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The Vanderbilt Professional Nursing Practice Program

Part 1: Growing and Supporting Professional Nursing Practice

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Professional practice programs are designed to attract, retain, and reward nurses. This three-part series will describe Vanderbilt's performance-based career advancement system, the Vanderbilt Professional Nursing Practice Program (VPNPP). Part 1 outlines the overall program's foundation, philosophical background, and basic structure. The VPNPP is built upon Benner's work, distinguishing among four levels of practice: novice, competent, proficient, and expert. Work by many in the organization identified the expected behaviors for nurses at each level, which were then used to develop clear process evaluation criteria. Part 2 will examine the performance measurement and evaluation system created to support the program. The process of advancing within the program will be described in part 3.

Facing the challenges of the growing nursing shortage in a rapidly evolving healthcare environment, a group of nursing leaders from a large academic medical center formed a steering committee in the spring of 1997 to revamp the clinical ladder program. The goal was much broader than merely revising an existing program in which nurses had expressed dissatisfaction. We wanted to change the culture of nursing by defining professional nursing practice in a way that supported the growth of nurses in their careers and stimulated a satisfying environment in which to practice. At the core of this desire was the belief that a happier, more effective workforce would ultimately have a positive impact on the quality of care provided. We wanted to create a program that would be dynamic and responsive to changes in the internal and external healthcare environment, as well as promote the success of the individual practitioner and the broader organization.

The work resulted in a four-tiered performance-based career advancement system that recognizes and rewards the professional growth and application of clinical nursing expertise. The program also allows the recognition of "above the standard" performance of each nurse, whether he or she is beginning a career in nursing or functioning at the advanced levels of practice.

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Mission, Vision, and Values

The Vanderbilt Professional Nursing Practice Program (VPNPP) is a *performance-based* career advancement system that promotes, supports, recognizes, and rewards the application of clinical nursing expertise in direct patient care. Professional nursing

at our institution is seen as a process wherein nurses grow in their clinical acumen and their skills as team members. Internal/external practice standards, environmental influences, and organizational culture largely guide their work. The VPNPP is built on the premise that there are clear levels of clinical practice with distinct, observable differences applicable across the clinical enterprise. The clinical enterprise includes all of the diverse practice areas included in an academic medical center, from outpatient to inpatient to procedural areas. Procedural areas are defined as practices having an episodic encounter with patients (emergency department, operative services, radiology).

Nurses are promoted in the program based exclusively on their observed and consistent performance to standards. These standards are broadly defined in job descriptions, and specifically defined through the behavioral criteria of data collection tools used in the performance evaluation system. Formal education, years of experience, and national certification may facilitate performance of higher levels of practice, but it is the *consistent demonstration* of practice that determines eligibility for promotion. Performance is observed over time, from a variety of perspectives. Performance data collected over time provide a more complete representation of consistent clinical practice, and demonstrate the nurse's influence on the team and work culture.

The steering committee wanted to ensure the new program was not viewed as an "add-on" or an optional activity. While nurses maintain a choice regarding whether they want to advance to the highest levels in the program, the process for evaluation of performance is part of the ongoing performance appraisal system for every nurse. The VPNPP supports the organization's performance-based infrastructure, and recognizes nurses that consistently perform at higher levels through promotion and salary commensurate with that practice.

In developing the VPNPP, the steering committee valued the opportunity to create a program that would serve to define professional nursing practice as well as encourage nurses to continue practice at the bedside as they advance in their careers. Rewarding nurses tangibly, and intangibly, for remaining in direct patient care is considered essential. The medical center's ability to attract and retain the "brightest and the best" in the practice of direct patient care is deemed critical as healthcare faces the current nursing shortage. Consistent with the educational mission of Vanderbilt, this program creates a culture that both expects and supports professional growth. Development of a system with clear levels of practice and observable practice differences, the VPNPP provides a clear depiction of what professional growth looks like, as well as a milieu in which opportunities to grow abound.

Environment for Change

During the phases of our redesign efforts, we faced two major forces that were working in parallel to our overall efforts. The first was an internal institutional effort to create a merit-based employee evaluation process to be utilized throughout the medical center. The second was the overall knowledge that we were facing one of the most severe nursing shortages in the history of the American healthcare system. This impending shortage coupled with the increasing age of the general population and the growing need for management of chronic disease conditions suggested that the overall requirement for nursing services would increase. This increased demand for nursing fueled our desire to create a positive work environment in which nurses felt valued and rewarded for their unique contributions to quality patient care.

