Promoting Professional Nursing Practice: Linking a Professional Practice Model to Performance Expectations

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KEYWORDS

• Professional practice model • Clinical advancement system
• Performance expectations • Magnet

Professional practice models (PPMs) provide a conceptual framework for establishing professional nursing practice. According to the American Nurses Credentialing Center's Magnet Recognition Program, a PPM is a schematic description of a system, theory, or phenomenon that depicts how nurses practice, collaborate, communicate, and develop to provide the highest quality of care for those served by the organization.[1,2] Integrating a PPM into the nursing practice arena may require complex organizational change. One strategy for integration is to directly link the PPM with performance expectations, thus ensuring that the underlying principles are supported and evident in everyday practice. This article describes the development, implementation, timeline, and successful outcomes of a clinical advancement system (CAS) that was aligned with a newly adopted PPM.

Rush University Medical Center (RUMC) is a tertiary-care academic medical center located in Chicago, Illinois, with more than 8000 employees. Each component of the four-part mission of the organization—patient care, research, education, and

This work was supported by Center for Clinical Research and Scholarship, Rush University Medical Center, Chicago, Illinois.
The authors have nothing to disclose.
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Nurs Clin N Am 46 (2011) 67–79
doi:10.1016/j.cnur.2010.10.009 **nursing.theclinics.com**
0029-6465/11/$ – see front matter

community service—is driven by a focus on the provision of high-quality health care. The Division of Nursing at Rush has a long history of innovation, professional accountability, and leadership in support of this mission. Innovations, including shared governance, clinical advancement, and a practitioner-teacher model, were initially established in the 1970s and early 1980s. These structures have become embedded in the culture, beliefs, and practice of nursing and were evident when the organization received Magnet designation in 2002 and redesignation in 2006 and 2010.

RUMC nursing leadership spearheaded the development and adoption of a PPM in 2005 to promote continued advancement of professional nursing practice within the system. A comprehensive process was undertaken to develop The Rush Model of Professional Nursing Practice. The model is consistent with the mission, vision, and values of RUMC while integrating key beliefs and practices set forth in nursing's mission and philosophy. **Table 1** illustrates the alignment and integration of the Rush Model within the medical center.

The Rush Model describes the concepts of relationships and caring as the basis for nursing practice at RUMC (**Fig. 1**). This is depicted in the outer circle of the model. Nursing practice exists within the caring, therapeutic relationship between the nurse and the patient/family. The Rush Model identifies key characteristics of the nurse-patient relationship, which include collaboration, intentional presence, cultural sensitivity, compassion, and respect. The model also depicts three intertwining circles that represent the primary domains of skill that the professional nurse integrates to meet the needs of patients and families. These skills include critical thinking, application of evidence-based interventions, and technical expertise. As these three domains develop within each nurse's individual practice, leadership skills begin to emerge. Leadership takes shape in each situation in which the nurse practices and differs in scope by nursing position.

INTEGRATING PROFESSIONAL PRACTICE MODELS

Many organizations are at some phase of the Magnet journey and are, therefore, interested in the development of a PPM for nursing. The Magnet Recognition Program identifies a PPM as an overarching conceptual framework for nurses, nursing care, and interdisciplinary patient care. The alignment of nursing performance expectations with the PPM has been one strategy for adoption. At Strong Memorial Hospital, a PPM was developed to support the mission, vision, and values of the institution and is evident in daily work.[3] This model was used to develop nursing job descriptions and performance evaluation mechanisms. The key concepts of caring services, discovering new knowledge, teaching others, and continuous learning were used as common threads in the development of the model, job descriptions, and evaluation methods. Vanderbilt University Medical Center developed a performance-based career advancement system based on the Vanderbilt Professional Nursing Practice Model and Benner's model for developing clinical excellence.[4,5] The practice model includes six key functions for the nurse—planning and managing care, care planning, education, communication, collaboration, and continuous learning—and has been successfully implemented in a variety of practice settings.[4]

Clarian Health Partners in Indianapolis adopted the American Association of Critical-Care Nurses Synergy Model for Patient Care to guide their process toward Magnet recognition.[6] This model includes three components: nurse competency, patient characteristics, and the organization. The eight competencies for professional nursing practice in the model serve as the infrastructure for the professional advancement process. Titles for professional nurses in this system are associate partner, partner,

