Southern California CSU DNP Consortium
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CLINICAL LADDER FOR A COMMUNITY HOSPITAL

A DOCTORAL PROJECT PROPOSAL
Submitted in Partial Fulfillment of the Requirements
For the degree of
DOCTOR OF NURSING PRACTICE

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2015
ABSTRACT

According to a 2013 hospital employee engagement survey at a southwestern medical center, nurses indicated that they had limited opportunities for professional growth and career advancement. In addition, they perceived that their hard work and effort were not recognized. These perceptions led to high nurse turnover rate, a disengaged work force, and decline in patient care quality, substantiated by data provided by the Human Resource and Performance Improvement Departments. If these negative trends were to continue, they might result in substantial decreases in reimbursement and increases in expenditures due to high nurse turnover rates. An exhaustive review of the literature on clinical ladders was conducted. Based on strong evidence, a Clinical Ladder Program (CLP) provides a means to recognize and reward nurses’ expertise in clinical practice and keep them at bedside. A CLP can potentially improve retention and job satisfaction, and enhance professional development and patient care quality. The purpose of this project was to develop a CLP for a community hospital. Benner’s “Novice to Expert” was selected as the theoretical framework for the proposed CLP.

A CLP with four clinical nurse levels was developed. The CLP plan included the ladder itself, a detailed description of each clinical nurse level, including clinical skills, job description, performance standard, educational requirements, and application and credentialing processes. During development of the CLP, an overall campaign to increase awareness about the possibilities of a CLP was begun. Discussions unearthed perceived and local barriers and facilitators associated with adoption and implementation
of the CLP. These included the need for administrative support and monetary incentives for nurses who perceived that the CLP required large investments of time and energy due to the need for pursuing further nursing education. The CLP implementation plan addressed these in a realistic timeline that is dependent upon the adequate financial stability of the hospital (due to projected costs associated with raising salaries for nurses at the higher levels of the ladder). Potential outcomes measures and evaluations associated with CLP were postulated to give hospital administrators a complete overview of the project scope before implementation; these include enhanced nurse retention and job satisfaction (with subsequent lower turnover rates), increased educational levels of the staff (necessary in a Magnet environment, which the hospital is discussing), and improved clinical outcomes such as decreased errors and better safety outcomes. Lessons and perspectives gained during this project are as follows: identification of potential barriers to a CLP such as the strongly held perception of experienced nurses about the recognition that experience and education have differential effects on nursing skills; the necessity of the hospital’s being able to afford a CLP; and overall limited awareness of staff and key stakeholders about CLPs. Thus, the planned implementation and evaluation take into account empiric evidence as well as local needs.
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ACKNOWLEDGMENTS

I wish to express sincere gratitude to many people who have been supportive in the completion of this project. Special thanks to all the management team and Professional Development Council members at my hospital who gave their time to offer valuable ideas and direction for the development of this clinical ladder program. In addition, my appreciation to the executive team of this community hospital who allowed me this great opportunity to contribute.

Recognition and special thank you to my colleagues, director, and nurse executive who have supported my endeavor. Personal thanks to my husband, Louis, who has been so supportive and patient during my project. This project would not have been possible without the guidance and support of Dr. Jon Christensen, my committee chair. His ideas, suggestions, critical thinking, and encouragement made the completion of this project possible.
BACKGROUND

Clinical Ladder Program for a Local Community Hospital

A nursing clinical ladder system in the United States is well known for its ability to enhance retention, job satisfaction, and professional development, as well as improve employee engagement (Korman & Eliades, 2010; J. Nelson & Cook, 2008; Riley, Rolband, James, & Norton, 2009; Winslow et al., 2011). The clinical ladder structure is similar to a grading system, defining levels of clinical practice in nursing based on years of experience, academic preparation, demonstrated expertise in clinical and leadership skills, and competency (Bitanga & Austria, 2013; Buchan, 1999). Clinical ladder programs (CLPs) appeared in the literature in the early 1970s, advocating potentials for fostering professional development, strengthening the quality of nursing practice, and enhancing nurse retention and performance (Pierson, Liggett, & Moore, 2010; Zimmer, 1972). According to Buchan (1999), CLPs were widespread in the United States, especially in Magnet hospitals, and were predominantly based on either a three-level system or a four-level system.

The target of this study, Hospital M (a pseudonym), was established in early 1900s in California. The facility takes great pride in its reputation for providing high-quality care services for patients based on a strong, experienced, and seasoned nursing division. Its mission is to “provide high-quality healing services while caring for the patient’s emotional and spiritual needs and enabling them to achieve health for life” (Hospital M’s 2011 Mission Statement). During the nursing shortage of the 1980s, the hospital maintained a strong and steady track record of retention and outstanding registered nurse (RN) job satisfaction scores. According to the Human Resources Vice
President, retention and job satisfaction in the nursing department have always been exceptional (B. Budbinsky, personal communication, December 2013). However, approximately one year ago, due to major organizational changes, both nursing retention and satisfaction began to decline. The purpose of this paper is to propose implementation of the CLP ladder program to address the issues of retention and staff satisfaction. This proposal includes the hospital needs assessment, the problem statement, the project’s theoretical framework, goals, implementation strategy, and an evaluation plan.

**Needs Assessment**

A CLP is not entirely new to Hospital M. In the early 1980s, a professional recognition program with concepts similar to those of a clinical ladder was established in response to the nursing shortage crisis. The belief was that nurses who participated in the program would experience greater job satisfaction, which would in turn promote retention, resulting in lower turnover rates. However, due to the complexity of the application process, low participation rate, lack of follow-up and financial constraints, the program lost momentum in the late 1990s and was terminated in 2010.

In 2012, Hospital M, which is a nonprofit, nonunionized health care organization, experienced a complete turnover of the executive management team, including the Chief Executive Officer (CEO), Chief Operating Officer (COO), Chief Financial Officer (CFO) and the Chief Nursing Executive (CNE). Not only did this change in leadership spur resignation by senior managers; it affected seasoned staff nurses throughout the hospital. According to the Human Resources Department, the RN turnover rate has doubled since 2012 and is still climbing (Budbinsky, personal communication, December 2013). The employee engagement survey conducted in November 2013 indicated that a high
percentage of nursing staff expressed intention to leave the hospital within a year, as well as low job satisfaction rates related to salaries and opportunities for growth. The 2013 survey also indicated the nurses lacked motivation, and a large percentage commented that their efforts to maintain quality care were not being recognized or rewarded by hospital administrators.

Marie Zimmer (1972), who presented the first clinical advancement philosophy in 1972, utilized the clinical advancement program to recognize nurses while promoting professional growth, improving patient care outcomes, and RN retention rates. To that end, the CNE at Hospital M has approved implementation of a CLP to improve RN retention, career engagement, and professional growth. The CLP at Hospital M will be implemented as part of the hospital’s shared governance system. The CNE stated that improving the quality and professionalism of RNs at Hospital M is part of a larger vision of attaining Magnet status in the near future (D. Neal, CNE, personal communication, December 2013). Based on the current literature, it is posited that the implementation of a CLP at Hospital M will be vital in achieving these aims.

**Problem Statement**

Based on the data from the needs assessment and other supporting information, one can conclude that Hospital M could benefit from a change. It appears that Hospital M nurses are experiencing low morale, lack of recognition, high turnover rates, low satisfaction scores, and lack of motivation to develop professionally, which could negatively affect the future growth of the organization. If this negative trend continues, the hospital could suffer consequences, such as a disengaged work force and declines in patient care quality and safety, which might lead to substantial decreases in
reimbursement and increases in expenditures due to turnover (J. Harter, Schmidt, Agrawal, & Plowman, 2013).

The purpose of this project is to develop a CLP for Hospital M based on the mid-range theoretical framework of Benner’s “Novice to Expert.” By implementing such a program, the hospital could ameliorate this negative trend. With a tailored CLP, nurses’ expertise in clinical practice would be recognized and rewarded. This change would improve and promote retention, job satisfaction, professional development, and quality of care (Bjørk, Hansen, Samdal, Tørstad, & Hamilton, 2007; Korman & Eliades, 2010; J. Nelson & Cook, 2008; Riley et al., 2009; Winslow et al., 2011).

Theoretical Framework

According to Moran, Burson, and Conrad (2014), a theoretical framework provides guidance for project management, defines variables, and provides a structure for evaluating outcomes. It also enhances understanding of relationships among concepts and provides focus for the project organizer.

Benner’s Model

In most of the literature reviewed, the scientific theoretical underpinning for implementing a CLP is drawn primarily from the 1972 paper by Marie Zimmer and the 1980s publications by Patricia Benner (Benner, 1982, 1984). Benner’s novice-to-expert concept is the most frequently cited and used theoretical framework for CLPs globally.

Buchan (1999) reviewed literature beginning in the 1970s on utilization of CLPs and found that most hospitals around the world based their programs on Benner’s framework, which focuses on clinical experience, educational background, and competencies as criteria for advancement. The Benner model is also mentioned in recent
literature and continues to be the most frequently selected conceptual framework in most facilities as they design and implement CLPs (Goodrich & Ward, 2004; Korman & Eliades, 2010; J. Nelson & Cook, 2008; Riley et al., 2009; Tetuan, Browder, Ohm, & Mosier, 2013).

The professional development committee (PDC) at Hospital M has concluded feels that Benner’s “Novice to Expert” framework is most appropriate for developing and implementing a CLP. The CLP at Hospital M will have four levels. The PDC considers the CLP to be a proactive approach to augment retention and job satisfaction within the health care organization.