Internal employee satisfaction data supported the premise that work environment and professional development were key aspects in determining satisfaction for clinical nursing personnel. The body of research about magnet hospitals provides impressive evidence that the organizational attributes that support professional nurses in hospitals are associated with lower Medicare mortality rates, higher levels of patient and nurse satisfaction, lower levels of nurse emotional exhaustion, and fewer nurse-reported needlestick injuries.[1] Nurses working in magnet hospitals reported significantly more job satisfaction than their nonmagnet hospital counterparts. Furthermore, when compared with nonmagnet hospital nurses, the magnet hospital nurses reported that their administrators were more supportive and placed a higher value on nursing, indicating the elevated status of nursing in these organizations.

These findings suggest that the organizational design of the magnet hospital has a positive impact on the job satisfaction of the professional nursing staff, which is essential for attracting and retaining qualified and experienced nurses. In addition, professional satisfaction also has been linked to positive patient outcomes.[2] Given this external supporting data, we were challenged to develop a program that would provide the organization with an effective

strategy for the recruitment and retention of professional nursing personnel who are strongly committed to the core value of the provision of quality patient care.

Internal Forces

We were fortunate to gain synergy from the overall organization's desire to implement a new employee evaluation system. The performance development model became the medical center's philosophy and plan for continuously improving job performance by developing and recognizing staff. It was designed to encompass the following key principles:

- focus on doing the right things all the time;
- link individual performance to medical center goals and strategic initiatives;
- follow an annual cycle for continuous learning, development, and improvement; and
- rely on shared responsibility of the employee and supervisor to achieve expected performance levels.

The system would ultimately allow staff to understand what was expected of them and how they would be evaluated. In addition, staff were able to see how their specific job expectations fit into the overall goals for the medical center. Supervisors found the system supported their ability to manage by providing tools for attracting, orienting, developing, and assessing individuals. Ultimately, the performance development system would provide the foundation for a process that aligned the staff's goals with the departmental goals/initiatives in support of the overall organizational performance. Given the context of the internal work related to performance development, we were able to craft the VPNPP to be consistent with the organization's requirements for performance evaluation.

External Forces

The second major force we continue to face is the nursing shortage. Hospitals, long-term care facilities, rehabilitation facilities, psychiatric facilities, and other healthcare providers are experiencing significant nursing staff shortages. An aging workforce and a decreased enrollment of students entering college-nursing programs reinforce the need to address the nursing shortage with creative strategic initiatives. To successfully develop these initiatives, organizations must first understand the current supply and demand issues surrounding the shortage.

According to data from the Census Current Population Survey,[3] the average age of working RNs increased 4.5 years (from 37.4 to 41.9 years of age) between 1983 and 1998. The percent of working RNs under 30 years of age dropped from 30.3% to 12.1% of the total workforce. The actual number of working RNs under the age of 30 decreased 41%. The primary factor that has led to the aging of the RN workforce appears to be the decline in younger adults choosing nursing as a career during the last 2 decades. Unless this trend is reversed, the RN workforce will continue to age and eventually shrink at a time when the American population trends indicate the strongest nursing workforce demand. Within the next 10 years, the average age of RNs is forecast to be 45.4 years representing a 3.5-year increase over the current age; more than 40% of the RN workforce is expected to be older than 50 years.[3]

By the year 2020, the RN workforce is forecasted to be roughly the same size as it is today, declining nearly 20% below projected RN workforce requirements. The shortage will occur at a time when the first of the 78 million baby boomers begin to retire and healthcare demand increases substantially. This supply and demand issue has significant implications for the population's access to healthcare and engenders growing concern from providers regarding their ability to sustain the quality of care provided.[4]

In addition to the aging workforce issues facing the nursing profession, hospital consolidations and staff restructuring have prompted accusations of disenfranchisement from nurses. Many nurses are opting out of hospital nursing and large numbers are leaving the profession entirely. The American Nurses Association Staffing Survey found that 75% of responding nurses felt that the quality of nursing care at their facility had declined over the past 2 years.[5] Mandatory overtime has become an issue of national importance as short-staffed healthcare facilities work to cover staffing deficits. Many nurses are overwhelmed by heavy workloads and industry cost-cutting strategies that divert them from providing quality patient care.