Table 1
Linkage between CAS and RUMC's mission, vision, and values

RUMC Mission, Vision, and Values	Division of Nursing Mission and Vision	RUMC Model of Professional Nursing Practice	Accountable Professional Nursing Practice	Patient/Family Outcomes
• Innovation • Collaboration • Accountability • Respect • Excellence	Rush nurses *R*espond to cultural differences *U*se evidence-based practice *S*upport family centered care *H*elp patients move through a continuum of care PNS goals • To promote a high level of professional performance among professional nurses	• Relationships and caring Care is patient/family centered Respect Collaborative practice • Critical thinking Reasoned clinical judgment Applies science • Technical expertise Patient safety Patient education • Application of evidence-based interventions Interventions based on research Standards of care reflect current research • Leadership Accountability Continuous learning	Rush clinical advancement system	• Satisfaction with care • Quality care • Safety Nursing staff • Job satisfaction • Retention • Career Progression • Scholarly activities Organizational outcomes • Foundational values evident in everyday practice of professional nurses

Illustrates the integration of the RUMC model of professional nursing practice within the medical center. Column 1 describes RUMC's core values. Column 2 represents an excerpt from the Division of Nursing mission and vision, along with the shared governance model goals. Column 3 describes the domains of the PPM. Column 4 identifies practice and the CAS as primary outcomes. Columns 1–4 influence significant medical center outcomes, which are listed in column 5.