**Components of Benner’s Model**

Benner (1982, 1984) generalized the Dreyfus model of skills acquisition developed by two University of California, Berkeley, professors, mathematician Stuart Dreyfus and philosopher Hubert Dreyfus, who studied chess players and pilots; she transferred the model to the clinical nursing setting. According to Benner (1984), professional growth in nursing happens in five stages: novice, advanced beginner, competent, proficient, and expert.

**Novice: Level I.** The novice stage of professional development is characterized by nurses who are new to the nursing profession and have minimal experience at performing tasks. Benner (1982) described these practitioners as new beginners who lack the ability to use discretionary judgment; thus, they are expected to perform measurable, context-free tasks, such as obtaining vital signs and other measurable parameters of patient assessment. During this stage, the novice is coached by more experienced nurses to use context-free rules to face clinical situations that they have not experienced. In
Benner’s recent work (2004), student nurses who have just graduated from nursing programs are assigned to the novice level.

**Advanced beginner: Level II.** According to Benner (1982, 1984), the advanced beginner exhibits marginally acceptable performance. Nurses at this level utilize knowledge gained from experience to cope with situations with the help of their preceptors. They are efficient and skillful in certain clinical practice areas but still require coaching during challenging situations. In this stage, the nurses are accumulating knowledge (Benner, 1982).

**Competent: Level III.** Nurses at the competent level are confident because they have been on the job and have experienced similar situations for approximately 2 to 3 years. At this level, nurses demonstrate the ability to prioritize daily tasks and engage in planning to establish perspectives based on abstract, conscious, analytical thought regarding the problems (Benner, 1982, 1984). This deliberate conscious planning assists the nurse in employing skills efficiency and organization of patient care. Level III nurses can function confidently with minimal or no support (Benner, 1982).

**Proficient: Level IV.** According to Benner (1982), proficient nurses are independent and perceive situations at work holistically instead of as fragmented parts or aspects. They know what to expect and can make-long term plans accordingly or modify them to fit a given situation. This skill of examining the situation as a whole allows the proficient nurse to refine decision making, diagnose accurately, and handled the problem at hand (Benner, 1982).

**Expert: Level V.** An expert nurse, with experience as well as background knowledge, no longer relies on guidance; instead, he or she is intuitive about the situation
at hand and solves problems with precision without wasting time (Benner, 1982, 1984). These nurses have deep understanding of the overall situation; their job performances are smooth, fluid, and superbly proficient. They utilize their highly skilled analytic skills to cope with new and unfamiliar clinical situations.

**Exemplar.** Benner (1984) described the exemplar as narration that provides examples of outstanding nursing skills and discusses clinical practice levels. The exemplar is shared with professional colleagues during the time of application or status renewal. Benner (1984) emphasized the value of the exemplar as a means for the nurse to advance clinical knowledge and recommended that the hospital consider publishing the outstanding exemplars for employees to share. In addition, the storytelling allows the nurse to demonstrate his/her ability by describing how a clinical situation is handled and how an intervention makes a difference in the patient’s outcome (Benner, 1982; Owens & Cleaves, 2012). Detailed information helps readers to envision the situation and understand the decision-making ability of the applicant. By describing a patient case scenario, the nurse can exhibit his or her role as a provider, teacher, and patient advocate (Pierson et al., 2010).

The efficacy of an exemplar was substantiated by a descriptive study by Norman, Rutledge, Keefer-Lynch, and Albeg (2008). In this study, the researchers differentiated less experienced nurses from expert clinicians by dissecting their clinical narratives that described care dimensions related to caring. The researchers posited that, by evaluating the exemplar, the reader can visualize what these clinicians consider as central in patient care and what comprises their professional core values. S. Nelson and McGillion (2004) gave valuable insights to the exemplar’s structure. They proposed that nurses should
write about extraordinary and challenging clinical incidents to exemplify the quintessence of expert nursing. The nurse’s intentions, thoughts, and concerns related to this extraordinary clinical situation should be included in the narrative, which could make a difference in their practice (S. Nelson & McGillion, 2004).

The exemplar should include the applicant’s name, title, unit, and years of experience and a narrative detailed description of what happened, including outcome, concerns, and the applicant’s reflections during and after the event. The writing should include information about the intervention and the patient’s or family’s outcomes, as well as what was learned from the experience.

Benner (1982, 1984) supported interpretive, situational-based approaches to identify and describe knowledge embedded in everyday practice. Her definitions and descriptions of the domains were harvested from a multitude of exemplars submitted by bedside clinicians: helping role, teaching coaching role, effective management of rapidly changing clinical situations, diagnostic and monitoring functions, monitoring to ensure patient care quality, refining clinical competencies, and administering interventions and facilitating workflow (Benner, 1984).

Nurses can be assisted to write meaningful exemplars by considering certain criteria. The exemplar should be based on events that occurred within the past 12 months and should include at least three domains from Benner’s model. The applicant should describe personal and professional feeling about the situation, the rationale behind the intervention (why it was important), and how the situation would be handled by a less experienced nurse. The story should demonstrate a positive and rewarding outcome for patient, family, and applicant.
The Hospital M Clinical Ladder Program: A Proposal

Benner’s five stages of clinical competence was presented to the PDC members as the model for the CLP. The chair and her advisers shared the results of RN turnover rate, as well as results of the engagement survey, with all unit base councils. All voting members unanimously agreed that a CLP based on Benner’s model would assist the organization in changing the current culture, improve the level of employee engagement, and improve retention and job satisfaction. The shared governance advisory council approved Benner’s “Novice to Expert” model as the framework for the hospital CLP. A permission to use the “Novice to Expert” model was obtained from Patricia Benner via e-mail (Appendix A).

Examples of CLPs were submitted and reviewed by PDC members. The information was disseminated among staff by the unit-based councils to familiarize everyone with what a CLP could look like. The committee decided that a four-level CLP would be sufficient to demonstrate advancement of RN practice. The CLP will be built on the following pillars: years of experience, educational and professional achievements, mastery of job responsibilities and clinical skills, and professional growth and development. The exemplar will be included as part of the application and renewal process for Levels III and IV to demonstrate how well the applicant understands essentials of practice. The committee also agreed that, once the CLP is implemented, the nurses’ perceptions of the program will be evaluated annually for feedback and revisions. For the ease of viewing and understanding the structure, a clinical ladder grid (Appendix B) was prepared for the committee members. The PDC committee suggested that each level’s description should include the components of nursing process, resource
utilization, professional growth and development, performance improvement, and education and experience. The final approved CLP consists of four levels as described below.

**Clinical Nurse I (CN I)**

The CN I level includes novices and advanced beginners as described by Benner (1982). Nurses in this category are at an entry level to nursing practice, with 1 or more years of experience. In Benner’s recent work (2004), she identified that student nurses who have just graduated from nursing programs should practice at the novice level. RNs at this level focus on developing knowledge and skills. The novice and advanced beginner has limited or no experience in assigned work situations. Nurses in this category need precepting or mentoring from more experienced clinicians and will benefit from frequent and extensive feedback.

The CN I nurses are required to show evidence of nursing process skills in the area of assessment, problem identification, implementation of a plan of care, and evaluation of patient progress and outcome. Other job responsibilities include resource utilization, professional growth and development, and performance improvement activities.

**Assessment.** CN I nurses perform and document basic admission and initial assessment according to unit routine and guidelines. They are aware of their limitations in practice and decision making. They recognize basic abnormal findings and seek assistance as needed.

**Problem identification.** CN I nurses can identify signs and symptoms of patients with similar diagnoses. They utilize resources to identify, prioritize, and document
patients’ problems, needs, and diagnosis by analyzing data available. They use resources to select care plans that are patient and family focused. They know how to transfer or discharge according to unit policy. Preceptors or mentors should assist CN I nurses to search the evidence for best practices.

**Implementation of the plan of care.** CN I nurses document and implement care plans based on assessment according to unit standards. They follow unit protocols and standardized orders. They communicate the care plan and outcomes with patients and other care providers. They understand the importance of cost containment in patient care delivery. They implement physicians’ orders and administer and document medications and therapies according to policies and guidelines. With preceptor assistance, they organize time and workload based on priorities. They document patient education according to unit standards. When they encounter issues, they seek assistance from preceptors or mentors.

**Evaluation of patient progress and outcome.** CN I nurses evaluate, communicate, and document patient progress toward desired outcomes with assistance of preceptors. They document review of the patient’s care plan per unit policy.

**Resource utilization.** CN I nurses demonstrate ability to manage patient care effectively. They understand their roles and support multidisciplinary care processes. They delegate tasks and supervise activities of unlicensed care providers. They manage daily patient assignments effectively. They communicate patient issues to other members of the health care team (e.g., charge nurse, physician).

**Performance improvement activities.** This is not required for nurses at this level.
**Professional growth and development.** CN I nurses maintain required unit and organizational competencies and certifications. They demonstrate accountability for practice and maintain professional growth and development by doing one of the following activities with assistance of a preceptor or mentor: (a) join a unit-based committee, (b) negotiate projects with the unit manager, (c) attend learning activities as assigned (nonmandatory inservice sessions and classes), (d) join a professional organization, and (e) pursue education advancement (e.g., Bachelor of Science in Nursing [BSN]).

**Education and experience.** The education qualification includes a diploma in nursing, an Associate degree in nursing (ADN), a BSN, or a master’s-level degree (Master of Science in Nursing [MSN]). There are no additional requirements for the CN I, except to meet all standards on the annual performance evaluation. After the orientation period, every RN at Hospital M is expected to practice at least at this level, even if further advancement is never sought. The application will be processed at the unit level by the department manager.

