Clinical ladders ramp up staff’s enthusiasm and participation

The staff are volunteering for committees, seeking out education, and stepping up to mentor new staff. They willingly sign up to give in-services and join in performance improvement committees. When they have time, they ask if there are patient charts that need auditing.

What made the difference? Managers attribute the enthusiasm to their clinical ladders for RNs and surgical technologists (STs).

“The staff tend to be much more involved, volunteer more, and take responsibility for things,” says Karen Dumond, RN, MSN, CNOR, nursing director of the Bramhall Campus OR at Maine Medical Center (MMC) in Portland, Maine.

A community hospital system in central California also finds participation is up among RNs in its clinical ladder program.

“The staff will say, ‘Sure, I’ll float to that unit. I can get clinical ladder points for that,’” says Marilyn Harris, RN, MSN, CNOR, director of surgical services for Hanford Community Medical Center and Central Valley General Hospital in Hanford, Calif. “You hope it also is because they want to help their fellow nurses, but it adds an extra incentive.”

Though the hospitals don’t have data linking the ladders to improved recruitment and retention, both ORs are fully staffed.

Something to reach for

MMC, a teaching center with 21 ORs on the main campus, a 5-OR surgery center, and a surgical volume of about 18,000 cases a year, introduced its ST ladder about 2 years ago, in addition to its RN ladder. The staff is 50% RNs and 50% STs.

“We are equally in need of recruitment and retention for techs as for RNs,” says Dumond. “We wanted to give them something to reach for if they don’t want to go back to school.” All STs must be certified within 3 months of employment.

The ST ladder has 3 rungs:

• **CST I:** Entry level. Performs scrub role on core cases for assigned services.

• **CST II:** Automatic advancement after 2 years as a CST I with a 2% increase in pay. Performs core and specialty procedures in assigned services.

• **CST III:** 5 years of experience plus approval of application with a 4% increase in pay. CST IIIIs are expected to work at least 32 hours a week and function independently and proficiently in the scrub role in complex cases in their assigned area and maintain competency in other specialties. CST III candidates must document 20 hours of continuing education a year, including some classes outside the hospital.

“We also look for them to give in-services themselves,” adds Dumond. “We ask them to teach the difficult learner, such as the person who is having a hard time with orientation.” CST III applicants also must document participation in a department quality or improvement committee or community involvement, such as visiting schools to talk about careers in the OR.

Submitting a portfolio

The clinical ladder pay increases are in effect as long as STs stay at their level.

“In their yearly evaluation, if at Level III, they have to continue to meet the criteria for a Level III, or they drop back a level—you have to live up to that level on a yearly basis,” Dumond notes.

To advance from CST II to CST III, STs submit a portfolio, similar to what the nurses compile for their ladder. In the portfolio are letters of recommendation, proof of educational credits, a letter from the candidate addressing how he or she has fulfilled the requirements, and an interview with the review committee.
The review committee is made up entirely of STs. Dumond has been impressed with their leadership and impartiality. “They make decisions about people they work with every day, and they really do hold people to the line,” she says.

It took some time for the committee to learn to make decisions based on the documentation presented to them, such as peer reviews and recommendations from managers, rather than adding their own impressions about applicants or their performance.

In organizing the committee, Dumond asked for volunteers. It was key that the STs who volunteered had the respect of the staff and could drive the process.

A role for lead techs

Lead techs are an additional advancement opportunity for STs but are not part of the ladder. Lead techs assist with technical management of a cluster and earn 2% more than a CST III.

“Lead techs are viewed as leaders, even by the nurses. They are a great resource and are willing to share their information,” Dumond says.

Among their functions are to know the competencies of other STs in their cluster and give assignment advice to RN leaders, give input on STs’ performance evaluations, order instruments and equipment, send equipment out for repair, communicate with surgeons about instrument and supply needs, and help to arrange in-services. In the cardiac service in particular, the lead tech “has provided a huge role in keeping the team together,” Dumond says.