These national trends provide nursing leadership with a unique opportunity to develop innovative strategies to strategically place nursing in a positive position in the marketplace. Simultaneously, nursing leaders need to work to decrease the nursing shortage through development of creative recruitment and retention strategies for the profession. To this end, we began the process of developing the conceptual framework for the VPNPP, which would define and support professional nursing practice within our organization.

Conceptual Framework

The VPNPP is largely based on three bodies of thought: (1) the Vanderbilt Professional Nursing Practice Model, (2) a revised system for clinical advancement of nurses, and (3) Benner's model for developing clinical excellence.

Vanderbilt Professional Nursing Practice Model

Practice models are characteristic of groups and employed professionals, and serve to translate the values and ideals of a profession into organizational reality.[6] The VPNPP is based on a nursing practice model that evolved between 1993 and 1996 as managed care was introduced to the southeastern United States. With the shift toward managed care, nurses, ever on the frontlines of healthcare, experienced uncertainty and the daily frustration of trying to deliver quality patient care to sicker patients in less time, and often with fewer resources.[7] Added to these pressures were changing systems of healthcare reimbursement, restructuring of the systems within which healthcare providers function, reengineering the way work was completed, and budget cuts. Yet the need for hospital systems, and nursing, to assure optimal quality, cost, and satisfaction outcomes for patients and families continued and continues to grow.

The evolution of managed care in the mid-1990s required new mindsets and behaviors for healthcare organizations to succeed. These mindsets were based on the work of Karen Zander, who described mindset transitions for the 1990s.[8] Zander describes the need for the practice and thinking of nurses in direct patient care to evolve from a task-oriented focus to an outcome-oriented approach. While nursing education, particularly at the baccalaureate level, teaches nurses goal-directed care, short staffing and the pressure of lofty patient workloads often leads nurses to focus on task completion. However, in the new mindset, the goal of focusing on following orders and completing tasks or treatments on a shift needed to yield to focusing on outcomes. Though the goal of delivering quality care remains in the new environment, quality must now be coupled with cost efficiency. Thus, nurses must be able to:

- use limited resources efficiently (versus assuming "more is always better"),
- focus on the entire episode of illness (versus focusing on an individual shift),
- anticipate predictable patterns in the course of illness (based on evidence rather than habit),
- value collaboration (versus focus on what an individual discipline can achieve),
- be systems savvy (knowing how to "work" the system for maximal efficiency).[7]

As staff nurses and nursing leaders across the medical center focused on these new mindsets, six key functions emerged that were believed to be integral to nursing practice and applicable across the clinical enterprise. These key functions applied to nurses functioning in the various settings (inpatient, outpatient, procedural, and operative), within various specialties (surgical/medical, adult/pediatric), and at various levels of care (intensive/general care units). Emphasis was placed on team function as much as clinical practice. The six key functions became known as The Vanderbilt Professional Nursing Practice Model (Figure 1). This model holds that every nurse engaged in direct patient care is responsible for six key functions (located in the interior of Figure 1). Measures of our effectiveness in these key functions could be illustrated by our organization's ability to sustain and improve the quality of patient and family care, promote patient and job satisfaction, and remain cost effective in a highly competitive market.

A System for Clinical Advancement of Nurses

Clinical advancement systems, often identified as clinical ladders, were created in the 1970s to provide a means for the promotion and retention of professional nurses working in the acute care hospital setting. Successes and failures over the past 3 decades have been evident as nurse leaders have struggled to redefine the work of professional nursing in a rapidly changing healthcare environment.[9] The clinical ladder at Vanderbilt was first established in 1976 and underwent a major revision with decentralization to the unit level in the early 1990s. However, poor staff satisfaction ratings on three consecutive internal satisfaction surveys (1990, 1993, 1996) revealed the clinical ladder was viewed as "laborious, insignificant, inapplicable to daily practice, unrealistic, and poorly rewarded." The inapplicability of many clinical ladders, specifically, that clinical ladders had little relevance to the role of the nurse, has been clearly seen in the literature.[10]

The original clinical ladder was focused on nurses on inpatient units with limited opportunity for nurses in the outpatient, procedural or operative service areas to participate. Additionally, managers on the units had sole responsibility and discretion for weighing the information submitted by their