**Clinical Nurse II (CN II)**

RNIs at the CN II level are equivalent to competent clinicians in Benner’s model (1984). The CN I should be able to advance to CN II after 1 year working full time as a bedside clinician. CN II nurses are competent clinicians who apply appropriate theoretical knowledge to the care of patients. They are responsible and accountable for safe nursing practices and are focused on expanding skills and knowledge. CN II nurses provide safe and effective direct care as part of the interdisciplinary team to a variety of patients with complex diagnoses. They assume a beginning leadership role but seek
mentoring. They demonstrate leadership abilities at the unit level and may be team leaders or relief charge nurses. They demonstrate mastery of specialized techniques and are skilled in setting priorities. They function independently, with minimal supervision. They possess comprehensive skills in patient assessment.

CN II nurses are required to show evidence of nursing process skills in the areas of assessment, problem identification, implementation of a plan of care, and evaluation of patient progress and outcomes. Other job responsibilities include resource utilization, professional growth and development, and performance improvement activities.

**Assessment.** CN II nurses show an increase in clinical nursing judgment through a process of integrating academic knowledge to differentiate patient changes. They intercept or predict patient issues or problems. They perform and document comprehensive admission assessment and reassessment according to unit routine and guidelines. They identify areas of concern that call for further investigation or intervention. They interpret the patient’s physical and psychological data correctly. They determine the patient’s functional or dysfunctional patterns on admission. They recognize patient signs and symptoms that require immediate attention and document appropriate action plans. They communicate plans of care and pertinent information to other care providers and the nurse in charge.

**Problem identification.** They identify, prioritize, and document patient problems, needs, and diagnoses based on available data. Problems are prioritized and are patient centric. They discharge and transfer patients with proper process and documentation.
**Implementation of the plan of care.** CN II nurses incorporate patients and their families into plans of care with outcome statements and actions. They implement physicians’ orders in accordance with hospital policies. They identify nursing actions to meet patients’ needs. They incorporate and document cost containment principles into their nursing care. They plan and use time management skills in delivering patient care. Medications and therapies are administered and documented timely according to unit policy. They are independent in educating patients and families and document the process appropriately.

**Evaluation of patient progress and outcome.** CN II nurses continuously evaluate, communicate, and document patient progress toward desired outcomes on the care plan. They review and document the patient’s response to care. They involve patients and families in evaluation and revision of the care plan. They modify the plan of care appropriately in collaboration with other disciplines or professions.

**Resource utilization.** CN II nurses effectively manage the patient assignment. They recognize the need to help others when assistance is requested or needed. They know their limitations in knowledge and skills and seek assistance from resources such as the charge nurse or manager as needed. They assist in orientation of new employees or student nurses as requested by the charge nurse. They direct patient care activities of other health care providers and work with ancillary personnel according to unit and hospital policy. They delegate tasks and supervise activities of other care providers such as nursing assistants.

**Performance improvement activities.** CN II nurses begin to participate in performance improvement activities, such as data collection or chart review, to improve
practice and patient outcomes per the manager’s direction. They read nursing journals specific to their practice and question patterns observed in nursing practice. They participate in unit quality improvement activities by contributing ideas or suggestions on projects.

**Professional growth and development.** CN II nurses participate in at least 8 contact hours in their specialty area each 12 months. They demonstrate accountability for practice and maintain professional growth and development by doing two of the following activities: (a) serve on a department or hospital committee, (b) serve on a department or hospital task force, (c) join a professional nursing organization, (d) obtain national certification, (e) serve as specialty instructors such as basic life support or advanced life support, (f) participate in a community health service or project such as an annual heart fair, (g) participate in community health education activities such as curbside cardiopulmonary resuscitation training, (h) organize and conduct educational inservice sessions (minimum 15 minutes) for staff preapproved by management, (i) participate in a health support group, (j) serve as a chairperson or active participant on a unit-based committee, (k) serve as a chairperson or active participant on a unit-based task force, (l) conduct a unit project preapproved by management, (m) serve as a preceptor to new employees, and/or (m) assume charge nurse responsibilities or relief charge nurse responsibilities at least 24 times per year.

**Education and experience.** The minimum educational qualifications for CN II include diploma and Associate degree. They should have completed at least 12 months at the CN I level, including at least 6 months as part-time employee (0.5 FTE) in Hospital M. They must have worked at least 1 year in the designated specialty area. During initial
application or annual renewal, they must complete the CLP Participant Agreement Form (Appendix C). They submit proof of 8 hours of continuous education in the specialty area within the past 12 months. They meet or exceed minimal hospital standards on the annual performance evaluation. The CN II RN or new applicant must consistently meet or exceed the performance standards based on annual evaluation. The application and approval process will be done at the unit level by the department manager.

Clinical Nurse III (CN III)

RNs at the CN III level are equivalent to proficient clinicians in Benner’s model (1984). CN III nurses are clinicians characterized by the ability to perceive situations holistically. They demonstrate understanding of situations by making conscious and deliberate goals or plans. They modify plans or goal in response to changes in the situation. They demonstrate exceptional skills in prioritization, clinical reasoning, and decision making at the bedside. They are highly organized, demonstrate technical proficiency, and demonstrate the ability to think critically. They incorporate evidence-based research into practice and into the leadership role. They value the inter- and intraprofessional approach and creatively implement the nursing process across the care continuum. They mentor others to promote professional growth and improve care outcomes.

CN III nurses are required to show evidence of nursing process skills in the areas of assessment, problem identification, implementation of care plans, and evaluation of patient progress and outcome. Other job responsibilities include resource utilization, professional growth and development, and performance improvement activities.
Assessment. CN III nurses have met all CN II-level competencies in assessment. They utilize advanced assessment and interview techniques to anticipate and correlate similarly diagnosed patients. They anticipate the patient’s needs and issues.

Problem identification. CN III nurses have met all CN II-level problem identification competencies. They are very in tune with their patients, anticipating a problem before it surfaces. They utilize problem statements in documentation.

Implementation of plan of care. CN III nurses are proficient at evaluating standards, identifying strategies, and incorporating these strategies into plans of care for both patients and their families. During the plan of care, they involve inter- and intraprofessional teams. They survey and identify and incorporate the strengths of the patient and family into the care plan.

Evaluation of patient progress and outcome. CN III nurses evaluate effectiveness, propose changes, and participate in development of unit routines, standards, protocols, care plans, or pathways. They analyze patient or family problems or variances and make recommendations for improvement.

Resource utilization. CN III nurses demonstrate leadership qualities at the unit level. They function as team leaders, preceptors, role models, and resources for staff on their units, especially for CN I and CN II nurses. They possess advanced assessment skills and apply theoretic knowledge to manage patient care proficiently. They have time management skills in the delivery of patient care without delay. They know who needs assistance and provide that service to others. They anticipate appropriate resources so that equipment and supplies are available when needed. They recognize and initiate consultation with other health care workers, such as physical therapists or respiratory
therapists, for specific patient problems or developmental needs. They know their limitations in skills or knowledge and are proactive in seeking assistance from appropriate resources. They never appear to be stressed by situations; instead, they respond to stress in a calm, positive manner, which influences others positively. They delegate tasks and supervise the activities of licensed and unlicensed care providers.

**Performance improvement activities.** CN III nurses question clinical practice as it relates to evidence-based practice. They utilize evidence to advance and approach performance improvement activities. They regularly assist managers to collect and interpret data and apply findings to improve practice and patient care outcomes.

**Professional growth and development.** CN III nurses and applicants must participate in at least 16 contact hours (at least 12 hours in their specialty area) within the past 12 months. They demonstrate accountability for practice and maintain professional growth and development by doing at least four of the following leadership activities: (a) assume charge nurse responsibilities, (b) participate in peer performance evaluation, (c) act as a preceptor or mentor for new employees, (d) serve as chair of a unit-based council or committee (may repeat once), (e) serve as chair or active participant in a unit-based task force (may repeat once), (f) act as a mini expert (possess a special skill or area of knowledge where the applicant demonstrates expertise above and beyond the requirements of a staff nurse) in the unit or area, such as on the Rapid Response Team (may repeat once), (g) cross train in other specialty area (may repeat once), (h) serve on a department or hospital committee (may repeat once), (i) serve on a department or hospital task force (may repeat once), (j) implement or organize an activity or project negotiated with management (may repeat once), (k) obtain a national certification (may repeat once),
(l) serve as a specialty instructor in an activity such as basic life support or advance life support (may repeat once), (m) participate in a community health service or project such as an annual heart fair (may repeat once), (n) coordinate a community health activity or event such as curbside cardiopulmonary resuscitation training (may repeat once), (o) participate in any community health activity or event (may repeat once), (p) participate in a community health education activity or event (may repeat once), (q) conduct or organize an educational inservice session approved by management (may repeat once), (r) participate as a ongoing volunteer (may repeat once), (s) participate or organize family and patient educational materials or programs (may repeat once), (t) facilitate a health support group such as Mended Heart (may repeat once), (u) offer professional or health-related presentations approved by management (may repeat once), (v) publish professional or health-related articles in nursing publications (may repeat once), (w) conduct or actively participate in an evidence-based practice, performance improvement, or research-related project approved by management (may repeat once), (x) join a professional nursing organization (may repeat once), (y) serve as an officer or hold a committee position in any professional nursing organization (may repeat once), and/or (z) organize and present professional or health-related presentations or posters at nursing conferences (may repeat once).