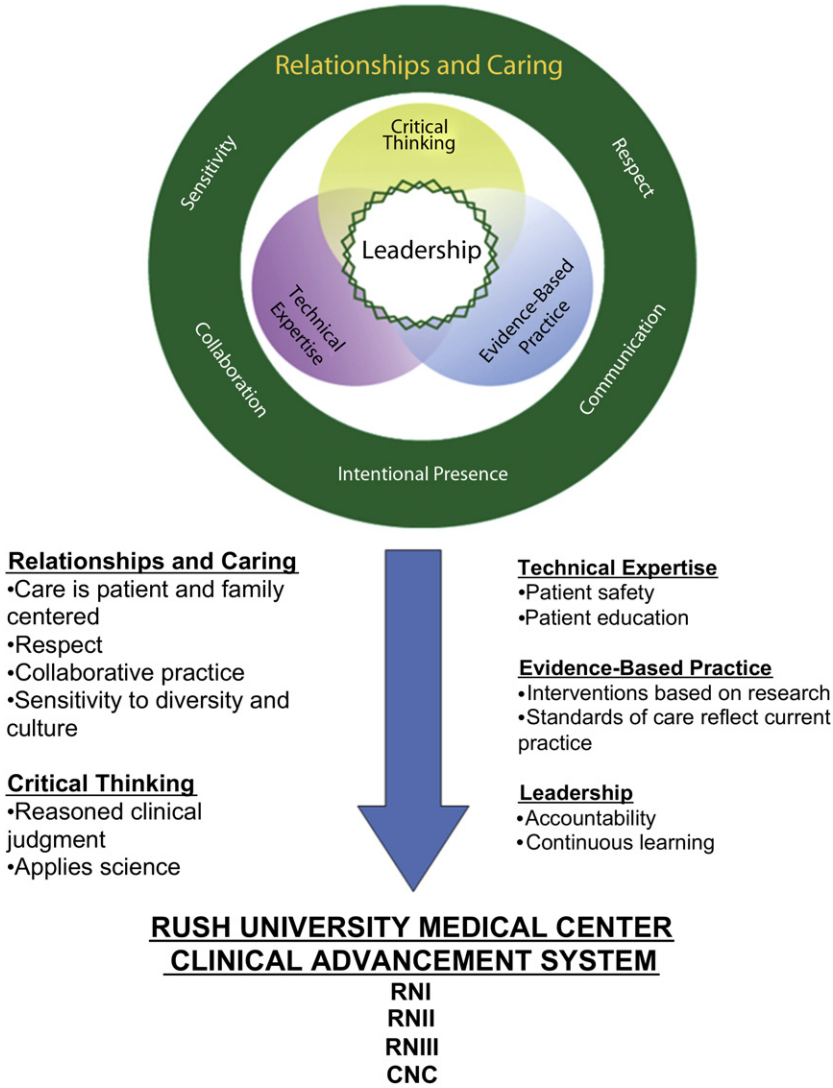

Fig. 1. The Rush Model of Professional Nursing Practice. This figure is a pictorial representation of The Rush Model of Professional Nursing Practice. The primary domains of the model are listed along with key aspects within each domain. The arrow depicts the alignment of the PPM with the clinical advancement system.

and senior partner. Partners must hold specialty certification and senior partners must hold a baccalaureate degree, thus supporting professional advancement. Clarian has used the synergy model to measure outcomes. Vacancy and turnover rates have decreased and nurse, patient, and family satisfaction has improved.[5] In addition, the number of nurses with specialty certification increased from 15% to 40%.

Holy Cross Hospital in Maryland integrated the quality care model into the design of a care delivery system.[7] The registered nurse (RN) job description was revised to reflect the model, including the development of desired behaviors and competencies.

This system identified the importance of leadership development, staff education in the implementation of a PPM, and inclusion of the director of human resources (HR) as a key stakeholder.

PROCESS AND TIME FRAMES AT RUMC

The first step in the integration of The Rush Model of Professional Nursing Practice at RUMC was the redesign of the CAS. Although the CAS was well established and had been in place since the 1970s, it had not been updated for 12 years. This system included three clinical levels and a clinical leadership role, providing career advancement for Rush nurses. Performance expectations were defined for each level as well as within position descriptions. In 2006, however, it was recognized that the previous system did not integrate and support the newly adopted PPM. Two project directors were appointed to lead the project with the goals of (1) aligning performance expectations with the new PPM and (2) updating the clinical advancement. The overall process began the summer of 2006 and culminated in the rollout of the new CAS in September of 2008.

The Kellogg Foundation Logic Model Development Guide[8] was used as the framework for change, including program planning, implementation, and evaluation. This process began with a well-defined problem and basic assumptions. The assumptions were (1) nursing at RUMC has a history of leadership, innovation, and professional accountability; (2) the Illinois Nurse Practice Act, American Nurses Association Social Policy Statement, and American Nurses Association Code of Ethics guide professional nursing practice; (3) a PPM drives role responsibilities as defined by position descriptions; (4) the professional nurse directs care as part of a health care team; unlicensed, assistive personnel are part of the team; (5) seasoned, experienced nurses possess intellectual capital that is valued by the organization; (6) baccalaureate-prepared nurses possess the scientific and theoretic knowledge base to meet the complex needs of patients and families; and (7) national certification demonstrates that an individual has mastered a body of knowledge and acquired skills in a particular specialty. These assumptions served to guide the development of project objectives, activities, and outcome evaluation plan.

The initial phase (summer of 2006) of this process was to obtain input and support for the project from key stakeholders in the organization, including the vice president of nursing, nursing directors and unit directors, executive committee of the professional nursing staff (PNS), vice president of HR, and the Magnet coordinator. The executive committee of PNS is the leadership group of the shared governance model and is composed of staff nurses representing the various specialties in the medical center. A PowerPoint presentation was developed to describe the problem statement, assumptions, goals, activities, timeline, outcomes, and impact to solicit input as well as to gain support from the key stakeholders of this project. This inclusive, collegial process engaged stakeholders in the development of the project plan. These key stakeholders enthusiastically provided support for this project, which was important to secure the necessary resources to accomplish the project goals. It was also important to establish the foundation for the future sustainability of this project.

The next phase (fall of 2006) of the project was to use a focus group format to solicit input from nursing staff regarding their current role responsibilities. This was the initial step of a comprehensive process to develop and validate competencies per level to gain a better understanding of current role responsibilities across all levels of staff. In addition, this approach facilitated the direct involvement of nurses in this major change initiative. Unit leadership invited staff nurses to volunteer to participate in

this process. Twelve focus groups were conducted with 7 to 10 nurses in each group representing the various departments within the Division of Nursing. The groups were homogeneous in terms of level within the current advancement system. More than 100 professional nurses participated in this process. An additional focus group was held, which was composed of unit directors representing the various departments.

