A Clinical Advancement Program: Evaluating 10 Years of Progressive Change

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Abstract

Objective: To report the evolution of a clinical advancement program, UEXCEL, at a western teaching hospital and the outcomes associated with evaluation over time.

Background: The clinical ladder program was initiated in 1989 to provide a professional framework for developing, evaluating, and promoting registered nurses. The program is derived from Benner's Novice to Expert model. Over a 10-year period, the program has undergone three significant revisions. Program evaluation data have been used to guide institutional change.

Methods: Structure and progression of program development and change are outlined. Evaluation data were collected using a 23-item clinical ladder satisfaction scale developed by Strzalecki. Data were collected in 1993, 1994, 1996, and 1998 using standard survey methods after institutional review board approval. Subjects were registered nurses holding clinical positions at the University of Colorado Hospital. Data were trended across units and time periods and were compared with other institutional evaluation data sets.

Results: Improvement in nurse satisfaction with the UEXCEL program has been steady and incremental, after low baseline measurement. Satisfaction has improved after each program revision. A significant demographic variable over time is the correlation between higher registered nurse education and program satisfaction. Human resources issues are reported with data results.

Conclusions: Sustaining a clinical advancement program represents a challenge in the current healthcare environment. Institutional commitment, staff involvement in revisions, and activities to improve professional nurse development are critical strategies so progress can be achieved.
Clinical advancement systems, often identified as clinical ladders, were created in the 1970s to provide a mechanism for the promotion and retention of professional nurses working in the acute care hospital setting. Advancement programs have recorded successes and failures over the past two decades as nurse leaders have struggled to redefine the work of professional nursing in a rapidly changing healthcare environment.

In addition to the dual purposes of recruitment and retention, clinical ladders have also served an important secondary function: to shape a workforce that enters the nursing profession with varying educational backgrounds, differing skill abilities, and uneven levels of professionalism and career commitment. Along with the challenges of building a dedicated, knowledgeable workforce, the nurse executive must determine how best to reward and promote nurses under conditions of nursing shortages and constrained resources, while continuing to sustain the professional components of the ladder.

With nationwide nurse shortages already building in some geographic areas, it is timely to refocus on the role of clinical ladders. Bauer 3 suggests conditions are in place for an increased demand for registered nurses (RNs), with both short- and long-term shortages in the nurse labor market. The role of clinical ladders, therefore, seems increasingly important and warrants continued review as the profession enters the millennium. The 10-year experience of a western teaching hospital’s clinical advancement program is described, including human resources issues, process problems, and evaluation measurement.

**Literature Review**

Clinical ladders were first reported in the 1970s by Zimmer 1 and others, but did not become the market norm for recruitment and retention until the 1980s. The Magnet Hospital Study 7 identified career ladder programs as one of the characteristics that served to retain and attract professional nurses. Nurses who worked for magnet hospitals identified on interviews that the clinical ladder was highly valued because it provided opportunities for advancement through recognition and salary enhancements and still permitted the nurse to continue in clinical practice. A decade later, Murray 8 surveyed 543 hospitals and found 44% had ladder programs, with 45% planning to implement such a program within a year. In 1989, Strzelecki 9 surveyed 385 nurses representing 24 hospitals, identifying the significant outcomes of clinical ladders: differentiation of clinical competence, reinforcement of responsibility and accountability, guidance to evaluate clinical performance, professional growth opportunities, and increased autonomy and decision making. In contrast to the magnet hospital study results, however, Strzelecki 9 did not report a relationship between clinical ladders and continued nurse employment at a hospital.

