Hospital Authority

Career Progression Model for Nurses

Purpose

This paper aims to provide an update of the implementation of the career progression model for nurses and the results of an evaluation study of the Nurse Consultant (NC) pilot.

Background

2. To help retain nurses, guide and improve nursing staff’s competency and career development, the Human Resources Committee (HRC) and subsequently the Hospital Authority (HA) Board have supported a new three-tier career profession model for nurses and associated strategies for introduction in June 2008 (HRC 312, 315 and AOM 534 and 540). This provides nurses with a clinical career ladder in addition to the existing nursing management pathway. The three tier progression structure endorsed for implementation is as follows:

- Tier 3: Nurse Consultant (NC)/Department Operations Manager (DOM)
- Tier 2: Advanced Practice Nurse (APN)/Ward or Unit Manager (WM/UM)
- Tier 1: Registered Nurse (RN)

3. The key elements of this new structure included the introduction of a clinical career path whereby a registered nurse can progress from APN to NC in a clinical field. A pilot implementation of the new NC post has begun in early 2009 with the appointment of 7 NCs in 5 clinical specialties including Community Psychiatric, Continence, Diabetic, Renal and Wound & Stoma Care. The Nethersole School of Nursing of the Chinese University of Hong Kong was the successful tenderer to conduct and evaluation study of the pilot. The findings of the study will be reported in this paper.
4. In addition to the creation of the NC post, a set of strategies to support the implementation of the career progression model for nurses and help improve the retention of nurses was developed and implemented in 2008. These additional strategies and current status are at the Annex.

**Progress on the implementation of the Nurses’ Career Progression Model**

**Tier 3 : Nurse Consultant (NC) / Department Operations Manager (DOM)**

5. The new position to provide a clinical career progression for nurses is the NC posts. An evaluation study of NC employed a multiple case study design, using both qualitative and quantitative methodologies. It was conducted after the NCs were in post between 3 to 6 months in 2009. A total sample of 7 NCs and a purposive sample of nurses, doctors and patients were interviewed. The study also included a convenient sample of patients who have received care from NCs and nursing colleagues who worked closely with the NCs to provide feedback on the NCs’ role. Patient documentations were also reviewed for service and patient outcomes.

**Summary of key findings of the NC study**

6. Key findings of the evaluation study are as follows:

(a) NCs spend most of their time (87%) as expert practitioner (47.7%) and service developer/planner (35%) and their other roles included educator (8.7%); quality assurer (5%) and researcher (3.6%).

(b) NCs work within a wider intra- and inter-disciplinary context as well as intra- and inter-cluster service sectors through working with various partners at different levels such as policy making bodies; the multi-disciplinary health and social care team; patients/ families/ communities and educational institutes.

(c) NCs followed a dual reporting system with 2 reporting lines:

(i) The clinical specialty line, reporting to clinical operations leader such as Chiefs of Service or Service Consultants; and

(ii) The professional line, reporting to Cluster General Managers (Nursing).

(d) NCs have made major contributions as identified by triangulation of the qualitative and quantitative data in the study:

(i) Achieve significant reductions in hospital admission (p<.001), A&E visit (p<.001) and length of hospital stay (p<.001) for patients who were under NC care as compared to those who were not.
(ii) Achieve significant improvements in specialty-specific indicators (such as improved urea level, improved HbA1c level, and decreased number of dressing changes in the respective renal, wound/ stoma specialty) \( (p<.05) \) for patients who were under NC care as compared to those who were not.

(iii) Facilitate patients’ earlier and timely access to specialty care.

(iv) Innovate practices to improve/reform existing procedures/ care processes.

(v) Strengthen cross-specialty collaboration to improve service delivery.

(vi) Secure continuous quality improvement and care standardization.

(vii) Enhance patient satisfaction and empowerment.

(e) The qualitative and quantitative data indicated that the focus of the NC’s work was on improvement in service outcomes while that of the other nursing staff, including APNs, was on individual and direct patient outcomes.

(f) The analysis of the qualitative and quantitative data collected from the interviews and the Advanced Nursing Practice questionnaires have provided information to suggest standards for credentialing of educational programs which aim to prepare NCs.

7. This evaluative study has identified the many positive contributions of the NCs to both service and patient outcomes. It has also recognized the discrete roles and the difference in the level of practice with APNs. The researchers concluded that the HA can capitalize on the effectiveness of the new NC role and develop an appropriate approach to establishing a new clinical nursing career structure that reflects discrete roles, level of practice and autonomy.

Way forward for the creation of NC post

8. The 7 NCs in 5 clinical specialties have demonstrated that they have made significant contributions to patient care in their respective clinical areas in a relatively short time period. Following the evaluation report, the HA has planned the following steps to move forward on this important post in the clinical nursing career:

(a) The NC post would be formally established with the 5 proven clinical areas, namely Community Psychiatric; Continence; Diabetic; Renal and Wound & Stoma Care, implementation of which would be based on the needs of individual clusters.
(b) Clinical areas other than the 5 mentioned in (a) above would be assessed in the context of the annual planning exercise of 2011/12, through cautious, controlled and evaluated process; and

(c) The process would be centrally coordinated with guidelines established by HA Head Office (HAHO).

9. In order to provide training support, a training package including leadership, people management, presentation skills etc. has been developed for the training and development of NCs. The HAHO will continue to coordinate, set guideline and monitor the implementation of this new post.

