11/18). Prior to the 1987 report, nurses were trained and educated as generalist nurses without any specialization. Because of increasing challenges with the introduction of more technologies, the growing number of patients with complex health conditions, increasing complexity of nursing care, and the challenges of infection rates and multidrug-resistant

organisms within the hospitals at that time, the government realized the need for the CNS in Japan.

JNA founded a Credentials Committee that worked for 7 years to develop a CNS system, influenced by the CNS role in the USA (Dr. Keiko Okaya, personal communication, 6/11/18; Komatsu 2010). In 1994, the CNS system was established by JNA and the rules and bylaws completed in 1995. In 1996, JNA contracted with the Japanese Association of Nursing Programs in Universities (JANPU) about the roles of each organization in relation to the CNS. The role of JNA is to certify the individual CNS; the role of JANPU is to accredit education programs preparing CNS students. From 1996, JNA began certifying CNSs in three specialties: cancer nursing, psychiatric and mental health nursing, and community nursing. In 1998, JANPU began accrediting CNS education programs at the master's level (Dr. Keiko Okaya, personal communication, 6/11/18). As of December 2017, there were 2104 certified specialists in Japan who were working in hospitals, outpatient clinics, and community settings in 13 specialties. The specialties are cancer, psychiatric mental health, community health, gerontology, child health, women's health, chronic care, critical care, infection control, family health, home care, genetic, and disaster nursing. The top three specialties by number were cancer, psychiatric mental health, and critical care nursing (JNA, n.d.).

In 2007, the Japanese Association of Certified Nurse Specialists (JACNS) (http://jpncns.org/) was formed with goals of improving nursing care quality, being involved in quality assurance, and making policy recommendations to promote people's health (Komatsu 2010). Inclusive of all specialties, the JACNS has held conferences since 2014. Of all CNSs, 70% belong to the JACNS. The JACNS promotes research to show the effectiveness of CNSs and makes policy recommendations to the government (Usami 2015a, b).

The CNS was the first advanced practice nurse (APN) role in Japan; they encountered problems with intraprofessional collaboration. Many CNSs experienced problems with effective utilization in healthcare due to misunderstanding by administrators about how to best use CNSs to improve patient care, possibly because of the social importance of age-based seniority and a perceived difficulty of individual CNSs fitting into organizations where the social culture involves belonging to a group. Early visionary nurse administrators and those who later worked with CNSs provided strong support. Over time, however, hospitals began to receive funding from the central government healthcare financing system for CNS services in selected specialties such as oncology and palliative care and the psychiatric liaison consultation team. Currently, the JACNS is advocating for reimbursement for dementia teams.

There are far fewer numbers of CNSs than RNs in Japan. CNSs have been practicing in Japanese hospitals since the early 1990s but often work in staff nurse roles with one day per week to work as a CNS. Many CNSs are faculty in graduate schools of nursing. Some CNSs practice as a CNS and teach part-time in a school of nursing. Prefectures farther away from Tokyo and rural prefectures are less likely to have CNS roles in healthcare institutions. Appropriate utilization of CNSs will increase their visibility and show their effectiveness.

12.3 Definition and Practice of the Certified Nurse Specialist

The CNS credentialing system of JNA contributes to the development of healthcare and welfare as well as improves nursing science by credentialing CNSs with specific advanced specialty nursing knowledge and skills. The CNS provides efficient, high-level nursing care to individuals, families, and groups that have complex nursing problems (JNA 2016). CNS roles and activities include providing excellent nursing practice to patients, families, and communities, consultation with nurses and other healthcare providers, coordination, ethical coordination to protect the rights of individuals and others, education of nurses, and research activities (JNA 2016).

12.4 Conceptualizations/Models of CNS Practice

The US CNS was the model for the Japanese CNS. Initially, the model focused on inpatient hospital care with both direct and indirect care activities. The emphasis is on excellent direct patient care, but indirect activities are also important. One of the original motivations for developing the psychiatric liaison CNS role in the late 1980s to early 1990s was to provide nurse support in hospitals (an indirect care activity) (Minarik and Sato 2016). Now, approximately 30% of CNSs practice in community settings such as home visiting centers and outpatient clinics (Dr. Mieko Tanaka, personal communication, 6/11/18).