With clinical ladders identified as a retention strategy, evaluating the relationship between nurse job satisfaction, retention, and clinical ladders has been a persistent focus of study. Malik 10 compared job satisfaction scores between the nursing staff in two hospital intensive care units (ICUs), one with a career ladder and one without. Nurses with more experience were equally satisfied at both institutions, with salary the most significant indicator of satisfaction across sites. However, nurses at the hospital with a clinical ladder held more overall job satisfaction. Bell, 11 Schultz, 12 and Corley et al. 13 also studied job satisfaction and its relationship to clinical ladders. In all three studies, job satisfaction was not higher for those who had advanced nor was the ladder identified as the reason for retention. However, in all reports professional development was rated as a positive benefit of clinical ladders.
Although Aiken 14 has identified critical issues related to nursing education, including the need for more highly prepared nurses to manage complex practice, it is significant to note that most clinical ladders do not identify formal education as a requirement for advancement. Clinical ladder progression is primarily linked to continuing education. Thornhill's 20 study, comparing the relationship between perceptions of nurses who did not participate in clinical ladders, raises further questions regarding outcomes. Most respondents did not clearly identify whether clinical ladders held relevance to their role as a nurse. Respondents were primarily associate degree-prepared nurses. Thornhill 20 suggested that many nurses view clinical practice as a job, not a career, and challenged basic nursing education programs to prepare clinical nurses to participate in and value career planning and advancement. Thornhill 20 concludes that clinical ladder programs have little impact on enhancing recruitment and retention if nurses do not value career development.

Reports of reexamination and reconfiguration of clinical ladders have increased, confirming French's 21 recommendation in 1988 that clinical ladders must be continually evaluated and revised every 3 years to maintain relevance as a significant marketing force. Nuccio et al. 22 described the changing a traditional clinical ladder to one requiring clinical narratives to describe practice behaviors and placement on a continuum of five developmental stages of nursing practice. Goodloe et al. 15 reported revising a well-established clinical ladder, one first reported in 1993 by Hamric et al. 16 This generation of revisions included refocusing on clinical practice domains; removing nurse practitioners, clinical specialists, and case managers from the ladder because of the advanced practice nature of their positions; and enhancing the role of the nurse manager as a coach. Kravutske and Fox 23 reported revisions made to place more emphasis on clinical practice: menu "points" allowed nurses to emphasize their own unique contributions. The revision, however, retained an educational requirement for a Bachelor of Science in Nursing (BSN) to advance (an exception to the reported norm) and eliminated the requirement to join a professional organization. More recently, Gustin et al. 24 reported revising one of the earliest identified clinical ladders, developed originally in 1978, to require a certain number of years of experience to advance to another level, improve salary bonuses, and increase educational benefits for those who advanced.

Shapiro 25 conducted a recent review of the literature on career ladders specifically related to Benner's 26 model and identified the outcomes of staff, patient, and physician satisfaction; professional development; number of expert nurses; and cost as ways to measure ladder effectiveness. Although focus on clinical ladders has been primarily been on nurse satisfiers for retention and recruitment purposes, Shapiro introduced a more multifaceted approach, linking ladder outcomes with patient and physician outcomes. Shapiro concludes that, whereas Benner's 26 model is the "only developmental model to endure the test of time," rigorous outcomes have been under-researched and only generalized effects can be noted.

And, finally, attention is now being directed toward examining whether the identified levels of clinical ladders to accurately reflect increased nurse competency on progression. Snyder 27 conducted a research study measuring nurse response to two quantitative measurement scales to determine if nurses at one ladder level held different scores on these clinical competency measures than nurses at a higher ladder level. Although most results did not report significant differences, some indication was seen that nurses at the higher ladder level moved from using a single strategy problem-solving approach to a mixed, integrated approach using both intuition and analytic problem-solving skills. An important finding of this study was the lack of an identified mentor by more than 60% of the nurses at both levels, indicating that nurses advancing on the ladder may not have role models or, in turn, know how to model others. Mentoring is a process that has been identified as a significant source of stimulation and growth for the experienced nurse in the clinical ladder system. 13 Further research to measure differences in levels of clinical competence within a clinical ladder system may contribute significantly to clarify the purpose and value of these advancement programs.