The focus groups were planned carefully. Three components define successful focus groups: a well-defined purpose, carefully planned environment, and skilled facilitator.[9] The groups had a clearly defined purpose. Convenient, comfortable conference rooms were identified for the focus groups. Scheduling included consideration of staff working all shifts and weekends.

Open-ended questions were developed to solicit staff nurse perspectives regarding their current practice based on the domains of the Rush PPM. Two facilitators were present during the sessions. One facilitator led the discussion while the second took detailed minutes. The focus groups were taped. Written, informed consent permitting the taping of the session was obtained from each participant. Internal review board approval was secured.

The next phase of activities (January through May of 2007) was to write the first draft of the PNS position descriptions. The comprehensive qualitative data from the focus groups served as an analysis of current nursing responsibilities. A job analysis is a systematic way of gathering information about the content, context, and human requirements of jobs.[10] The minutes and tapes from the focus groups were analyzed. The data were coded and synthesized to identify themes, which were used in the development of the first draft of the redesigned position descriptions.

Benner's model[5] was used as the theoretic framework to define clinical advancement. Several organizations have used this model to guide the development of their CAS successfully.[4,11] A summary profile was written to clearly differentiate practice levels and guide the development of competencies within each specific position description (**Box 1**).

The competencies within the position descriptions were organized based on the domains of the Rush model of professional nursing practice. These domains include critical thinking, evidence-based interventions, technical expertise, leadership, relationships, and caring. Competencies per level were written based on the job analysis data. In addition, key documents were also analyzed and synthesized into the development. These documents included Illinois Nurse Practice Act; PNS bylaws; organization's mission, vision, and values; and national safety goals. This process culminated in the development of three clinical advancement levels and a clinical leadership role. An example of the leadership domain is shown in **Table 2**.

The next phase (May through July of 2007) of project activities focused on validation of the draft position descriptions, which included an expert panel review and pilot study. A review of the nursing literature did not reveal an example of validation of competencies within CASs. Because of the scope of this change, it was considered essential that validation of position descriptions occurred before transitioning more than 1000 staff nurses into the new system.

An expert panel review was used to establish content validity.[12] The expert panel included staff nurses representing the five departments, unit directors, and departmental director. The group achieved consensus on the appropriate level for each specific competency. Each competency was examined for clarity and relevance for current practice. Minor revisions were made in the first draft of the position descriptions based on the input from this expert panel.

A pilot study was conducted in June of 2007 on five units representing the various departments in the Division of Nursing. The purpose was to determine content validity

Box 1
Clinical advancement system levels

RN1

The novice is a beginning level nurse. Uses scientific and theoretic knowledge base along with policy and procedures, standards of care, and protocols to guide practice. Relies on the experience judgment and support of others while developing knowledge in practice. Words/phrases characteristic of this level: beginning, seeks appropriate information, with guidance.

RN2

The competent nurse has mastered the technical skills. Is aware of patterns of patient responses and can use past experiences to identify solutions for current situations. Continues to consult other members of the health care team when the need for assistance is identified. Word/phrases characteristic of this level: consistent, prioritize care activities, able to individualize care.

RN3

Proficient nurses have an in-depth knowledge of patient management. Can accommodate unplanned events and can respond with efficiency, flexibility, and confidence. Immediately sees the whole situation while being able to discriminate what is most relevant. Has developed advanced communication and collaboration skills along with system savvy. Assumes a leadership role in the clinical practice area, using clinical experience to serve as a role model and coach. Words/phrases characteristic of this level: advanced, role model, resource, critically analyzes, anticipates.

Clinical nurse coordinator (CNC)

Experienced nurse with the responsibility and accountability for nursing practice as delegated by unit director. Provides leadership for nursing staff in collaboration with unit director.

and to determine whether or not the position descriptions accurately reflected practice at each level. Two staff nurses were randomly selected from each level to participate with a total of 38 nurses participating in the pilot study. Each nurse completed a log at the end of each shift for 2 weeks, which included competencies from the draft position descriptions. Staff were asked to check the competencies that they performed during each shift. They were also asked to respond to two open-ended questions: (1) Which of the above competencies that you did not perform today would you consider important if you had the opportunity? (2) What did you do today that was not captured in the above competencies?