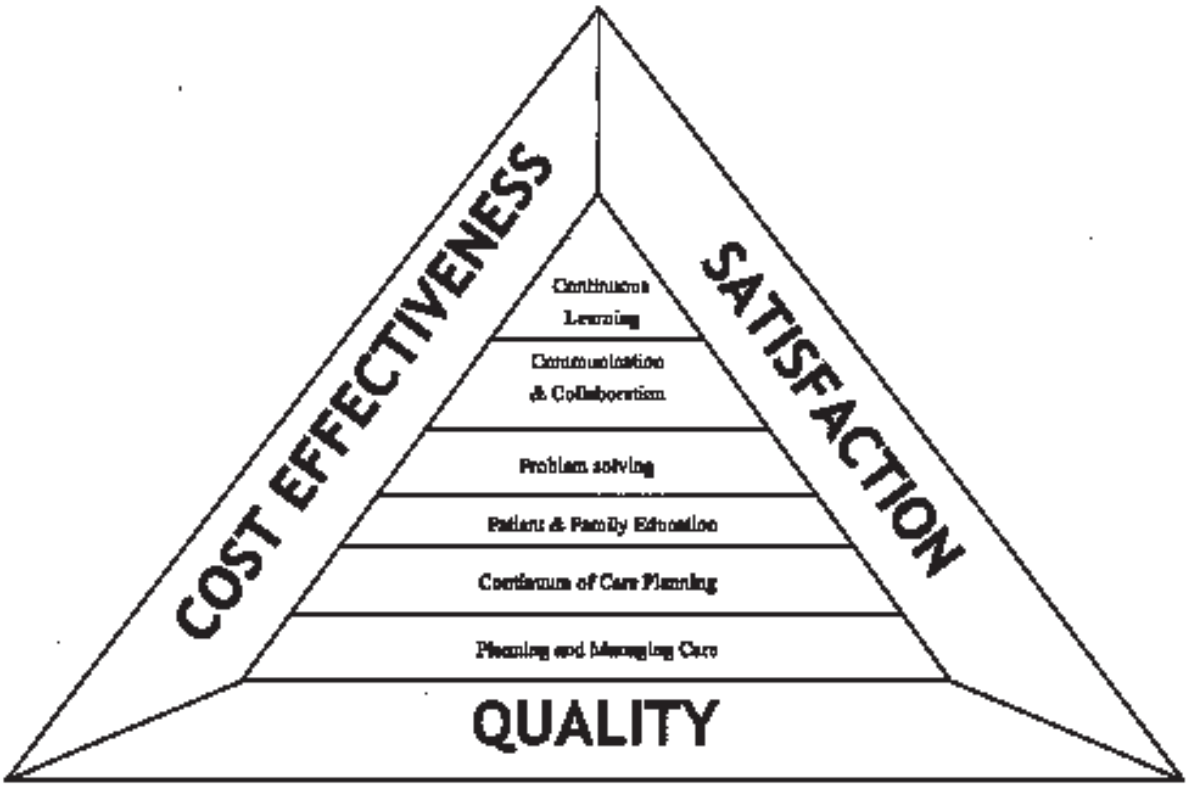

Figure 1. Professional Nursing Practice Model at Vanderbilt University Medical Center.

staff, and determining whether the nurse would advance. This led to variability in application of the advancement process across inpatient units. Advancement was seen as a process that rewarded the applicant's ability to write, or tell, a "tear jerker" story. Once the nurse advanced there was frequently a lack of follow-up to assure the nurse continued to perform at the higher level of practice. This led to a weakening of the program.

The original program was based on a single RN job description that neither addressed the natural evolution of practice or career development nor sought to address long-term changes in nursing practice or the healthcare environment. Thus, inherent in the goal to create a new clinical advancement system was the desire to change the culture of nursing within the organization, rather than merely revise the ladder program. The challenge was to create a framework that would strategically move nurses closer to this vision in the midst of turbulent times. This is supported by the knowledge that creating a healthy work environment requires system-wide structures as well as individual effort. System-wide structures are needed to provide clear expectations for the role/work of the RN, as well as support systems that steer nursing closer toward the vision.[11]

The literature, and our experiences, supported the fact that often career advancement was contingent upon leaving direct patient care for teaching or administrative positions. Our goal was to create a clinical ladder that allowed nurses to develop and advance based on their growth in clinical expertise and experience, and remain in direct patient care. To address this natural evolution of nursing practice, the new professional practice program replaced its single RN job description with four RN job descriptions that addressed this growth. Advancement to the two highest levels of practice was standardized with central committee review to avoid the variability experienced as individual managers applied their own interpretation to the old clinical ladder.