Program Description
In 1989, the University of Colorado Hospital converted from a state institution to a private authority, a structural change that necessitated reconstruction of the performance appraisal process. An advancement program, called UEXCEL, University Hospital’s Focus on Nursing Excellence in Clinical Care, Education and Leadership, was created by a task force of staff nurse and leadership representatives using Benner’s 26 novice-to-expert theoretical framework. A unique characteristic of this clinical ladder program is the use of professionally framed performance standards for multiple purposes: serving as the yearly employee evaluation, as a means to define the nursing role at each level of the system, and as the foundation for the credentialing advancement process. Figure 1 shows the UEXCEL professional practice model.

![UEXCEL Professional Practice Model](image)

**Figure 1. UEXCEL professional practice model.**

**Program Objectives**

The UEXCEL program objectives are consistent with those reported by other institutions' clinical ladder programs 12,16,17,22,24:

- To create an environment that promotes professional behaviors and attitudes, incorporating peer review to increase nurse account-ability, autonomy, and collaboration

- To define role expectations within each practice level, incorporating Benner’s 26 model of professional development into the institution’s values, goals, and mission

- To provide a guide for professional credentialing that is integrated with the institution’s performance appraisal system, including compensation and rewards commensurate with advancing levels of practice

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• To provide opportunities for professional development, affording nurses advancement while remaining actively involved in clinical patient care

Program Structure
UEXCEL consists of five levels of clinical nurse practice, each level differentiated by degrees of clinical expertise, competence, and increased professional responsibility. Level I represents the novice, new graduate nurse; level II, the competent nurse who manages a workload of acutely ill patients; level III, the proficient nurse who has shown increased clinical expertise and leadership on the unit (enrolled in or holding a BSN degree); level IV, an advanced nurse who contributes expert skills and leadership across services; and level V, a Master’s of Science in Nursing (MSN) advanced practice nurse, considered a clinical expert and active in professional activities beyond the hospital environment.

The core components of UEXCEL provide the structure for both evaluation and credentialing advancement, with nurse performance measured in the areas of clinical practice (nursing process), education and professional involvement, quality management or research and management or leadership. Each of these components incorporates standards of care, practice, and performance to define nurse role expectations. A sample of the standards can be seen in Figure 2. As the nurse advances, the weights of the practice areas change to reflect the increase in expertise at that next level, similar to the system reported by Kravutske and Fox.23 A level I nurse, for example, as a new graduate, has most of the percentage weights on nursing process, whereas a level V nurse has weights equally distributed among all the categories of performance. Weights can be seen in Table 1. Included in the system is a strong peer review component, an integral part of the evaluation and advancement process, with activities including peers auditing documentation and rating one another on performance criteria. Peers also support the credentialing process by writing letters for inclusion into the applicant portfolio.
<table>
<thead>
<tr>
<th>Practice Standards</th>
<th>Performance</th>
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<tr>
<td><strong>LEVEL I</strong></td>
<td></td>
</tr>
<tr>
<td>1. Oriented to department and unit QM/research activities</td>
<td>Critical Standards</td>
</tr>
<tr>
<td>3. Identifies relationship between quality/practice.</td>
<td>b. Oriented to unit/practice area activities, such as quality monitors, critical pathways, other.</td>
</tr>
<tr>
<td>4. Increases knowledge of research/quality.</td>
<td>c. Familiarizes self to research conducted in area: medical, nursing, pharmacy, other.</td>
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**LEVEL II**

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<th>Critical Standards</th>
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<tr>
<td>1. Completes module of competency baseline annually.</td>
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<td>2. Identifies three (3) monitors; participates in improvement.</td>
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<tr>
<td>Additional Standards</td>
</tr>
<tr>
<td>3. Participates in outcome activities: journal club, data collection, other.</td>
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<td>4. Attends research/quality educational session/workshop.</td>
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**LEVEL III**