**Education and experience.** The minimum educational qualifications for CN III include diploma RN, ADN, and BSN. Nurses with a diploma or an Associate degree must also have a national certification plus at least 6 years of acute care experience, including 4 years at Hospital M. Nurses with a bachelor’s degree or higher must have worked at least 3 years full time or 2 years part time (0.5 FTE) in their specialty area at
Hospital M. The CN III RN or new applicant must consistently meet or exceed performance standards during annual evaluation.

**Application and renewal.** At the initial application or annual renewal of the CN III level, applicants must prepare or update their portfolios to include four exemplars, 16 hours of continuing education (12 hours in the specialty area), a signed agreement of participation, a letter of recommendation from the unit manager, a letter of recommendation from a peer supporting advancement (Appendix D), verification from the Human Resources Department of at least part-time status for the required period of, and all other required elements for the PDC review committee. Participants can retrieve the CLP participant agreement and portfolio checklist from their unit managers. The requirements for application and renewal are listed on the clinical ladder assessment tool (Appendix E).

In addition to the application document, applicants must provide supporting documentation of leadership activities listed on the checklist (Appendix F). To achieve CN III status or maintain current status, applicants must demonstrate at least six leadership activities. All CN III applications or renewals will be reviewed by the PDC review committee.

**Clinical Nurse IV (CN IV)**

RNs at the CN IV level are equivalent to the expert level described Patricia Benner’s model (1984). They are considered to be experts in their field and are characterized by an intuitive grasp of clinical situations (Benner, 1984).

Based on their experience and background knowledge, they no longer rely on guidance; instead, they are intuitive about the situation at hand and solve problems with
precision without wasting time (Benner, 1982, 1984). They have a deep understanding of the overall situation so job performance is smooth, fluid, and superbly proficient. They utilize their highly developed analytic skills to cope with clinical situations that are unfamiliar to them. They function independently in complex situations. They maintain all competencies and have met and fulfill requirements for CN III. Their high level of expertise is achieved by working with the same group of patients with similar diagnoses for several years. They are leaders, charge nurses, teachers, preceptors, role models, professional communicators, and resources for staff on their units and the hospital. They are involved in staff development and implementing evidence-based nursing practice.

CN IV nurses are required to show evidence of nursing process skills in the areas of assessment, problem identification, implementation of care plans, and evaluation of patient progress and outcome. Other job responsibilities include resource utilization, professional growth and development, and performance improvement activities.

**Assessment.** CN IV nurses possess advance comprehensive assessment skills and anticipate patient outcomes based on patterns of response. They recognize trends and implement evidence-based knowledge into their practice. Based on their expertise, astute clinical observations, and current evidence, they make recommendations to revise policy or practice. They may be involved in departmental or hospital standards development.

**Problem identification.** CN IV nurses teach other how to identify problems and how to document patient needs, problems, and diagnoses. They utilize consistent language to document problem statements and they coach other to do the same.
Implementation of the plan of care. CN IV nurses collaborate an in effort to reduce length of stay and thus reduce hospital cost. They plan and evaluate how to control hospital expenditures and coach other staff members to do the same.

Evaluation of patient progress and outcome. CN IV nurses collect and monitor results and data to participate in variance analysis and aim for practice change if needed.

Resource utilization. CN IV nurses orient their peers to the preceptor and charge nurse roles. They assist in design of orientation to specialty preceptorship. They serve as mentors.

Performance improvement activities. CN IV nurses utilize evidence for performance improvement and research activities. They initiate change based on performance improvement. They change nursing practice by using research evidence. They initiate performance improvement projects.

Professional growth and development. CN IV nurses and applicants must participate in at least 24 contact hours (all in their specialty area of expertise) within the past 12 months. They demonstrate accountability for practice and maintain professional growth and development by doing at least six of the following leadership activities: (a) assume charge nurse responsibilities, (b) participate in peer performance evaluation, (c) act as preceptor or mentor for new employees, (d) serve on a unit-based council or as chairperson of the committee (may repeat once), (e) serve as chairperson or active participant in a unit-based task force (may repeat once), (f) act as a mini expert (possess a special skill or area of knowledge where the applicant demonstrates expertise above and beyond the requirements of a staff nurse) in the unit or area, such as on the Rapid Response Team (may repeat once), (g) cross train in another specialty area (may repeat
once), (h) serve on a department or hospital committee (may repeat once), (i) serve on a department or hospital task force (may repeat once), (j) implement or organize an activity or project negotiated with management (may repeat once), (k) obtain a national certification (may repeat once), (l) serve as a specialty instructor in an activity such as basic life support or advance life support (may repeat once), (m) participate in a community health service or project such as an annual heart fair (may repeat once), (n) coordinate a community health activity or event such as curbside cardiopulmonary resuscitation training (may repeat once), (o) participate in any community health activity or event (may repeat once), (p) participate in a community health education activity or event (may repeat once), (q) conduct or organize an educational inservice session approved by management (may repeat once), (r) participate as a ongoing volunteer (may repeat once), (s) participate or organize family and patient educational materials or programs (may repeat once), (t) facilitate a health support group such as Mended Heart (may repeat once), (u) offer professional or health-related presentations approved by management (may repeat once), (v) publish professional or health-related articles in nursing publications (may repeat once), (w) conduct or actively participate in an evidence-based practice, performance improvement, or research-related project approved by management (may repeat once), (x) join a professional nursing organization (may repeat once), (y) serve as an officer or hold a committee position in any professional nursing organization (may repeat once), and/or (z) organize and present professional or health-related presentations or posters at nursing conferences (may repeat once).

**Education and experience.** The educational qualifications for CN IV nurses include BSN, MSN, or higher. Nurses with a bachelor’s degree in nursing must possess
current national certification and must have worked at least 10 years full time in their specialty area. (This special classification of BSN for CN IV nurses will not be applicable after year 2020.) Nurses with MSN or higher must also possess current national certification and work at least 6 years full time in their specialty area. CN IV RNs or new applicants must consistently meet or exceed performance standards during annual evaluation.

**Application and renewal.** At the initial application or renewal, CN IV applicants must have been at CN III level for at least 1 year. The portfolio must include five exemplars, 24 hours of continuing education in their specialty, a signed agreement of participation, their unit manager’s letter of recommendation, three letters of recommendation from peers supporting their advancement, Human Resource Department verification of at least part-time status (0.5 FTE for at least 2 years), and all other requirements for advancement to the CN IV level for the PDC to review. Participants can retrieve the CLP participant agreement and portfolio checklist from their managers. The requirements for application and renewal are listed on the application document (Appendix E). In addition to the application document, the applicant must provide supporting documentation of leadership activities listed on the check list. To achieve or maintain CN IV status, participants are required to demonstrate at least seven leadership activities. Nurses at this level must meet or exceed minimal hospital and unit standards on annual performance evaluation. All CN IV applications will be reviewed by a PDC peer review committee prior.
Process for a Review of the Literature on CLPs

The literature review for this project was conducted on English language publications from 1971 to 2014 by using the electronic databases of Cumulative Index of Nursing and Allied Health Literature (CINAHL) and PubMed via the library of California State University, Fullerton. Main search terms were clinical ladder, professional advancement, job satisfaction, retention, and nurse turnover. The initial search using the term clinical ladder generated 801 articles.

An advanced search was conducted looking exclusively at research studies associated with the search term clinical ladder. Reports and unpublished manuscripts were excluded from search results. By narrowing the search to research studies, the number of articles was reduced from 801 to 90. All studies that described use of a clinical ladder by disciplines other than nursing were excluded. All studies that related CLPs to job satisfaction and retention were included. Articles dated before 1990 were excluded, except for the seminal studies by Patricia Benner.

Twenty-four article abstracts were reviewed; articles that did not associate clinical ladder outcomes with job satisfaction or retention were excluded. Three additional articles were retrieved by title search via CINAHL and by interlibrary loan: Benner (1984, 2004) and Zimmer (1972).

The final count was 14 articles that examined clinical ladder structure, framework, how it affected satisfaction and retention, and its implementation. The table of evidence (Appendix G) includes six quantitative studies, three mixed method studies, and three other pertinent articles. The literature will be reviewed on a frequent basis to
identify newly published studies that may pertain to or contribute to implementation of this project.
LITERATURE REVIEW

The American Association of Colleges of Nursing (AACN; 2014) predicted that the United States will experience another major nursing shortage as Baby Boomers age and the need for health care grows, especially with enactment of the Affordable Care Act. It is projected that the total number of nursing job openings will exceed 587,000 by the year 2016 (U.S. Bureau of Labor Statistics, 2008). The 2008 National Sample Survey of Registered Nurses indicated that the average age of RNs was 47 years, and RNs over age 50 comprised 44.7% of the total RN population (as cited in U.S. Department of Health and Human Services Administration [HRSA, 2010]). The U.S. Bureau of Labor Statistics (2012) supported the prediction that the RN work force will be the fastest-growing occupation through the year 2020. The number of RNs was predicted to increase from 2.74 million in 2010 to 3.45 million in 2020; this translates to almost one million job openings for RNs by 2020 (U.S. Bureau of Labor Statistics, 2012). Therefore, shortages will become more pronounced over the next few decades. The average cost of hiring and orienting a nurse ranges from $80,000 to $84,000 (Korman & Eliades, 2010). According to N. Harter and Moody (2010), the cost is even higher in specialty areas. They claimed that it costs institutions $92,000 to $145,000 to advertise, recruit, hire, and orient an RN in a specialty area such as critical care or the operating room (N. Harter & Moody, 2010).