Tier 2: Advanced Practice Nurse (APN) / Ward or Unit Manager (WM/UM)

10. Besides piloting the new NC post, the HA has also taken action to support the implementation of the other tiers of the career progression model for nurses. Changes have already been implemented for the provision of post-registration certificate courses (PRCC) for nurses to increase specialty training opportunities for nurses. A partially decentralized approach with the clusters and a collaborative model with tertiary education institution have been adopted. The number of programs has increased from 14 in 2008/09 to 17 in 2009/10 for 610 and 812 participants respectively. The current level of nurses with specialty training varies across specialties with an overall average of about 57%. It is planned to work towards at least 50% specialty trained nurses on average in major specialties, and for some highly specialized areas such as Intensive Care, Renal Care or Obstetrics, the percentage of training is expected to approach 100%. It is planned to continue the expansion of the PRCC programs to meet service and its training needs.

11. It is also recognized that there is a need to develop more clinical leaders with up-to-date knowledge on clinical practice development and innovation to improve the quality of patient care. A program of supporting clinical nurse leaders has been introduced with 44 APNs from 5 specialties attended overseas training and development programs in 2009/10. This will in term support the future development of future NCs.

Tier 1: Registered Nurse (RN)

12. In order to prepare nurses for the career progression model, the hospitals have continued to offer preceptorship program for newly graduated nurses and there are currently about 1,200 nurses on the 2-year preceptorship program. As these nurses move along their career path, they can undertake the specially designed online core specialty modules (with 9 programs) in preparation for specialty training. It is observed that these have been keenly taken up by nurses as the number of module completion has jumped from 3,162 in 2008/09 to 28,687 in 2009/10. This was also partly due to the introduction of a four-part module on pharmacology for nurses in 2009/10.
13. In the career progression model for nurses, nurses at Tier 1 will need to have clinical experience and specialty qualification in preparation for an APN post. A recognition program for these nurses who have attained the required specialty experience and qualification has also been implemented in 2009/10. A total of 1,516 applicants have successfully attained the requirement and will be granted the title “Specialty Nurse” for their achievement. This will further consolidate the support to individual nurse’s progression along the career model.

**Conclusion**

14. The introduction of the career progression model for nurses is well underway and positively impacts on the nursing workforce. With the gradual introduction of the NC in proven clinical areas, more opportunities will be available for appropriate qualified nurses to advance their clinical career and contribute to HA service at a senior level. The plan to continue expansion of training and development opportunities in support of the nurses’ career progression model thus improves nurses’ professional competency for better patient care.

**Advice Sought**

15. Members are requested to comment and note the report of the career progression model for nurses.
HA’s retention package in support of the nurses’ career progression model:

(a) Restructure the management related allowance (MRA) classification for DOM

(b) Increase the number of APN posts to enhance supervisory support and emerging role of nurses

(c) Formalize APN (Ward & Unit Management) post and rename those posts as either Ward or Unit Manager

(d) Introduce more flexible contract for RNs by offering 6 years contract to RN upon appointment

(e) Delegate the authority to CCEs of flexibly granting incremental credits to new recruits for experience up to full month rather than total years where appropriate

(f) Convert contract to permanent employment for nurses at any stage in the contract subject to their attaining 2 years “effective” and 1 year “good” SDR assessment in the immediate past 3 years instead of requiring full-time employment for 6 years

(g) Develop a training system to build a competent nursing workforce with flexible mode of learning

Summary of implementation of the retention strategies is as follows:

1. The restructure of MRA for DOMs was implemented to reflect the increased responsibilities in management duties and there are currently 12 DOMs from various hospitals receiving a higher level of MRA.

2. For the APN(W&UM) position, we have converted about 170 APN(W&U) positions to WM. During the past two years, the WM posts were increased from 598 to 634 representing a net gain of 36 positions in this category. The number of Senior Nursing Officer and above positions was also increased from 224 to 243 representing a net gain of 19 positions at this level. Overall, the strength of nurses at APN and above level has been increased by about 700 or 23% during the period.

3. The plan was to increase about 450 APN posts for improving supervisory coverage and adding 11 additional nurse clinics for the emerging role of nurses. There has been an overall increase of 650 APN posts from June 2008 to end March 2010. With the increase in APN posts, HA hospitals were able to increase
clinical senior nursing coverage and supervision for nurses particular during night shift and it is noted that there was a 50% increase in the number of nurses at APN level on night shift from June 2008 to February 2009.

4. A number of flexible human resources initiatives have also been implemented since June 2008. It is noted that the number of nurses who are on 6-year contract has increased from 1,369 at the end of 2008/09 to 2,001 at the end of 2009/10. The initiative for early conversion from contract to permanent term is being taken up by nurses with a total of 812 nurses converted in 2008/09 and 2009/10 compared with 211 nurses converted in 2007/08.

5. It is observed that the overall turnover rate of nurses has declined from the peak of 4.7% in 2008/09 to 4.1% in 2009/10. It is also noted that the turnover of experienced RNs (with 11 years and above experience) has also decreased from 4.0% in 2008/09 to 3.2% in 2009/10. The number of experienced RNs increased from 8,269 (65% of the total RN population) at the end of 2008/09 to 8,720 (67% of the total RN population) at the end of 2009/10.

6. In addition to the above strategies supporting the career progression model for nurses, HA has also re-opened some of its nursing schools in 2008/09 with a yearly intake of about 650 trainees (RN/EN) contributing to the increase in supply of nurses in the coming few years.