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<th>Critical Standards</th>
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<tbody>
<tr>
<td>1. Assumes active role in quality or practice outcome project, such as initiating unit-based quality project, participating on a critical pathway team or evidence-based practice project.</td>
</tr>
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<td>2. Communicates outcomes of projects in unit staff meeting or by other ways of reporting.</td>
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<tr>
<td>Additional Standards</td>
</tr>
<tr>
<td>3. Acts as a leader of a journal club session, choosing a journal article for review and facilitating discussion of how article reflects evidence-based practice; implications to use in unit practice.</td>
</tr>
<tr>
<td>4. Participates in evaluation of NIC/NOC/critical pathway/other activities.</td>
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**LEVEL IV**

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<th>Critical Standards</th>
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<tbody>
<tr>
<td>1. Acts as leader of evidence-based research team. Conducts review of literature and facilitates group analysis and discussion. Leads group to complete and implement project.</td>
</tr>
<tr>
<td>2. Communicates outcomes/findings of project by formal presentation (symposium, poster).</td>
</tr>
<tr>
<td>Additional Standards</td>
</tr>
<tr>
<td>3. Actively participates in conducting research, taking responsibility for a structured phase/stage of another investigator's project.</td>
</tr>
<tr>
<td>4. Serves as an active member of a quality team that crosses unit boundaries with institutional impact.</td>
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Figure 2. Sample of UEXCEL standards.
Credentiaing Process

Professional nurses consider the UEXCEL program and standards to be challenging. The process of advancement is managed by the UEXCEL Board, which consists of staff nurse representatives from the different clinical areas, as well as representatives from nurse recruitment, management, and human resources. Nurses must meet standards at the level to which they desire advancement in order to apply for credentialing. A portfolio is used to demonstrate contributions, such as excellence as a clinician, educating peers by inservice sessions or precepting, completing a quality improvement project or research activity (e.g., journal club), unit clinical leadership, and professional involvement (e.g., professional organization membership). Portfolio presentation also includes writing a narrative exemplar to describe a clinical situation that personifies how the nurse is practicing at a more advanced level, peer and manager letters of support, and a copy of the performance evaluation. The portfolio is submitted to the UEXCEL Board, which evaluates applicant materials to determine if the application meets criteria for the next level of advancement.

Evolution Over Eight Years

As with other reported programs,15,22,24 UEXCEL has undergone several generations of major and minor improvements, and the revision process is ongoing. The program was not well received on initiation in 1989. Nurses perceived the standards to be cumbersome and hard to understand, and the process complex. It was an especially dramatic change from the previous brief, generic state personnel evaluation process that had been in place. As the volume of complaints continued to build, however, echoing some of the experiences reported by Jones,28 the first major revision was initiated in 1993 to 1994. At that time, during a retreat attended by representatives from all sectors of the clinical enterprise and leadership group, the program was streamlined to include 1) reducing the categories of performance from seven to four through consolidation; 2) decreasing the numbers of exemplars (narratives) required for credentialing; 3) streamlining the wording of the standards; and 4) clarifying the credentialing process. The revisions process continued, including streamlining the evaluation tool to reduce evaluation time, better defining of expected performance standards within clinical areas, and revising weights at different levels.

Human Resources Considerations
Issues related to financing clinical ladder systems are described to varying degrees in the literature. Schultz 12 identified the benefits and costs of one of the first clinical ladder programs, noting that, although a lower turnover rate was actualized, the benefits did not outweigh the costs during the 8 years of program operation, and the program was terminated. Although the indirect benefits of professional development in this program were strong, Schultz 12 recommended further research into the fiscal dimensions of ladders. Some programs manage the fiscal requirements by budgeting a certain dollar amount to support the salary increases associated with advancement, 17, 24 whereas others make only general reference to human resources considerations. Another program used the strategy of setting a cap for the numbers of nurses permitted to advance as a way to predict the dollar amounts for advancement. 12 Glenn and Smith 29 report increased satisfaction with a clinical ladder when the performance appraisal was uncoupled from the credentialing, so merit pay increases were not jeopardized by advancing to another level. Worthy 19 described an additional dimension to the fiscal implications of clinical ladders with a financial case study used as part of the credentialing process to document how nurses advancing on the ladder can contribute to institutional fiscal cost savings.