Thus, retention of experienced nurses becomes one of the most obvious components of a strategic plan for a health care organization to maintain viability and profitability. According to Pierson et al. (2010), a CLP can enhance recruitment and retention of competent and seasoned nurses and strengthen the quality of nursing care.
This literature review provides valuable insights into potential benefits and barriers of CLP implementation.

**Benefits of Adoption and Implementation of CLPs**

The many research studies evaluating clinical ladders are typically descriptive in nature. Three main themes are frequently examined: job satisfaction, nurse retention, and benefits of implementing or revising a CLP (Bjørk et al., 2007; Goodrich & Ward, 2004; Korman & Eliades, 2010). Although numerous studies address job satisfaction and retention of nurses who participate in CLPs, clear relationships among CLPs, job satisfaction, and retention have yet to be clearly demonstrated (Bjørk et al., 2007; Goodrich & Ward, 2004; Korman & Eliades, 2010). Despite the vague relationship between CLPs and job satisfaction and retention, researchers have described noteworthy results of nurses being satisfied with their jobs and expressing intentions to stay when they are at a higher level in the clinical ladder system (Bjørk et al., 2007; Goodrich & Ward, 2004; Korman & Eliades, 2010).

In a systematic review conducted by Lu, Barriball, Zhang, and While (2012) studying job satisfaction, job satisfaction was found to be a complex phenomenon that displays close association with autonomy, reward (verbal, written, and financial), and recognition by peers and administration. Drenkard and Swartwout (2005) reported that hospitals offering CLPs had more satisfied staff than those that lacked internal means for professional advancement. Thus, one can conclude that job satisfaction can be achieved by hospitals that offer staff opportunities for advancement, rewards (verbal, written, and/or financial) and recognition by peers and administrators.
As nurses advance through the CLP, they receive financial incentives associated with the advancement, as well as recognition by peers and management. When rewards and recognition are timely, nurses experience job satisfaction. Nurses who are satisfied at their work tend to be more engaged and committed to their workplace, thus improving retention, quality of care, and patient outcomes (Yin & Yang, 2002). Tetuan et al. (2013) reported that the turnover rate in their facility dropped from 8.33% to 1.96% in 5 years (2007–2012) after implementation of the CLP. A meta-analysis of the relationship between engagement and organizational outcomes conducted by the Gallup business journal (as cited in J. Harter et al., 2013) further linked employee engagement to critical business outcomes such as turnover rate, patient safety incidents, productivity, and overall quality of care. Organizations with engaged personnel showed 3.9 times the earnings per share growth compared to a similar facility with lower scores (J. Harter et al., 2013).

In the meta-analysis, Yin and Yang (2002) addressed related factors that could affect retention of nurses: job satisfaction (associated with reward and recognition), autonomy, opportunities for promotion, job stress, and educational level (the higher the education level, the greater likelihood of staying). Evidence in current literature supports that organizations with CLPs in place enhance job satisfaction in nurses by recognition and financial incentives; the CLP infrastructure also allows promotion opportunities and professional growth, which are keys for retention (Korman & Eliades, 2010; J. Nelson & Cook, 2008; Riley et al., 2009; Winslow et al., 2011). Human resource executives have reported that one of the most effective ways to retain nurses is to provide opportunities
for career advancement, and the literature suggests that CLPs may accomplish those goals (Mercer, as cited in Korman & Eliades, 2010).

The availability of a CLP in an organization might not be the key determinant of whether nurses stay or leave, but the literature strongly suggests that CLP participants at higher levels of the program are more involved in leadership activities, such as precepting and mentoring, as compared to their counterparts (J. Nelson & Cook, 2008; Riley et al., 2009). Nurses in a CLP expressed that they valued recognition by peers and management and, as they advanced up the ladder, they had more opportunities for professional growth (Riley et al., 2009). The study by Riley et al. (2009) supported that CLPs provided opportunities for nurses to acquire clinical knowledge and skills in a systematic way, which ultimately led to better patient care, a sense of accomplishment, and personal satisfaction.

Bjørk et al. (2007) examined benefits associated with CLP. They concluded that CLP participants were more aligned with the organization’s mission and vision than are nonparticipants. These CLP nurses were perceived by others as being more competent, proficient, willing to collaborate, engaged in evidence-based practice, and able to provide quality patient care that resulted in better patient outcomes.

**Barriers to Adoption and Implementation of CLPs**

Organizations may be concerned about the financial impacts associated with implementation of CLPs. Finances can be an issue for successful implementation of a CLP. Evidence suggests that financial incentives associated with the CLP were rated very high by most nurses when they initially joined (Riley et al., 2009). As they advanced, they perceived the true benefits of the program as described in the previous
section. Hospitals that are interested in implementing the CLP should perform a cost analysis to determine the financial impact versus benefits (Bitanga & Austria, 2013). It would be beneficial for health care organizations to understand that reported outcomes, such as increased salary bonus and education benefits, could improve program satisfaction, which might lead to lower turnover rates (Goodrich & Ward, 2004; Korman & Eliades, 2010; Tetuan et al., 2013).

Many studies on evaluation of CLPs have identified additional barriers, such as participants’ perception of unknown time commitment. Nurses are concerned that they will be required to invest undetermined additional time beyond their work schedules to achieve certain advancement levels (Bjørk et al., 2007; Riley et al., 2009). Nurses close to retirement age were less likely to perceive the benefits of joining CLPs and younger nurses were concerned about time constraints, family commitments, and the ability to meet eligibility requirements (Tetuan et al., 2013). Other nurses were concerned about the complexity of the application process and lack of management support (Tetuan et al., 2013, Ward & Goodrich, 2007). This information should be considered by the facility administration prior to implementation of a CLP.

Very few studies have focused on evaluating nurse satisfaction with CLPs included multiple tracks focusing on various nursing roles (e.g., clinical, education, and administration). A gap in the literature was noted: quantitative evaluation of nurses’ satisfaction with specific advancement programs and descriptions of CLPs inclusive of nonclinical nursing roles.
Summary Review of CLP

A CLP can be an essential piece in building a healthy organizational environment for nurses. The reviewed literature indicates that CLPs have many perceived benefits, such as enhancing and promoting retention and job satisfaction, empowerment by recognition, professional development, and improvement of the quality of patient care (Korman & Eliades, 2010; J. Nelson & Cook, 2008; Riley et al., 2009; Winslow et al., 2011). The barriers to implementing CLPs were identified as being related to age, time constraints, complex application processes, and lack of management support (Tetuan et al., 2013; Ward & Goodrich, 2007). The literature on CLPs supports the position that health care organizations that are seeking to improve workforce engagement, retention of professional nurses, and work culture could benefit from implementation of a CLP.

Goals and Objectives

Current evidence from the literature supports that implementation of a CLP could provide a means for Hospital M to recognize nurses’ expertise in clinical practice through rewards and recognitions, which would in turn improve retention, job satisfaction, professional development, and quality of patient care (Bjørk et al., 2007; Korman & Eliades, 2010; J. Nelson & Cook, 2008; Riley et al., 2009; Winslow et al., 2011). In 2013, Hospital M experienced an exceptionally high nurse turnover rate (12%) and an unsatisfactory score on an engagement survey. The survey indicated that a high percentage of nursing staff planned to leave the organization within a year, as well as low job satisfaction attributed to lack of rewards, recognitions, and opportunities for growth. The 2013 engagement survey conducted by Hospital M further suggested that nurses lacked motivation, which might be reflected in a decline in workforce engagement. The
overall goal of this project is to design and implement a CLP to mitigate these potentially negative effects. Three specific goals are delineated to achieve the overall goal.

Goal 1

The first goal of this CLP project is to improve nurse retention through increased job satisfaction. This might be accomplished by appropriate and timely recognition and reward when nurses advance from one level to the next. Compensating CN III and CN IV with financial incentives will be proposed to the hospital executive team and the human resource department for consideration in December 2014. If this proposal is approved, nurses will be rewarded financially for pursuing advancement to become competent and more engaged in education advancement, committee or project participation, and other unit activities to improve patient care and professional nursing practice. It is intended that, with implementation of the CLP, the RN turnover rate will improve, which would correlate directly with decreased hospital costs related to recruitment, training, and retention of skilled and committed employees.

Goal 2

The second goal for this project is to empower nurses to pursue educational development and advancement, refine clinical skills, encourage development of expertise in their specialties, and grow professionally. These perceived benefits might foster self-growth in leadership, as well as professional development, and encourage expert nurses to stay at the bedside. A succinct description of the CLP detailing the application process and requirements will assist nurses to achieve these goals. Nurses will be motivated to grow professionally and refine their skills due to activities such as training provided by qualified preceptors and peer review evaluations. The facility and its clients could
benefit through development of a more competent staff, which might positively influence quality indicators such as fall rates, hospital-acquired pressure ulcers, and infection rates.

**Goal 3**

The third goal of this project was developed collaboratively with the chief nursing executive of Hospital M, whose vision is to achieve Magnet status designation for the hospital in 2017. To meet this goal, the clinical ladder competency criteria will be written with consideration of the new five Magnet model components stipulated by American Nurses Credentialing Center (ANCC; 2008). These criteria state that the forces of magnetism within the model must be demonstrated in areas such as quality of care (Empirical quality results: Component 5, force 6), quality improvement (New knowledge, innovation, & improvements: Component 4, force 7), community and hospital (Structural empowerment: Component 2, force 10), nurses as teachers (Exemplary professional practice: Component 3, force 11), image of nursing (Structural empowerment: Component 3, force 12), interdisciplinary relationship (Exemplary professional practice: Component 3, force 13), and professional development (Structural empowerment: Component 2, force 14; ANCC, 2008).