Practice must be measured over time, and not with a single "snapshot." The focus would be on integrated, collaborative practice, and not on nursing alone. Thus, practice must be evident to all members of the healthcare team in which the nurse functioned, and their perceptions must be measurable.

Providing quarterly feedback and incorporating manager, peer, and other healthcare team members became the method to ensure feedback from the team over time. The program itself must ensure the ability to remain competitive and meet standards set by institutional policies and procedures, including JCAHO and other regulatory agencies. Most importantly, we sought to create an environment where nurses felt empowered and satisfied in their work, professional growth, and ability to impact the broader healthcare system in which they functioned.

Based on the Work of Benner

After reviewing several conceptual frameworks, Benner's novice-to-expert framework[12] was selected as the basis of the new clinical advancement program. In her study of the development of clinical expertise in nursing, Benner describes five levels of clinical practice: novice, advanced beginner, competent, proficient, and expert. The pathway from novice to expert is described by Benner in terms of how a nurse perceives, assimilates, interprets, and acts in response to clinical situations. Benner's model provides a framework that defines how clinical excellence develops. Defining or being able to reflect the essence of clinical expertise at the various levels is essential if a program is to succeed in the larger scheme of enhancing professional nursing practice.[13] According to Benner, "Only when ladders of clinical promotion match and reflect increased levels of proficiency will they serve as a basis for real career development."[12]

Additionally, for our organization to continue to prosper the VPNPP had to move closer toward the ongoing goal of quality care. Benner's belief that "recognition, reward, and retention of the experienced nurse in positions of direct clinical practice-along with the documentation and adequate description of their practice-are the first steps in improving the quality of patient care"[14(p407)] resonated within the hearts and minds of early developers of our new clinical ladder.

In considering Benner's five levels of practice, the distinction between novice and advanced beginner was unclear, and therefore difficult to quantify. By combining these two levels into a single entry level of practice the VPNPP defined a total of four distinct levels of practice: novice (RN 1), competent (RN 2), proficient (RN 3), and expert (RN 4). Practice is defined on this continuum, which assumes that nurses will grow professionally as a result of their experience and continuous learning.

Levels of Practice

To develop the program, the professional nursing practice model with its six key functions (Figure 1) was applied to four levels of nursing practice. The expectations for performance were built upon previous practice levels. Key words and phrases were identified to differentiate behaviors or performance expected at each specific level (Figure 2).

RN 1

The novice is generally new to nursing. The nurse practices from a theoretical knowledge base while recognizing and providing for routine patient needs. The RN 1 is beginning to incorporate his/her theoretical knowledge into clinical situations and is able to perform basic skills and carry out a plan of care. The RN 1 can identify abnormal findings, but may seek consultation for solutions. The RN 1 nurse's practice is primarily guided by policies, procedures, and standards. Words/phrases in the job description for the RN 1 include *basic, uncomplicated, seeks appropriate information*, and *may require assistance*. It was anticipated that 15% of the nursing staff would be in this novice category. However, the expectation was advancement to the next level of practice within 1 year.

RN 2

The competent nurse has mastered the technical skills. He/she is aware of patterns of patient responses and can use past experiences to identify solutions for current situations. There is a focus on outcomes. Patients and families are incorporated into the clinical focus. Care is delivered using a systematic approach. A competent nurse is able to make independent decisions guided by experience as well as policies and standards; however, he/she continues to consult other members of the healthcare team when the need for assistance is identified. Key words/phrases that define the RN 2 include *consistent, independent, able to individualize care, and prioritizes care activities.* At this level of practice, the nurse can comfortably care for any patient in the clinical area. The majority of nurses (60%) in the organization are expected to be in this category.

RN 3

Proficient nurses have an in-depth knowledge of nursing practice. The RN 3 relies on previous experience for focused analysis of problems and solutions. Situations are recognized as a whole. He/she can accommodate unplanned events and respond with speed, efficiency, flexibility, and confidence. Pa-

Figure 2. Vanderbilt Professional Practice Continuum.

tients are viewed holistically with an integrated, collaborative approach to care. Standards of practice are used as guidelines with individual patient modification in order to meet outcomes. The RN 3 is beginning to assume a leadership role within the clinical practice area, using expertise to serve as a role model, preceptor, and coach. In the job description, RN 3 is described by words and phrases such as *anticipates, critically analyzes, is a role model,* and *resource person*. Approximately 20% of nurses in the organization will be RN 3 category nurses.