**UXCEL Fiscal Dimensions**

Human resources was considered to be an integral and critical part of the UXCEL program, because the professional framework was intended to be one of the forces to directly change the organizational culture. The UXCEL system was regarded as one of the “levers” to transform a workforce toward increased professionalism and autonomy, to help move the culture from the previous state system focused on rewarding longevity, low salaries, and bureaucratic regulation to a more dynamic entity. These cultural levers have been clearly described by Galpin, 30 who relates the importance of connecting culture to organizational change.

One important early structural decision was to leave uncapped the number of nurses who could potentially advance yearly, so unlimited opportunity would exist for professional nurse advancement. Approximately 15% of nurses have advanced under the UXCEL system. Institutional data outlining numbers of nurses advancing yearly and salary dollars can be reviewed in Table 2. A second component built into the design of the program was for advancement increases to be in addition to and awarded separately from pay-for-performance increases. All institutional performance appraisals are due on a calendar date in October. UXCEL credentialing portfolios are submitted after the performance appraisal to the UXCEL Board. Employees receive a pay-for-performance increase, then an additional promotional increase if approved for advancement by the UXCEL Board.

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<tr>
<td>Program demographics:</td>
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<tr>
<td>UCH UXCEL RNs</td>
<td>561</td>
<td>640</td>
<td>605</td>
<td>701</td>
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<tr>
<td>RNs advancing</td>
<td>22</td>
<td>55</td>
<td>55</td>
<td>28</td>
</tr>
<tr>
<td>Promotional costs</td>
<td>$47,000</td>
<td>$74,000</td>
<td>$52,000</td>
<td>$34,508</td>
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<tr>
<td>UXCEL Satisfaction survey</td>
<td></td>
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<td></td>
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<tr>
<td>RN survey respondents</td>
<td>309</td>
<td>224</td>
<td>261</td>
<td>310</td>
</tr>
<tr>
<td>Response rate</td>
<td>55%</td>
<td>35%</td>
<td>43%</td>
<td>44%</td>
</tr>
<tr>
<td>Score (mean ± SD) (range, 23-115)</td>
<td>50.16 ± 17.45</td>
<td>57.23 ± 19.05</td>
<td>62.12 ± 18.00</td>
<td>63.84 ± 20.60</td>
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Table 2, UXCEL Profile

**Human Resources Issues**
Human resources data indicate it is more rewarding financially for the nurse to credential into a more advanced level. The decision to use the same standards for performance evaluation and credentialing has the advantage of promoting unified evaluation standards using Benner’s 26 professional nursing theoretical framework. However, the activity of credentialing is sometimes linked by employees to satisfaction or dissatisfaction with the actual conduct of the appraisal itself rather than to the advancement process. Another human resources constraint has been the available advancement dollars for promotion. Although University of Colorado Hospital Human Resources department data report it is more rewarding financially for a nurse to credential into a more advanced level, nurses may perceive the rewards to be variable. Although all nurses who advance receive a financial reward, the dollar amount is managed within a matrix framework using years of institutional service, experience as a professional nurse, market forces, and salaries of those nurses occupying similar positions already at that level as determinants of promotional reward. The complexity of this matrix system may be well understood.

One lesson learned over the past 10 years has been the importance of keeping a competitive salary scale, for all nurses as well as to nurture the continued growth of a professional advancement system. When salaries are at a competitive level, morale increases and motivation for sustaining the professional components of the advancement system and the environment are enhanced. In particular, educational benefits are essential to stimulate the continued development and professionalism of the staff.

**Program Evaluation**

Evaluation research has been conducted since 1993 to measure the professional nurse’s perceived satisfaction with the UEXCEL program. Data from these surveys have been used to stimulate program revisions.