These goals were shared during Professional Development Council (PDC) and Advisory and Operations Council meetings. The Advisory and Operations Council requested that PDC members work with their unit-based shared governance councils to evaluate and finalize these proposed goals and objectives. Three goals and objectives of the CLP were approved: (a) enhance recognition and retention of competent and experienced staff to promote quality patient care, (b) foster self-growth in leadership and professional development to provide opportunities for skill development and encourage
experts to stay at bedside, and (c) provide a clear delineation of competence levels in preparation for Magnet recognition.
METHOD

The goal of this project is to develop a CLP for Hospital M. This section describes the methods that this project will use to meet this goal. Evidence from the literature supports that most hospitals’ CLPs are based on Benner’s model. The PDC at Hospital M adopted Benner’s “Novice to Expert” model as the framework for their CLP. The section titled “The Hospital M Clinical Ladder Program: A Proposal” described in detail the four clinical nurse levels of Hospital M utilizing the Benner’s model. Each decision point was established by vote of PDC review committee members. Actual program implementation will not start until April 2015 or later.

Although it is beyond the scope of this proposal, it is imperative to discuss key items that will affect implementation of the CLP. Ethical considerations, sample, and setting are identified and addressed. The framework and details of the program are explored, with an in-depth look into perceived barriers and facilitators. An estimated implementation timeline for the project is proposed. The financial resources needed for program implementation are discussed. A proposal for methods of evaluation of the project is presented.

Ethical Considerations

This proposal is not a research study that involves human participants. Retrospective data regarding satisfaction, retention, and quality metrics from performance improvement and human resource department of Hospital M are used to substantiate the problem statement. All identities of engagement survey participants are masked. This project encompasses developing a clinical ladder for bedside RNs at Hospital M. The project will utilize only retrospective anonymous results and data
collected from the 2013 employee engagement survey released by the Human Resources Department. Data such as the turnover rate of the RN workforce and demographic information are also considered and utilized in this project. Other de-identified data provided by the Human Resources Department, such as age group, gender, education background, employment status, and years of experience may also be used. Data on the nursing quality dashboard are supplied by the Performance Improvement Department. Although portions of these data are public knowledge, the executive team requested use of terms such as *pass, fail, or needs improvement* instead of publishing actual number data. An application for waiver of review was submitted to the Institutional Review Board at California State University, Los Angeles, and was approved December 8, 2014.

The Clinical Ladder Assessment Tool by Dr. Sarah Strzelecki will be recommended to the PDC to evaluate nurses’ perception of the CLP 1 year post implementation so meaningful revisions can be made. Dr. Strzelecki granted permission to use the tool (Appendix H). Dr. Patricia Benner granted permission to use the “Novice to Expert” framework (Appendix A).

**Setting and Sample**

Hospital M is an independently owned nonprofit, 325-bed, acute care community hospital. There are 1,960 employees on staff (C. Montoya, Human Resources Department, personal communication, December 2013). According to records of the Human Resources Department, about 659 RNs work in various departments, including 465 classified as full-time employees and 115 as part-time employees. Only these 465 RNS will be eligible to participate in the CLP. The nursing population at Hospital M is
comprised of 86% females and 14% males. Educational levels include 10% MSN, 38% BSN, 37% ADN, and 15% diploma RN.

**Problem and Evidence**

Based on data from the Human Resources Department and the Performance Improvement Department, Hospital M nurses are likely experiencing low morale, lack of recognition, high turnover rates, low satisfaction scores, and lack of motivation to develop professionally. This negative trend can affect the hospital adversely in terms of reimbursement and patient care quality, as well as safety. The aim of this project is to develop, implement, and evaluate a CLP at Hospital M, utilizing Benner’s “Novice to Expert” as the theoretical framework. Implementing a CLP could provide a means for the hospital to change this negative trend. Nurses’ expertise in clinical practice would be recognized and rewarded, which would improve job retention, job satisfaction, professional development, and quality of care (Bjørk et al., 2007; Korman & Eliades, 2010; J. Nelson & Cook, 2008; Riley et al., 2009; Winslow et al., 2011).

**Project Framework**

The scientific theoretical underpinning for implementing a CLP at Hospital M is primarily drawn from the framework of “Novice to Expert” by Benner (1982, 1984, 2004). Benner’s “Novice to Expert” was the most frequently cited and used theoretical framework for developing the clinical ladder in health care in 14 research studies selected for the literature review. Benner’s model is based on Dreyfus’s model of skills acquisition, which classifies five stages of skills competencies: novice, advanced beginner, competent, proficient, and expert (Benner, 1982). Each of these stages is characterized by certain thinking, performance, and behavioral patterns. Although they
are theoretically vague, Benner’s five progression levels provide room for innovation and flexibility for hospital application. The consensus of the PDC was that a four-level CLP based on Benner’s work will be effective to augment retention and job satisfaction and staff’s professional development. The PDC proposed that credentialing of CN III and CN IV nurses be processed by a peer review team comprised of PDC members.

**Application and Credentialing Process**

The application and credentialing process will be discussed extensively by PDC members. A 10-member review team will be comprised of nurses, educators, and PDC advisors. The team will meet every 2 weeks to reach consensus on the application and credentialing processes as described below.

At the CN I and CN II levels, the application process is carried out at the unit level, completed by the unit manager. All CN I nurses must advance to CN II after 1 year. For CN III and CN IV advancement and renewal, new applicants must notify the unit manager regarding the applications by completing the CLP participant agreement form (Appendix C). Applicants must have a current performance evaluation that reflects consistent compliance with performance standards, a portfolio, and a completed checklist (Appendix F). The portfolio must contain the following documents: (a) a signed copy of the CLP agreement (Appendix C), (b) a current résumé, (c) a list of job responsibilities on the unit (including job description and unit competencies), (d) a letter of support from the unit manager (may use template, Appendix I), (e) record of education contact hours (CN III = 16 hours, 12 within specialty, CN IV = 24 hours, all specialty) within 12 months, (f) exemplar(s) related to patient care (four for CN III, five for CN IV), (g)
record of national certification (required for CN IV), and (h) record of leadership activities (four for CN III, six for CN IV).

The process of credentialing and approval of the clinical ladder advancement will be managed by the PDC Clinical Ladder review committee. The team will consist of three to five nurse representatives from various departments, unit managers, and a representative from the Human Resources Department. For CN III application or renewal, the PDC Clinical Ladder review committee will evaluate materials in the portfolio and determine whether the application meets the criteria for advancement to the next level. For CN III nurses advancing to CN IV, in addition to the portfolio review, a face-to-face interview may be required. A denial decision will be written with statements outlining the rationale by deficiency, forwarded to the applicant and manager via email. CN III or IV nurses will include in their renewal applications their updated portfolios. Any incomplete application will be denied and returned to the applicant.

**Perceived Barriers**

Riley et al. (2009) identified essential barriers perceived by nurses, such as the undefined time commitment and financial incentives associated with advancement. Recognition on the unit level was highly valued by the nurses. During the PDC meeting at which the draft clinical ladder was presented, many voting members expressed similar concerns and posited that educational requirements associated with level advancement might discourage nurses from participating. They contended that years of experience should take precedence and considered the degree to be irrelevant. Feedback from units included potential conflicts between work activities and personal obligations.
Responding nurses expressed concern that they would be unable to complete requirements during their regular work shifts.

The PDC voting members suggested that the PDC advisor and chairperson bring their concerns to the executive level. The advisor reassured the team that the 2015 budget would make provision for financial incentives to accompany ladder advancement. The Chief Nursing Officer consulted the director of the nursing program at Pacific Azusa University in an effort to support nurses who expressed interest of advancing their education. Education hours will be calculated into the 2015 budget so nurses can attend meetings and participate in education activities.

**Perceived Facilitators**

The request to construct a clinical ladder came from the PDC, which is under the direction and guidance of the shared governance structure of Hospital M. To that end, the process of facilitating approvals is considered to be a priority on the council’s agenda. Although many suggestions start at the unit department level, the PDC and the Advisory and Operations Council are ultimately responsible for management, leadership, budgeting, and human resources planning. The CEO, CNO, COO, and CFO are convinced that a clinical advancement program within the shared governance structure will generate multiple valuable benefits. As reported by Bjørk et al. (2007), a clinical ladder in nursing fosters professional skills of nurses, recognizes clinical excellence, improves care quality, encourages personal accountability for individual professional development, improves staff satisfaction, and reduces the turnover rate.

Evidence supports that most bedside clinical nurses welcome CLP because they perceive potential financial gains, knowledge and skills acquisition, and peer recognition
as they advance up the clinical ladder (Bjørk et al., 2007; Korman & Eliades, 2010; J. Nelson & Cook, 2008; Riley et al., 2009). To this end, educating nurses about the CLP’s goals, criteria, level of classification, and application and peer review processes are important steps to facilitate participation when the program is implemented.