RN 4

The expert nurse functions from an intuitive base. He/she has developed a comprehensive knowledge base. The RN 4 is self-directed, flexible, and innovative in providing patient care. The RN 4 operates from a deep understanding of a total situation to resolve complex issues, and works collaboratively with the other healthcare team providers to support the patient/family in achieving goals. The expert nurse actively and positively influences the team, fosters critical thinking in others, and forms mentoring relationships with other nurses. He/she participates and leads activities that improve systems for quality patient care. Expert nurses serve as change agents to challenge themselves and others. Words used to define the RN 4 nurse include *expertly, initiates, mentors,* and *leads*. Approximately 5% of staff nurses are expected to fulfill the requirements for the RN 4.

The Process of Change

This development of the 4 RN job descriptions and implementation of the program involved change at many levels of the organization. It involved changing both thinking and behavior as related to nursing, and how we function within the broader healthcare system. Internal and external forces necessitated much of this change. Change can be described in a variety of ways; however, *planned change* was used to develop the new model. The definition of planned change is the "intentional, thought-out, deliberate process with equal power distribution among participants."[15] Planned change requires a carefully considered attempt by the group, utilizing skills in astute assessment, communication, collaboration, negotiation, and persuasion. These skills support problem solving, decision making, and critical thinking, which ultimately result in mutual goal setting.

The recognition that a problem existed, or the unfreezing phase, was determined early in the process when feedback from the staff satisfaction surveys was reviewed. External forces, particularly the nursing shortage, also contributed to the unfreezing phase. The next step of the process was the moving to a new level, which required considerable time. During this phase, the group began to generate a solution by gathering information and hearing from as many of the 1500 nurses across the organization as possible. This data-gathering process allowed nursing staff and managers to have input and to provide feedback and evaluation at key intervals throughout the process. Considerable information was gathered during this time, which had to be processed and reaffirmed. The Chief Nursing Officer provided suggestions and recommendations as well throughout the process. As we began to form solutions, the internal force of performance-based evaluation coincided with the development of the four RN job descriptions. Finally, the refreezing phase was reached; the time to incorporate the new process into action had arrived. A major educational effort was launched to help all levels of the organization to understand the roles and responsibilities of each RN level.

A case study was developed to help nurses see the practical difference between the newly developed job descriptions. The scenario begins in operative services with a 42-year-old single mother of two young children recently diagnosed with breast cancer who is being admitted for a modified radical mastectomy. The case study advances to the inpatient setting and finally to the outpatient area. In each setting, we defined how each level of RN (1, 2, 3, and 4) would plan and manage care, provide patient education and discharge planning, problem solve, and communicate/collaborate. This educational tool is designed to help nurses visualize the expectations at each level and across all practice areas of the organization. Figure 3 depicts the inpatient portion of the case study.

Conclusion

In this article we have discussed the comprehensive work collaborated upon by numerous nursing leaders and staff to build a basic understructure for the VPNPP. This work spanned 2.5 years, and resulted in four RN job descriptions, and a beginning vision for how nurses grow in their practice. Parts 2 and 3 in this series will detail the work that occurred over the next 3.5 years and the VPNPP as it functions today.

In reflecting over the first several years of development, perhaps the most difficult aspect of this

INPATIENT

A 42-year-old female, single mother of 2 children, ages 6 and 9 years, has been newly diagnosed with breast cancer. She was admitted for mastectomy and is now a postoperative patient on your unit. She is to receive chemotherapy as an outpatient beginning 6 weeks after surgery. When you enter her room for her morning assessment, you find her crying. When you examine her postoperative site, it is red and inflamed, with questionable serous drainage present. Her temperature is 99.9°F po. This is her second postoperative day, and she is scheduled for discharge this afternoon. Her mother, who is her support person, does not drive. The patient does not have transportation. Her insurance coverage is TennCare (Medicaid).

The following table illustrates how an RN 1, 2, 3, and 4 would assess, manage, and evaluate patient care.