**Methodology**

Initial baseline data were collected in 1993 using standard survey research methods. A convenience sample of all registered nurses were invited to voluntarily complete a 23-item, Likert-type instrument, the Clinical Ladder Assessment Tool, developed by Strzelecki.9 The questionnaire addressed nurse perceptions of the effectiveness of the clinical advancement system, and included questions related to how well UEXCEL defines roles and levels, provides opportunities for development, incorporates peer review, and is valued by colleagues, among other dimensions. Minor modifications to the instrument were made to incorporate the name UEXCEL in the questions. Content validity was established using a panel of experts; reliability by Cronbach's alpha is 0.95. Four open-ended questions were added to the instrument to solicit qualitative data, including perceptions of how the system had changed since the last performance appraisal, the process of peer review, representation on the Board, and opportunities to suggest changes.

**Demographic Data**

Baseline data collection in 1993 created a demographic profile of nurse respondents to compare data across time periods. Nurses at University of Colorado Hospital have remained a primarily female (> 90%) respondent group, with the most on rotating shifts (60%), and more than 55% working between 5 and 10 years at the hospital. At baseline in 1993, the sample nurse population was 56% BSN, 25% Associate Degree Nurse, 18% diploma, and 2% Masters of Science in Nursing. Ten years later, this profile has shifted to a higher proportion of more educated nurses with 62% BSN, 15% ADN, 10% diploma, 12% MS, and 1% Nursing Doctorate. The one significant correlation over the long-term data collection time period is that nurses with higher levels of education have held more positive perceptions of the UEXCEL program than nurses with less educational preparation ($r = 2.34, P = 0.02$). This is not a surprising finding given the program's educational requirement for BSN enrollment in order to advance beyond a level II competent nurse.

**Results**
Baseline results reported low levels of satisfaction, stimulating a series of town meetings to gain nurse feedback for revising the program and a retreat to reconstruct program components. Revisions included streamlining the categories from seven to the four, rewriting the standards to incorporate clearer language, and defining levels of practice more specifically. Revisions also included the requirement to meet standards at the next level in order to achieve an exceeds performance rating. Outcome measurement continued after the retreat, as well as over the following 3-year period. Mean score results in Table 2 show a low of 50.16 at baseline, then improvement to 64.00 in 1996 to 1997. In 1996, mean scores were slightly lower, but not at a statistically significant difference. When the 1998 aggregate mean score was tested against all years before 1998, the scores showed significant positive improvement over time: before 1998, 56.31 ± 79.83 (mean ± standard deviation); after 1998, 62.12 ± 17.99, Student's t = 4.6, P = 0.000. Of the 23 quantitative questions, all demonstrated statistically significant positive outcomes over the 5-year period when 1998 results were compared with all other aggregate-year scores by Student's t tests. A sample of the results by question can be reviewed in Figure 3. Specific items of less significant improvement are now part of a targeted revision process. These areas include improving peer review, encouragement to advance, and rewards and incentives to credential.

![Figure 3. UEXCEL mean scores by selected questions (1993-1998).](image-url)
Results were reported by 20 inpatient units over the 5-year period, for a total aggregate subject number of 876 nurses. Survey response rates are reported in Table 2, with other UEXCEL profile data. Ambulatory data, less consistently measured, are not reported. Unit results showed significant variation in nurse satisfaction with UEXCEL over a 5-year period. A sample of the results by units is shown in Figure 4. Analysis by unit shows one of the areas, operating room nurses, consistently recording the lowest satisfaction scores. This clinical area also has the fewest number of baccalaureate-prepared nurses. Scores for this specialty area act to significantly reduce the overall aggregate UXCEL mean score for the population of all nurses at the hospital, and has proved the most challenging group of nurse employees to engage in professional activities.

Figure 4. UEXCEL evaluation data by selected units (1993-1998); survey score range, 23-115.

**UXCEL Satisfaction Compared with Other Institutional Data**
Concurrent with UEXCEL evaluation, the University of Colorado Hospital has conducted measurement of nurse job satisfaction using the Mueller and McCloskey 31 satisfaction scale and nurse autonomy, measured by Schutzenhofer’s 32 nursing activity scale. As shown in Figure 5.33 UEXCEL satisfaction is linked closely to job satisfaction, whereas autonomy results are reported as higher and seem independent of the other two variables. These results will be further analyzed. Our goal is to have all three measures reporting significantly strong nurse satisfaction and role functioning.