12.5 CNS Practice Competencies

Competencies are commonly defined as the knowledge, skill, and behavior/attitude/aptitude to deliver high-quality and safe patient care. In Japan, practice competencies for CNSs are jointly endorsed among three organizations: the JNA, the JANPU, and professional nursing specialty organizations (JANPU 2015; Komatsu 2010). CNS competencies build upon registered nurse competencies (Komatsu 2010). These competencies are attained during the educational program through courses and supervised clinical experiences. Komatsu (2010) urged the Japanese Society of Cancer Nursing to develop core competencies along with curriculum and job descriptions for certification examinations. The JACNS has developed a CNS clinical ladder, based on Benner (Usami 2014). However, there is no standard list of core CNS competencies applying to all CNSs in all specialties.

12.6 Outcome Measures and Evaluation

Japanese nursing needs CNS outcomes data to show the effectiveness of CNS interventions and the impact of CNSs on quality of care. According to Komatsu (2010), cancer CNS outcomes data is limited to descriptive data in 14 years of published

case reports. Komatsu (2010) called for well-designed trials to measure the outcomes of cancer CNS interventions with complex patients. Currently, there are no published studies on CNS outcomes except by psychiatric CNSs (Dr. Atsuko Uchinuno, personal communication, 8/6/18).

Psychiatric CNS outcomes research has demonstrated the effectiveness of psychiatric liaison CNSs and has influenced health policy. Usami (2015) and Nozue et al. (2016) showed that psychiatric mental health CNS intervention improved depression scores in hospitalized physically ill patients. Research by Usami et al. (2009) demonstrated the effectiveness of the psychiatric liaison consultation team in the general hospital. Teams were comprised of CNS, psychiatrist, clinical psychologist, a nurse, and a social worker, usually led by the CNS. Usami and her colleagues submitted the 2009 paper to the government, and that resulted in a change in policy to fund hospitals for psychiatric liaison consultation teams. This reimbursement of liaison psychiatric CNS was the first time among psychiatric CNSs.

12.7 Education of CNSs

The Japanese Association of Nursing Programs in Universities (JANPU) accredits CNS programs. For CNS programs, there is a 26-unit, a 38-unit, or a 46-unit option. All CNS curricula must include the following common subjects (Common Subjects A): Nursing Education, Nursing Management, Nursing Theory, Nursing Research, Consultation, Nursing Ethics, and Nursing Politics (JANPU 2015). The 38- and 46-unit CNS curriculum must include Physical Assessment, Pathophysiology, and Clinical Pharmacology (Common Subjects B) in addition to the Common Subjects A. Additionally, all three CNS curricula must include a specialty educational curriculum as determined by the JANPU. An example of the specialty content for the education of a psychiatric mental health CNS is described in "An introduction to psychiatric liaison nursing in Japan" (Minarik and Sato 2016). Komatsu (2010) described the history, education, and practice of the oncology certified nurse specialist, including specialty educational content.

Although the goal of the CNS master's education is to produce an expert in clinical practice, Japanese curricula may not require enough supervised hours with a practicing CNS, constraining graduates' readiness for expert practice (Minarik and Chan 2014). In addition, practicing CNSs may not be geographically close, requiring CNS students to travel for supervised clinical experiences.

Of note, the role of the nurse practitioner has been introduced in Japan to help meet the general care needs of patients especially in rural isolated areas due to the lack of medical physicians (Fukuda et al. 2014; Kondo 2013). This emerging advanced practice role is still being developed among the various national nursing organizations. The JANPU (2015) approved a primary care curriculum. Further, differentiation and clarification are being determined.

In 2015, an amendment to the law governing nursing obliged nurses who perform medical interventions specified in the law to be trained for the 38 interventions (JNA 2016). This new system will allow trained nurses to perform the interventions

without waiting for physician decision-making. Completion of the training course with a certificate of completion and qualification is not a license and does not have a legal basis. How this new system will affect CNSs is unknown.

12.8 Credentialing: Regulatory, Legal, and Certification Requirements

In Japan, laws governing health professional scope of practice are national. National law stipulates the qualifications for licensure of Japanese healthcare professionals, such as nurses, midwives, public health nurses, physicians, and dentists. As a result, practice does not legally differ by prefecture. The law does not identify certification as a specialist, and there is no separate licensure for CNSs. The credentialing system by the JNA, which is socially recognized, certifies CNSs. However, not all institutions include CNS roles, and the activities may differ by institutional policy.

To obtain certification as a CNS, a nurse must complete a master's program at a graduate school, after obtaining a national nursing license, accumulate at least 5 years' experience as nurse, and then pass the credentialing examination given by the JNA. A graduate of a CNS program may sit for the exam 6 months after graduation (Dr. Mieko Tanaka, personal communication, 6/11/18). Certification is renewable every 5 years (JNA 2016).