**Timeline**

The conception of the CLP at Hospital M started in July 2013, when the PDC was formed. The theoretical framework for the ladder was selected and approved in December 2013. Based on Benner’s “Novice to Expert” framework, the four-level clinical ladder was developed and presented to the PDC and received approval in March 2014. The proposal was then submitted to Advisory Operations Council and was approved in June 2014. The peer review team, formed in June 2014, continued to work on processes such as application, credentialing, and other documents associated with CLP. Although the proposed CLP was approved, the CNE and the executive team placed it on hold due to financial issues. Pending the release date, the PDC will collaborate with Human Resources Department and the Finances Department to estimate the potential cost to implement the program. The Finances Department and decision support will continue to calculate and estimate the associated costs, which include implementing the CLP and staff education. Once the budget is approved by the executive team, implementation will start (projected for August 2015). When the CLP is implemented, PDC plans to evaluate the program annually. Revisions will be based on the yearly evaluation. An implementation timeline is included as Appendix J.
Finances and Resources

After development of criteria and structure of the clinical ladder, the next step is to estimate program costs. The decision support team and finance department will work with the CNO to produce a budget for the CLP. The plan is to present the program and its financial aspects to the executive team and board in December 2014. If the executive team approves the budget, the CLP will be implemented in April 2015 or later.

A robust CLP requires the hospital to commit financially. It is crucial to consider and plan for hidden costs during implementation. These costs can include but are not limited to the following: (a) increased education hours for nursing staff to learn about the clinical ladder (1-hours service sessions about CLP and the process for 659 nurses), (b) increased education hours when nurses engage in activities listed on the clinical level such as inservice or preceptorship or attending committee meetings, (c) increase education reimbursement due to nurses returning to school (source: foundation grant), (d) financial incentives to accompany advancement in CN III and IV levels, and (e) printing of flyers and documents for advertising, maintaining, and updating the CLP.

Once the decision has been made regarding how to reward nurses who advance in the CLP, the projection of costs should be relatively easy to calculate. The proposal is that only nurses at levels III and IV will receive monetary incentives. The reward can be in a form of a percentage raise or a one-time annual bonus. Hospital M most likely will base the reward on a bonus system. The final decision on how each level will be paid depends solely on decisions by the organization’s executive team and board of directors.

The amount of monetary incentive as participants advance in the CLP will also depend on the financial viability of the hospital at the time of implementation. The
proposal for the bonus reward for nurses who advance up the ladder are $2,000 per year for CN III and $3,000 per year for CN IV. The reward will be presented at the end of each year, pending approval by the clinical ladder review committee. In order to gain insight into how much money will be needed to sustain a clinical ladder in one unit, the critical care unit was used as a pilot.

The assumption is based on a 32-bed critical care unit at Hospital M. During the calculation, nurses were assigned to various CN levels by their current manager, based on experience, education background, unit activities, and most recent performance evaluations (March 2014). There are 90 RNs working in the critical care unit, of whom 66 nurses were deemed eligible (working > 0.5 FTE) and most likely to participate in the CLP. Currently, only four RNs are master’s-prepared nurses and possess Critical Care Registered Nurse (CCRN) certification. The majority of the full-time and part-time staff are ADNs with 10 or more years of critical care experience, as well as CCRN. Only 20 of 42 eligible RNs are qualified to stay at CN III. The total funds needed for clinical ladder in the critical care unit is about $52,000 per year based on the bonus assumption (Table 1).

Table 1

<table>
<thead>
<tr>
<th>Item</th>
<th>CN I</th>
<th>CN II</th>
<th>CN III</th>
<th>CN IV</th>
</tr>
</thead>
<tbody>
<tr>
<td>Qualified nurses</td>
<td>0</td>
<td>20</td>
<td>20 of 42</td>
<td>4</td>
</tr>
<tr>
<td>Bonus ($)</td>
<td>0</td>
<td>0</td>
<td>20 @ $2,000</td>
<td>4 @ $3,000</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>= $40,000</td>
<td>= $12,000</td>
</tr>
<tr>
<td>Estimate $730 per participant</td>
<td>0</td>
<td>$14,600</td>
<td>$30,660</td>
<td>$2,920</td>
</tr>
</tbody>
</table>
Korman and Eliades (2010) estimated an average cost of $730 should be budgeted for each clinical ladder participant per year, including average benefits, bonus, and education days. Based on the $730 per participant, the critical care unit will need around $48,108 ($730 x 66) to implement the CLP, which is very close to the previous estimation ($52,000).

Based on the critical care manager’s estimate, only about 50% of the unit staff are qualified and would participate in the program. To this end, the projection is that about 50% of the bedside RNs (580 x 50% = 290 RNs) housewide would participate. Based on $730 per participant, the estimated grant total would be about $211,700 annually to maintain the program. This is only a rough estimate, with an assumption of only 50% participation. A pro forma review should be conducted by the decision support department to generate a more accurate estimate for budget purposes.

Although implementation of a CLP will add costs for the organization, there is no comparison to the price of replacing an experienced CCRN, which can be as high as $80,000 to $145,000 (N. Harter & Moody, 2010; Korman & Eliades, 2010). One of the key benefits of an effective CLP is increased retention of RNs. With the current turnover rate of RNs at Hospital M, if a clinical ladder can mitigate this trend, this investment will repay with great dividends. With the potential benefits of increased retention and decreased RN turnover, the CLP implementation can potentially save money for the organization. Based on the 2013 RN turnover rate (12%), Hospital M lost about 79 RNs; it will cost Hospital M at least $632,640 (79 RNs @ $80,000) to replace these nurses, without including consideration of additional costs in specialty areas (Korman & Eliades, 2010).
Outcomes and Measures

Although the purpose of this proposal is to design a CLP for this community hospital, it is vital that potential outcomes and measures be considered so the administration will have a complete overview of the project scope. The first expected outcome associated with CLP is potential improvement in nurse retention and job satisfaction. Nurses will be recognized when they advance from one level to the next. Nurses who pursue advanced certifications or degrees will be rewarded financially. Furthermore, as they advance up the clinical ladder, they will engage in activities such as patient education, unit-level project participation such as educational inservice training, and serve as preceptors for new nurses, all of which will increase their job satisfaction. Although job satisfaction cannot be improved immediately, incremental progress should eventually be reflected in responses to the employee engagement survey. The PDC should track and report yearly on job satisfaction scores in the employee engagement survey.

With the CLP in place, the turnover rate should drop, which will decrease recruitment spending and training costs associated with new hires. This outcome can be measured by monitoring the turnover rate before and during program implementation. Results of this monitoring should reported to PDC on a quarterly basis by the Human Resources Department. The PDC chair will disseminate the information to the Advisory and Operations Council and the executive team. In order to support transparency in communication and track progress, the report will be posted online, sent via email, and documented in quarterly committee meeting minutes.
The second potential outcome for CLP implementation involves empowering nurses to pursue educational advancement and improve clinical skills and knowledge. The CLP will serve as a platform for participating RNs to foster self-growth in leadership and clinical expertise, which will empower them to advance up the ladder while retaining expert nurses at the bedside. To this end, the quality of nursing care in Hospital M will be enhanced.

This outcome can be measured by monitoring quarterly the quality indicators dashboard generated by the Performance Improvement Department. This report includes indicators in the areas of infection control (hospital-acquired central line infections, C-Difficile, urinary tract infections, etc.); clinical processes (timely discontinuation of antibiotics and timely removal of urinary catheter); rate of harms (medication error rate, fall rate, hospital-acquired pressure ulcer rate, severe event reporting); and patient experience of care, all of which is related to Hospital Consumer Assessment of Health Care Provider and System (HCAHPS) scores (nurse communication, discharge instruction, medication information, pain management, overall hospital rating; Hospital M Compliance Officer, personal communication, March 2014; Center for Medicare and Medicaid Services [CMS], 2013). With implementation of the clinical ladder, along with time, scores on the nurse quality dashboard should reflect improved quality of care for patients.

The third outcome of the CLP relates to setting the stage for Magnet status designation, which is the vision of the CNE. The clinical ladder competency criteria are written with consideration of the five new Magnet model components stipulated by the ANCC (2008). The forces of magnetism are embedded in the model and, when
incorporated into CLP, are reflected in areas such as quality of care (Empirical quality results: Component 5, force 6), quality improvement (New knowledge, innovation, & improvements: Component 4, force 7), community and hospital (Structural empowerment: Component 2, force 10), nurses as teachers (Exemplary professional practice: Component 3, force 11), image of nursing (Structural empowerment: Component 3, force 12), interdisciplinary relationship (Exemplary professional practice: Component 3, force 13), and professional development (Structural empowerment: Component 2, force 14; ANCC, 2008).

There is no measure associated with this outcome. However, the criteria content embedded in the CLP will be shared and discussed during shared governance meetings. The councils’ critiques and feedbacks will be considered and incorporated in revisions of the clinical ladder criteria as warranted.

**Outcomes and Evaluation**

The first outcome of CLP is to improve nurse retention and job satisfaction. The turnover rate should decrease, which will reduce recruitment spending and training costs associated with new hires. Research shows that employees who are satisfied with their job have a tendency to stay and are more likely to be part of an engaged workforce (J. Harter et al., 2013). This measure of success can be evaluated by examining the turnover rate quarterly and by trending the results of the employee engagement survey before and after CLP implementation. The engagement survey looks at three domains of the facility: organization, manager, and employee. If all three domains score high, one can conclude that the facility is a high-performance organization with an engaged work force. The survey contains questions with response choices on a 5-point Likert-type scale (1 =
strongly disagree, 2 = disagree, 3 = neutral, 4 = agree, 5 = strongly agree). The questions that provide insights on workforce engagement, including the lowest organization performing items, are listed in Table 2. Responses to these survey items will be reviewed for trends and compared to national benchmarks every year to determine whether scores improve after implementation of the CLP.