Overall, 80% of the competencies for the RN1 position were validated, 85% of the competencies were validated for the RN2 position, 75% for the RN3 position, and 64% for the CNC position were validated. A detailed analysis of the data influenced some revisions in the position descriptions. For example, the nurses who completed the log sheets in the CNC level identified that direct patient management was not adequately represented in the log. Therefore, revisions were made in the position description. Two competencies were added that reflect the direct management of patients.

Unit directors on these units also participated in this pilot study. The unit director completed an evaluation of a randomly selected staff nurse from each level. The evaluation tool was comprised of the competencies within the draft position descriptions. In addition, the managers were to respond to several open-ended questions. The overall proportion of statements validated for the RN1 position was 75%, RN2 position was 80%, RN3 position was 75%, and CNC position was 95%. Overall, the unit directors commented that the draft position descriptions differentiated practice accurately at each level and that the competencies were clear and measurable. No revisions were

Table 2
Leadership domain

RN 1	RN 2	RN 3	CNC
Supports unit goals and change initiatives	Demonstrates the ability to effectively precept staff and students on the unit	Serves as a role model whose beliefs, attitudes, and actions support unit leadership and unit goals	Assumes the accountability of administrative functions of the unit as delegated by the unit director
Demonstrates beginning delegation skills to meet the needs of patients	Demonstrates beginning leadership skills related to patient care	Demonstrates proficient leadership skills at the unit level	Functions as a mentor to staff on the unit
Demonstrates accountability for own professional practice, including progress toward achievement of annual goals	Delegates effectively and consistently to optimize patient outcomes	Demonstrates accountability for own professional practice, including progress toward achievement of annual goals	Assumes a leadership role in analytical problem solving of both clinical and system wide issues
	Demonstrates accountability for own professional practice, including progress toward achievement of annual goals		Demonstrates accountability for own professional practice, including progress toward achievement of annual goals

made in the position descriptions based on the analysis of the data from the unit directors. This pilot study along with the expert panel review culminated in a CAS with validated and feasible performance expectations.

During August and September of 2007, the project was presented again to key stakeholders to communicate project results, solicit input, and gain support. The response from the various groups to the presentation was positive and, ultimately, the new CAS was formally approved by Nursing Operations Council in October of 2007.

IMPLEMENTATION

An implementation task force was established in January of 2008. The goals of this group were to design and implement a strategy and process to transition all professional nurses into the new CAS. The transition of more than 1000 nurses was a substantial undertaking mandating a comprehensive, well-designed plan. The task force developed a timeline for their work. Employee evaluations based on the established position descriptions were conducted in July and August in anticipation of the transition to the new CAS in September of 2008. This timeline served as a useful tool to track the progress of the group work.

At the initial meeting, the task force members reviewed the performance expectations across the levels in the new CAS. The expectations were intentionally written in a general, rather than detailed, manner. This is consistent with typical position description format developed by HR.[10] Position descriptions written in this format allow for applicability across specialties and areas of practice.

The ultimate goal of the new CAS was to redefine practice at all levels of staff so that it would consistently reflect the PPM. Therefore, the task force thought that it was essential that staff and managers have "a clear picture of practice" at each level to gain an understanding of the new performance expectations. It was decided that it would be useful for staff and managers to have specific behavioral activities reflecting each expectation. The group decided that focus groups of nursing staff would be an effective way to develop these specific behaviors.[4]

At RUMC, the project directors conducted four focus groups. The groups represented each level in the current system and the various specialties across the medical center. The primary question posed to each group was, How would you demonstrate that you were meeting the performance expectations within this newly developed position description? The staff within each focus group developed a list of relevant, realistic behaviors that would serve to highlight the change in practice competencies at each level. This document later served as a key educational tool for all nursing staff and managers across the medical center. **Box 2** provides an example of these activities in the leadership domain for the RN2 position.