The term "advanced practice nurse" (APN) does not have a universally agreed upon definition about which roles are included. The JANPU uses the term but not the JNA. Universities use the term because of the influence of the JANPU. The idea has arisen to make a new APN national license to differentiate advanced practice from registered nurse practice (Dr. Keiko Okaya and Dr. Mieko Tanaka, personal communication, 6/11/18.). The use of the APN term is dynamic and not settled yet. Consensus building is difficult when participants (i.e., different professional nursing organizations) hold divergent views, especially with the introduction of the nurse practitioner role.

12.9 Moving Forward: Challenges and Opportunities

Overall, in Japan, there is limited public recognition and understanding of CNS roles. Therefore, CNSs in Japan can take some specific steps to help increase the visibility and recognition of the role. First, the CNS/APN role will be most effective if it is designed to fit the social and healthcare system context and the population needs. The Goals of Healthy Japan 2021 (http://www.kenkounippon21.gr.jp/kenkounippon21/about/kakuron/) can provide a guide for action (Minarik and Chan 2014). Second, those practicing as CNS/APNs can collaborate with the emerging nurse practitioners to ensure that both APN roles demonstrate the true value of advanced practice by including the nursing perspective in care, making the care more holistic than care focused primarily on the medical model and procedures. Third, a national consensus on curriculum standards, core competencies, scope of

practice, and minimum qualifications for recognition and practice as an APN have to be created so there is no ambiguity among the nursing profession, other healthcare disciplines, the government, and the public about who APNs are and what they are capable of doing to help improve health outcomes of the population.

Fourth, careful attention should be given when creating scope of practice, titles, certification, and educational standards for APNs. Architects of these key components of APN practice and regulation need to write the scope of practice and standards for licensure, certification, and education in a broad enough way to apply to various situations where APNs practice as well as when changes in science and practice naturally evolve over time. It is difficult to change laws through legislation as this process is heavily influenced by politics. If professional nursing organizations create national standards of education, competencies, and certification, then the law should reference those national standards as being the standards by which APNs are recognized and have authority to practice.

Universities and hospitals can support novice CNSs with mentorship through transition-to-practice support programs to help them firmly establish themselves in work settings (Minarik and Chan 2014). Such support will enable them to increase their ability to provide clinical experiences for CNS students, necessary for increasing numbers of CNSs visible and in practice.

To gain more role recognition and to create the evidence that CNSs improve patient, population, educational, and healthcare system outcomes, CNSs need to implement and study large-scale innovations.

Japanese nursing leaders are poised to define the scope of practice and the model for a Japanese APN. We recommend a single scope of practice for both CNS and NP roles in Japan (Minarik and Chan 2014).

12.10 Envision the Future APN

The following are the steps proposed for designing the APN role of the future. The authors cannot say what the future Japanese APN will look like nor whether these steps are necessary in Japan. Japanese nursing leaders must create the Japanese APN to fit the Japanese context (Minarik and Chan 2014). The following are some recommended steps:

1. Define necessary competencies (i.e., knowledge, skills, and attitudes) and scope of practice.
2. Define and codify the core educational foundation, including required clinical hours during education. Adequate supervised clinical hours are vital during the educational program to provide a foundation for developing clinical expertise. Supportive programs such as transition-to-practice programs to help new graduate CNSs are essential for the success of individual CNS role development and the role overall (Minarik and Chan 2014). After certification, CNSs need further training from CNS experts to improve their clinical competency, especially in direct patient and family care.

3. Design outcome studies from the outset to measure the impact of the CNS/APN. Outcomes should be selected for their importance to Japan, its healthcare system, and Japan's healthcare challenges (Minarik and Chan 2014). Evidence-based outcomes will result in CNS/APN effectiveness being visible to the public and other providers.

In a publication for a Japanese nursing audience, Minarik & Chan wrote "When providing advanced care, nurses bring a different perspective than their physician colleagues. They use the same scientific method (data, diagnosis, plan, treat, evaluate), obtain the same measurements of biopsychological data, including laboratory tests, and utilize many of the same interventions. However, the focus on active engagement of patient and family and adding health promotion and disease prevention strategies as central components of the plan of care as opposed to passive compliance with prescriptions and instructions is different as is the attention to environmental and resource factors in addition to medical symptoms and diagnoses. The APNs must include the nursing perspective otherwise, they will only become a mini-doctor and lose their nursing identity. Both CNSs and NPs can co-exist in the healthcare system since CNSs are specialists and NPs are generalists" (Minarik and Chan 2014: 46).