![Graph showing RN Autonomy, Patient Satisfaction, RN Job Satisfaction, and UEXCEL Satisfaction over years 1993-1998.](image)

**Figure 5. Summary of trended data (1993-1998).**

**Recent Change Initiatives**

Leadership analyzed most recent UEXCEL evaluation data results and decided it was time for a significant program revision. A new chief nursing officer was on board and it had been 4 years since the last substantive reconstruction. With only 15% of the nursing workforce choosing to advance beyond level II, the program needed to be perceived as a more active force for retention and job satisfaction under the current conditions of nurse shortage, not just a gradually improving system. Among the revisions adopted were the elimination of level V, the advanced master’s prepared nurse. Leadership and staff nurses together decided this level is not easily achieved by the staff nurse at the bedside, and a new and separate institutional credentialing process was established for advance practice nurses.

Another significant revision was designing a percent of the performance appraisal to be flexible weights, used in any category of practice matching the nurse’s interests and talents.

Further changes were designed to specifically address elements of the model that generated perceived dissatisfaction by staff nurses. The requirement to meet standards at the next level to exceed on the annual performance appraisal was eliminated, the titles of categories were streamlined to become *clinical practice, leadership, practice outcomes, and professional profile.* Standards were reviewed, with the wording and intent significantly clarified. These revised standards were circulated at staff meetings and received positive feedback. After lively discussion, the group affirmed the desire to retain the requirement for a BSN or enrollment in a program to apply for advancement beyond level II, reaffirming the institution’s mission as a major teaching hospital and continuous learning environment. Human Resources changes included increasing numbers of educational days awarded for further advancement levels, improving recognition ceremonies and publicity for those nurses advancing, and administrative time awarded to do projects designed to improve patient care outcomes or unit systems functions. Continued evaluation using the satisfaction survey will provide data informing us of the success of these recent changes.
Summary and Conclusions

University of Colorado Hospital has committed to ongoing improvement of its clinical advancement program, with significantly positive evaluation outcomes to date. Staff nurses, charge nurses, and nursing leadership together have actively partnered to construct a more flexible and responsible program. We anticipate our most recent revisions, tagged UEXCEL 2000, will continue to meet the career development needs for our professional nurses in the millennium. Timed collection of evaluation research data has been the key to effectively targeting problem areas for program revision. Formal evaluation data, as well as informal feedback from newly hired nurses in orientation who identify the ladder as a reason for choosing the hospital for employment, have further reinforced our institutional commitment to this program.

Successful clinical advancement programs must balance the professional dimensions and requirements of a clinical ladder with significant human resource rewards to create a model that motivates nurses to advance in their professional development, contribute to improved patient care outcomes, and commit to advancing the profession. Many nurses have not worked within a professional practice model and do not understand the responsibilities inherent in being recognized as professional. The issue of how to fully educate nurses regarding their role, accountability, and professionalism is a challenge in the present environment, wherein is a focus on filling positions rapidly and providing immediate incentives for nurses to take a job rather than to encourage career development. Creating strong clinical advancement programs to provide incentives for nurses to continue professional education and development, may be a critical force for ensuring nursing in the future remains a profession rather than just an occupation to provide technical workers for the job market. Monitoring evaluation data provides important information for driving program revisions and monitoring outcomes. The University of Colorado Hospital’s UEXCEL program hopes to make a difference for patient outcomes, nurse satisfaction, and the profession of nursing in the western region.

Acknowledgments

The authors thank University of Colorado Hospital Chief Operating Officer Joyce Cashman, RN, MS, MHA, for the vision and leadership to initiate UEXCEL 10 years ago, and Dr. George Fryer and Tom Miyoshi for statistical support.

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**IMAGE GALLERY**

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Figure 1

Table 2

Figure 3

Figure 5

Table 1

Figure 2

Figure 4

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