Key:
Block font—RN1 practice
Italics font—RN2 practice
Bold font—RN3 practice
Underlined font—RN4 practice

RN 1 (Novice)	**RN 2** *(Competent)*
1. Identifies that patient is depressed	1a. Identifies patient depression 1b. *Recognizes depression is common after mastectomies and provides emotional support*
2. Asks another nurse to help assess wound and documents inflammation and drainage	2. *Independently* assesses wound and documents inflammation and drainage
3. Notifies physician about wound assessment and elevated temperature	3. Notifies physician about wound assessment, elevated temperature, *and requests an order to obtain a wound culture*
4. Initiated discharge teaching for wound care and discharge medications	4a. *Independently provides* discharge teaching for wound care and discharge medications 4b. *Notifies charge nurse of transportation problems* 4c. *Verifies patient has referral to a medical oncologist before discharge*

RN 3 (Proficient)	**RN 4** (Expert)
1a. Identifies patient depression 1b. *Recognizes depression is common after mastectomies and provides emotional support* 1c. **Initiates consult with Pastoral Services**	1a. Identifies patient depression *1b. Recognizes depression is common after mastectomies and provides emotional support* 1c. **Initiates consult with Pastoral Services**
2. *Independently* assesses wound and documents inflammation and drainage	2. *Independently* assesses wound and documents inflammation and drainage
3. Notifies physician about wound assessment, elevated temperature, *and requests an order to obtain a wound culture.* **In addition, questions physician about impact of questions antibiotic order on planned discharge for that afternoon**	3a. Notifies physician of psychological and physical findings (wound assessment and elevated temperature) *and requests an order to obtain a wound culture.* **In addition, questions physician about impact of antibiotic order on planned discharge for that afternoon.** 3b. Questions MD about need for antidepressants
4a. *Independently provides* discharge teaching for wound care and discharge medications	4a. *Independently provides* discharge teaching for wound care and discharge medications and collaborates with HCT to revise plan of care to keep patient hospitalized for an additional day for IV antibiotics
4b. **Consults social worker directly for transportation needs**	4b. **Consults social worker directly for transportation needs**
4c. *Verifies patient has referral to a medical oncologist before discharge* **and reinforces preliminary teaching about chemotherapy**	4c. Collaborates with case manager and home health for home IV therapy and wound checks
4d. **Verifies patient's ability to return for her follow-up visit**	4d. Telephones patient's mother to update 4e. Assesses other support systems/home situation 4f. Requests social worker to obtain school counselor for children 4g. Initiates referral to local support group for postmastectomy patients 4h. *Verifies patient has referral to a medical oncologist before discharge* **and reinforces preliminary teaching about chemotherapy** 4i. **Verifies patient's ability to return for her follow-up visit**

Figure 3. Case studies illustrating practice differences at Vanderbilt Professional Nursing Practice Program.

foundational work was defining nursing practice at four levels. While nursing leaders and staff conceptually believed nurses grew in how they perceived, assimilated, interpreted, and acted in clinical situations, putting those beliefs into concrete words required tremendous work. It stretched leaders and staff at the medical center to define what practice looked like for the novice, the competent, the proficient, and the expert nurse. The work progressed slowly, with much discussion and rework. However, the work has helped us to define professional nursing practice in the organization. It has given nurses in direct patient care a road map for developing their practice, and concomitantly, for being rewarded for that growth.

The process of creating a program of this magnitude required much thoughtfulness. Wanting more than just an "add-on" program for clinical advancement meant much thought about how this program could be woven into the fabric of the organization. Having the advantage of an evolving performance development system allowed us to craft our clinical advancement program in such a way so that the two programs merged in philosophy and intent. Each actually supported the other. It was critical to realize this program would impact nurses' compensation and advancement within our system; therefore, the human resource issues were complex and required experts in the area of human resources to participate with nursing leaders and staff as they created this program.

Creating a program for 1500 nurses functioning in a wide variety of settings within a quaternary hospital meant devoting assiduous attention to consensus building at all levels of the organization. Involvement across the clinical enterprise, with representation from a variety of practice settings, generated a more comprehensive, and applicable, final product. While we found it did not ensure a lack of "bumps in the road" when we implemented the program, it gave us assurance when we hit those bumps that it was built on what was believed to be fundamentally right principles and thinking. In those bumps, we found that carefully listening to objections and questions of those trying to apply the program, and then addressing them in practical clear ways, became a way of improving the program.

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