The next major task was to develop a toolkit for each unit to aid in implementation. The contents of the toolkit included a letter from the vice president of nursing, the Rush PPM, the new CAS position descriptions, examples of specific behavioral activities to meet the competencies within each position description, a case study illustrating the nursing care interventions at each level, frequently asked questions, specific transition guidelines, and information regarding certification. Therefore, this comprehensive

Box 2
Sample behavior activities for RN2 leadership domain

Demonstrates the ability to effectively precept staff and students on the unit

- Monitors progress of new staff in meeting orientation goals along with unit leadership
- Collaborates with nursing instructors regarding student performance

Demonstrates beginning leadership skills related to patient care

- Functions as an effective charge nurse
- Participates in the staffing process of the department on a regular basis, including matching the competency of the nurse with the needs of patients
- Demonstrates accountability to ensure quality patient outcomes (monitors self and others)
- Use system resources in problem solving patient care situations
- Communicates issues to management that require additional follow-up

Delegates effectively and consistently to optimize patient outcomes

- Delegating patient assignments as charge nurse
- Demonstrates consistent and effective delegation to patient care technicians and other unit personnel

Demonstrates accountability for own professional practice, including progress toward achievement of annual goals

- Responsible for self-evaluation, maintains portfolio
- Takes advantage of learning opportunities throughout the medical center
- Presents in-services on unit
- Identifies professional goals

resource included information that addressed the commonly asked questions as well as implications regarding the transition to the new system as it was introduced on the unit level.

The educational and marketing plan included face-to-face sessions along with the toolkit and posters for each unit depicting the alignment of the new CAS with the PPM. Thirteen information sessions held on all shifts and weekends were conducted for staff nurses across the medical center. A goal of these sessions was to share the background, development, transitions guidelines, and expected outcomes of the new CAS. The focus of the questions from the staff revolved around the qualifications designated for each position. One concern that consistently arose was the lack of reimbursement by the medical center for part-time staff to pursue programs, such as certification review courses. A representative from HR was present at each session, who helped respond to questions and noted the theme regarding lack of financial support for part-time staff. Nursing leadership developed a proposal requesting a change in the corporation's reimbursement policies for part-time benefited employees. This proposal was submitted and, ultimately, HR was able to secure funds in their budget to support part-time staff's pursuit of educational offerings and certification.

Similar educational sessions were held for all unit managers. This group was the key stakeholder group to reinforce the new performance expectations throughout the year. Also, this group would be conducting the performance evaluations based on the new position descriptions so it was important to ensure consistency.

COLLABORATION WITH HUMAN RESOURCES

A subgroup of the implementation task force met with key representatives from HR. The nursing director was a key member of this group because of her in-depth, comprehensive knowledge of medical center operations. Three HR representatives were part of this group, including the director of HR. This type of initiative mandates effective collaboration with HR.[7] The initial meeting with HR focused on establishing guiding principles for this planning process. These principles included the following: the transition process to the new position descriptions will be conducted consistent with the Rush values, the salary structure remains the same, the number of clinical levels remains the same, and evaluations in summer of 2008 will be conducted according to current policy and the current position descriptions. This collaborative effort focused on developing specific transition guidelines. These guidelines addressed all levels and categories of staff across the medical center.

Additional work included formatting the new position descriptions into the standard HR format and the determination of qualifications per level. The new CAS differentiated practice at each level by advancing performance expectations. These expectations were achievable based on the development of an individual nurse's knowledge and skills within the domains of practice: relationships and caring, critical thinking evidenced-based interventions, technical expertise, and leadership. This new system posed the opportunity to establish qualifications necessary for consideration of promotion to the next level. The nursing director member of the implementation task force led discussions within the nursing leadership group regarding this. The initial project assumptions guided this process. Also, the strategic plan, which included a goal to increase the percentage of baccalaureate-prepared nurses, influenced this decision making. The vision and goals were considered along with practical recruitment issues in certain areas. The outcome of these discussions culminated in the qualifications depicted in **Box 3**.