Tips for success

She finds the clinical ladder process has elevated the STs’ involvement and initiative.

“They have been more willing to address issues with each other rather than going to management. They are looking for ways to improve the system, and they are more interested in taking advantage of educational opportunities.”

Dumond’s tips for being successful with ST ladders:

• Be clear if seniority is not a qualification for advancement. “Even though we were clear, we had excellent techs apply because they had 20 years or more of experience but didn’t necessarily meet all of the criteria,” she notes.

• If applicants are turned down, be clear about how soon the person can reapply and exactly which criteria must be addressed.

“We learned we needed to be really clear about the expectations, how they could succeed, and when they could reapply,” she says.

Fine tuning an RN ladder

Hanford and Central Valley have worked to refine their nursing clinical ladder for 4 or 5 years. The system, with 2 small hospitals and an ambulatory surgery center, is in a rural community south of Fresno.

Simple at first, the ladder has “evolved into something that is a lot more meaningful,” says Harris. One of the changes was to award bonuses for ladder advances instead of increases in hourly pay. That avoids the problem of having to take back pay if a nurse decides to drop back a level.

The ladder, with 4 steps for RNs and 3 steps for LVNs, is based on a point system that is clearly spelled out in a packet nurses receive. The packet has ladder policies and procedures as well as worksheets for recording achievements in each category of the ladder’s professional development process:

• development of self
• development of others
• commitment to patient care needs
• improvement of patient care
• improvement of unit or organization
• advancement of nursing/performance improvement.

“The ones who are the most successful fill out the worksheets as they complete
the activities. We thought it was important to make it user friendly because nurses are so busy,” Harris says.

New employees can apply for the ladder immediately if they work at least 40 hours per pay period and have at least 2 years’ experience as a nurse. Experienced nurses are hired as an RN II, while new graduates are hired as an RN I.

Nurses can apply for advancement by the first of every quarter, submitting 12 months of documentation. Applications are reviewed by the system’s clinical ladder committee, chaired by Harris.

Nurses often go above and beyond the requirements. An RN IV requires 150 points, but some applicants have 180 points.

The bonus for advancing is $1,000 per step. Thus, a nurse who moves from Level II to III receives $1,000. A nurse can earn an additional $1,000 for moving on to Level IV in the same year. Levels must be renewed each year, and nurses receive bonuses for renewing. For example, an RN IV who wants to stay at that level must accumulate enough points to renew at Level IV for the next year. If she renews both Level III and IV, she receives a $2,000 bonus. But if the nurse decides to renew only at Level III, she receives a $1,000 bonus. The amount of the bonus is tied to the hospital’s financial status.

“We have found that a lot of nurses are doing the work already. All they are doing is documenting it and presenting it to the ladder committee,” Harris says. “It’s a nice way for them to capture it and showcase it.

“It’s so heartwarming to see the development,” she adds. “We have nurses signing up to give in-services for CEUs. They also are doing the staff schedule. If they have time, they ask me if there are charts that need auditing.” They are taking the initiative to “close the loop” on performance improvement activities.

**Fully staffed ORs**

MMC and Hanford/Central Valley have no vacancies in the ORs.

“We are fully staffed, and we have been for about 3 years—we have not had a traveler in 3 years,” says Dumond. It helps that Portland has an ST educational program, and the hospital has an internship program for OR RNs. The OR’s turnover rate is about 3%, and the whole hospital’s turnover rate is under the national average.

MMC’s administration strongly supports clinical ladders and other education efforts. Says Dumond, “Education is a priority here. It’s not easy to get people free, but we will struggle for education.”

Hanford/Central Valley also have no OR vacancies and have not used a traveler since 1994.

“We have been blessed. Our folks are tenured, and we have hired new grads, who have worked out beautifully,” Harris says. As a rural community, Hanford tends to have a staff that stays in the area. And with 3 facilities, she has the flexibility to move staff around if necessary to cover peak times.