12.11 Conclusion

This chapter described and defined the Certified Nurse Specialist (CNS) role and practice in Japan from the history of the role's development to current challenges and opportunities. The CNS was the first graduate nursing role in Japan. The chapter includes a brief history of modern Japanese nursing since 1874 noting the first CNS practice in hospitals, modeled on the U.S. CNS, began in the early 1990s. A case exemplar described the practice of an expert Japanese psychiatric mental health CNS. In Japan, practice competencies for CNSs are jointly endorsed among three organizations: the Japanese Nurses Association (JNA), the Japanese Association of Nursing Programs in University (JANPU) and professional nursing specialty organizations. An example of psychiatric CNS outcomes research that demonstrated the effectiveness of psychiatric liaison CNSs, influencing health policy and research on CNS outcomes. Current issues in advanced practice nursing development have been reviewed in relation to challenges and opportunities for the future. In Japan, creating the future of APN roles importantly is done while respecting and building on past development of APN roles.

Exemplar: Psychiatric Mental Health Certified Nurse Specialist Practice
The CNS in psychiatric mental health nursing may work in psychiatric inpatient and outpatient settings with patients repeatedly hospitalized for psychiatric disorders, in general hospitals with patients who have undiagnosed

psychiatric disorders or problems in coping, or in ambulatory settings. Psychiatric CNSs provide psychotherapy to individuals, groups, and families and consult with nurses and other providers, educate nurses, coordinate care and ethical issues, and conduct research.

This case is an example of direct care and consultation by an expert CNS in psychiatric mental health nursing in Japan. This case involved a 34-year-old woman, Mrs. K, with a diagnosis of major depressive disorder and borderline personality disorder who was an inpatient in a psychiatric hospital. Her admission was due to self-harmful behavior of wrist cutting and overdose, behaviors labeled as acting out.

Her history included family stressors. She graduated from a university and then worked for 5 years as a city public officer. She married and had one daughter. After her husband died of cancer, she raised her child by herself. At 32 years old, she married again and had another child with her second husband. However, her husband was unable to help with childcare; she cared for both children by herself. The family moved to live closer to her husband's work. Following the move, she started to cut her wrist and overdose.

This third admission, due to acting out behavior (wrist cutting and overdose), was considered a repeat admission because it was within 3 months of discharge. At the unit, she expressed anger because nurses did not listen at night when she wanted a listener. And the multidisciplinary team was split and disagreed about both her treatment goals and treatment approach.

Prior to interaction with the CNS, Mrs. K's behavior included eating three to four meals daily, insomnia at night, and daytime sleeping. She was angry about nurses' behavior of not listening.

With the patient, the CNS implemented a theory-based approach to care (Psychoanalytic Systems Self-Care Therapy, PAS-SCT) that is designed to help difficult patients, who have acted out many times and have repeated admissions, to implement self-care with deliberate action. PAS-SCT is a self-care therapy developed by the CNS and her colleague Dr. Kotani [Usami and Kotani 2018]. The psychotherapy model was based on the Orem-Underwood self-care model, which is the foundation for psychiatric nursing care in Japan [Usami and Kotani 2018] and the psychoanalytic systems theory developed by Dr. Kotani [2018].

The CNS met with Mrs. K three times per week; psychotherapy focused on how to control her self-harmful behavior and improve her problems with overeating, her imbalance of activity and rest, and imbalance of solitude and social interaction. Using the theory-based psychotherapy (PAS-SCT), the CNS encouraged the patient to express her anger and clarify her unmet needs. The CNS and Mrs. K focused on setting self-care goals necessary for staying in the community. The goals set were to control food intake and develop activity and rest balance and solitude and social interaction balance.

With psychotherapy, Mrs. K gradually recognized she had been angry with her husband, because her husband complained about her money management and her lack of housekeeping. With therapy, Mrs. K came to control her impulsive self-harmful behavior and improved her self-care.

The CNS coached the primary nurse about the interventions for enhancing self-care. Following the coaching, the primary nurse used these interventions daily with the patient.

Addressing the multidisciplinary team, the CNS regularly shared information about Mrs. K's nursing care on the unit and informed the team of the psychodynamic assessment of Mrs. K. The shared information and focus on teamwork contributed to improved functioning of the team. The team was able to work together to set treatment goals for Mrs. K and determine the roles for each team member.

Then, the CNS provided psychoeducation and mental support for the husband. The CNS and Mr. K talked about how to respond to the patient and cope with her behavior. Gradually her husband understood her behavior and was able to cope with her.

In this case, CNS outcomes were improved self-care ability of patient and improvement of the teamwork and collaboration of the multidisciplinary team. In Japan, the role of the psychiatric CNS is to improve patients' self-care ability, provider teamwork, and the functioning of the organization or community. The CNS can facilitate discharge of challenging patients into successful community living.

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