Box 3
Qualifications for position descriptions

RN1

1. Baccalaureate degree in nursing or other major
2. Associate degree prepared nurse enrolled in a bachelor of science in nursing program, baccalaureate program, or master's in nursing program

RN2

1. Consistent proficient performance at RN1 position or equivalent experience
2. Baccalaureate degree in nursing or other major

RN3

1. Consistent proficient performance at RN2 position or equivalent experience
2. Baccalaureate degree in nursing or other major
3. National certification

CNC

1. Consistent proficient performance at the RN3 level or equivalent experience
2. Demonstrated progressive, proficient management and leadership skills
3. Baccalaureate degree in nursing or other major
4. National certification

OUTCOMES

A comprehensive outcome evaluation plan was developed in the following domains: turnover, professional practice, and satisfaction, with turnover identified as the key outcome of this project. The rollout of this new system represented a transformational change in roles and expectations for professional nurses. Moreover, the new qualifications had an impact on many practicing nurses who would be required to obtain a baccalaureate degree and/or certification. Therefore, the impact of the new CAS on turnover was important to evaluate. The overall turnover before implementation was 14.25%. One year after implementation, the turnover was 9.3%. Although many factors influenced this drop in turnover, including the economy, this outcome indicated a successful transition to the new CAS.

The outcomes related to professional practice included the percentage of staff with baccalaureate degrees and certifications. It was expected that the new qualifications would influence an increase in both categories. The percentage of nurses with baccalaureate degrees increased from 80% in 2008 to 83% in 2009, 1 year post implementation. The expectation is that this percentage will continue to increase. There was a substantial increase in the percentage of staff nurses with certifications. The number of newly certified nurses has nearly doubled, increasing from 55 new certifications in 2008 to 108 new certifications in 2009.

A survey was developed to determine both staff nurse and manager satisfaction with the newly adopted CAS. Content validity was established by a panel of three experts, including nursing leadership and a qualitative researcher.[12] Institutional review board approval was obtained before distribution of the survey. Sixty-eight surveys were sent via email to all unit directors and CNCs. Fifty surveys (74% response rate) were realized. Approximately 35% of staff nurses within each level

Table 3
Satisfaction survey results percentage of respondents who agree or strongly agree to this shaded area

Survey Question	Staff (n = 64)	Managers (n = 50)
The position descriptions reflect the PPM of the Division of Nursing at RUMC	95%	96%
The position descriptions reflect the values of RUMC	95%	96%
The position descriptions provide a mechanism for career advancement for nurses at RUMC	84%	92%
The position descriptions clearly differentiate practice at each level	84%	90%
The competencies within each position description are clearly worded	78%	86%
The competencies within each position description are attainable	87%	94%
The position descriptions capture all competencies necessary for practice within my/each level	85%	82%
I am satisfied with the new clinical advancement system	79%	85%
I know what is expected of me to advance to the next level (staff only)	80%	—
I am able to effectively evaluate my staff with the new position descriptions (managers only)	—	83%

were selected to receive the survey. A total of 350 surveys were sent to staff nurses. Sixty-four staff nurse surveys were returned (18% response rate), which is an 18% response. Several factors may have influenced this low response, including several new hospital initiatives, concurrent surveys, and annual employee evaluation time in the medical center.

The results of the staff and manager surveys are displayed in **Table 3**. Overall, the results are positive, with at least 78% of respondents agreeing and strongly agreeing on all survey items. Also, both staff nurses and managers are satisfied with the new CAS. The low staff response rate presents a limitation to this survey analysis.

SUMMARY

The process of aligning a PPM with performance expectations demanded a commitment of time and effort on the part of leadership and staff nurses. The transition at RUMC represents a transformational change because role responsibilities were redefined for more than 1000 nurses. There were several strategies that promoted the success of this project. First, a prerequisite to this initiative was a clearly articulated leadership vision. Additionally, a mature shared governance model promoted a commitment to continued advancement as well as innovation. Stakeholder support and involvement throughout the process promoted effective integration into medical center operations. Furthermore, 160 professional nurses and managers were directly involved in this process at some level. This grass roots approach facilitated successful implementation and transition of the CAS at RUMC and support the Magnet culture of excellence.

ACKNOWLEDGMENTS

Ruth Kleinpell, PhD, RN, FAAN, for editorial assistance and support. Rose Suhayda, PhD, RN, for assistance with survey development and data analysis.

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