The Human Resources Department will be accountable for collecting and trending these data. The results will be reported to PDC quarterly by the Department. The PDC chair will disseminate the information to committee members, the Advisory and Operations Council, and the executive team. After approval by upper management, the information will be posted online, sent via email, and documented in the quarterly committee meeting minutes.

The outcome measure of empowering nurses to pursue educational development, refine clinical skills expertise, and grow professionally will be evaluated via annual demographic data collected by the Human Resources Department. Monitoring the demographic profile of nurse respondents allows Hospital M to compare data across time. Currently, Hospital M employs 15% diploma nurses, 37% ADN, 38% BSN, and 10% MSN. The hope is that, with implementation of CLP, the percentage of nurses with degrees at the baccalaureate and master’s levels at Hospital M will comprise a higher percentage, with the goal that at least 50% of the nursing staff will be BSN prepared.

All hospitals are currently facing a reimbursement challenge due to implementation of the value-based purchasing initiative by the CMS. Medicare’s Value-Based Purchasing (VBP) Program stipulates that hospitals be reimbursed based on the results of 20 clinical process and patient experience measures (HCAHPS scores; CMS,
Table 2

*Highlights of the Hospital M Engagement Survey*

<table>
<thead>
<tr>
<th>Workforce Engagement Item</th>
<th>2013 Score Hospital M</th>
<th>% Unfavorable</th>
<th>National Average</th>
</tr>
</thead>
<tbody>
<tr>
<td>I would stay with this organization if offered a similar job elsewhere.</td>
<td>NI (^a)</td>
<td>15</td>
<td>3.83</td>
</tr>
<tr>
<td>I would like to be working at this organization three years from now.</td>
<td>NI</td>
<td>10</td>
<td>4.28</td>
</tr>
<tr>
<td>Overall, I am a satisfied employee.</td>
<td>NI</td>
<td>13</td>
<td>4.07</td>
</tr>
<tr>
<td>I would recommend this organization to family and friends who need care.</td>
<td>NI</td>
<td>7</td>
<td>4.33</td>
</tr>
<tr>
<td>I am proud to tell people I work for this organization.</td>
<td>NI</td>
<td>7</td>
<td>4.36</td>
</tr>
<tr>
<td>I would recommend this organization as a good place to work.</td>
<td>NI</td>
<td>11</td>
<td>4.17</td>
</tr>
<tr>
<td>My pay is fair compared to other healthcare employers in this area.</td>
<td>NI</td>
<td>34</td>
<td>3.45</td>
</tr>
<tr>
<td>The environment at this organization makes employees in my work unit want to go above and beyond what’s expected of them.</td>
<td>NI</td>
<td>26</td>
<td>3.59</td>
</tr>
<tr>
<td>I am satisfied with the recognition I receive for doing a good job.</td>
<td>NI</td>
<td>23</td>
<td>3.66</td>
</tr>
<tr>
<td>This organization provides career development opportunities.</td>
<td>NI</td>
<td>22</td>
<td>3.84</td>
</tr>
<tr>
<td>I am involved in decisions that affect my work.</td>
<td>NI</td>
<td>20</td>
<td>3.71</td>
</tr>
</tbody>
</table>

\(^a\)NI = needs improvement.
Hospitals face either a penalty or reward of 1% of their total Medicare reimbursement, which can be the difference between profit and loss (Raso, 2013). The VBP quality indicators can be directly affected by the next clinical ladder outcome of proficient and expert nurses providing exceptional patient care outcomes. Because these outcomes can lead to a stronger financial bottom line for hospitals, it is in Hospital M’s best interest to support programs that support professional expertise, such as the CLP proposed in this project.

The nurses’ expertise and ability to grow professionally can be evaluated by examining the nursing quality indicators dashboard generated quarterly by the Performance Improvement Department. This trending report (Table 3) includes 18 indicators in four major domains: infection control, clinical processes, rate of harms, and patient experience of care. All are related to HCAHPS scores (C. Toneck, Chief Compliance Officer, personal communication, March 2014; CMS, 2013). Currently, the nursing quality dash board of Hospital M indicates opportunities for improvement in the domains of infection control, clinical process, and HCAHPS (Table 3). It is generally agreed that, with implementation of the clinical ladder, the evaluated scores of the nurse quality dashboard will be at or above the benchmark. The facility goal is to be in the top 10th percentile in order to collect the 1% reward from CMS.

The final outcome will be measured after implementation of the clinical ladder and the facility should be ready to embark on the journey to attainment of Magnet status. The clinical ladder competency criteria are written with the consideration related to the five Magnet model components specified the ANCC (2008). The forces of magnetism are embedded in the model and have been incorporated into this CLP model. They are
Table 3

*Nursing Quality Dashboard for Hospital M*

<table>
<thead>
<tr>
<th>Nursing key indicator</th>
<th>Hospital score</th>
<th>Benchmark</th>
</tr>
</thead>
<tbody>
<tr>
<td>Infection Control</td>
<td>2013</td>
<td>CDC  CDPH</td>
</tr>
<tr>
<td>Central Line Infections/1000 Line days</td>
<td>Borderline</td>
<td>&lt; 1</td>
</tr>
<tr>
<td>Hospital-Acquired C. Difficile/1000 patient days</td>
<td>Fail</td>
<td>&lt; 1</td>
</tr>
<tr>
<td>Hospital-Acquired Catheter Assoc. Urinary Tract Infections/1000 cath days</td>
<td>Borderline</td>
<td>1.6%</td>
</tr>
<tr>
<td>Hospital-Acquired MRSA/1000 pt days (bacteremia)</td>
<td>Pass</td>
<td>0.05%</td>
</tr>
<tr>
<td>Hospital-Acquired VRE/1000 pt days (bacteremia)</td>
<td>Pass</td>
<td>0.04%</td>
</tr>
<tr>
<td>Overall Surgical Site Infection Rate</td>
<td>Pass</td>
<td>&lt;1</td>
</tr>
<tr>
<td>Hand Hygiene Observations</td>
<td>Fail</td>
<td>85%</td>
</tr>
<tr>
<td>Clinical Process</td>
<td></td>
<td>CMS (top 10%)</td>
</tr>
<tr>
<td>Antibiotic DC within 24 hours</td>
<td>Fail</td>
<td>99.96%</td>
</tr>
<tr>
<td>Urinary catheter DC post-op day 1or 2</td>
<td>Fail</td>
<td>99.89%</td>
</tr>
<tr>
<td>Rates of Harm</td>
<td></td>
<td>CalNOC</td>
</tr>
<tr>
<td>HAPU/100 patient discharge</td>
<td>Borderline</td>
<td>1.56%</td>
</tr>
<tr>
<td>Fall rate/1000 patient days</td>
<td>Pass</td>
<td>2.38%</td>
</tr>
<tr>
<td>Medication errors/100 patient days</td>
<td>Pass</td>
<td>NA</td>
</tr>
<tr>
<td>Severe medication errors/1000 patient days</td>
<td>Pass</td>
<td>0</td>
</tr>
<tr>
<td>Patient Care Experience (HCAHPS)</td>
<td></td>
<td>CMS (top 10%)</td>
</tr>
<tr>
<td>Communication with nurse</td>
<td>Fail</td>
<td>84.99%</td>
</tr>
<tr>
<td>Response from hospital staff</td>
<td>Fail</td>
<td>78.08%</td>
</tr>
<tr>
<td>Pain management</td>
<td>Fail</td>
<td>77.92%</td>
</tr>
<tr>
<td>Communication about medicine</td>
<td>Fail</td>
<td>71.54%</td>
</tr>
<tr>
<td>Hospital cleanliness and quiet</td>
<td>Fail</td>
<td>78.10%</td>
</tr>
</tbody>
</table>

*Note.* C. Difficile = Clostridium Difficile, CalNOC = Collaborative Alliance for Nursing Outcomes, cath = catheter, CDC = The Centers for Disease Control and Prevention, CDPH = California Department of Public Health, CMS = Centers for Medicare and Medicaid Services, HAPU = Hospital Acquired Pressure Ulcer, HCAHPS = Hospital Consumer Assessment of Health Care Provider and System, MRSA = Methicillin-resistant Staphylococcus Aureus, pt = patient, VRE = Vancomycin-resistant enterococci.
reflected in areas such as quality of care (Empirical quality results: Component 5, force 6), quality improvement (New knowledge, innovation, and improvements: Component 4, force 7), community and hospital (Structural empowerment: Component 2, force 10), nurses as teachers (Exemplary professional practice: Component 3, force 11), image of nursing (Structural empowerment: Component 3, force 12), interdisciplinary relationship (Exemplary professional practice: Component 3, force 13), and professional development (Structural empowerment: Component 2, force 14) in the clinical ladder criteria (ANCC, 2008). These criteria will be evaluated by the PDC and the Advisory and Operations Council to provide critique and feedback for revisions and improvement.

One year after implementation of the clinical ladder, it is recommended that Hospital M consider using standard survey research methods to evaluate nurses’ perceptions of the CLP. Although the advisory council has not accepted the suggestion, PDC is strongly recommending the survey. Many studies and projects have shown the benefit of using a Likert-type instrument such as the Clinical Ladder Assessment Tool by Strzelecki (1989; Appendix E) to address nurses’ perceptions of the CLP. The Clinical Ladder Assessment Tool can provide valuable insights regarding how Hospital M can improve the CLP. The results of the evaluation will allow the team to make revisions and improve the program in the future. Permission to use the tool was granted by the author (Appendix A).

**Limitations**

The limitations in this proposal are acknowledged. Since the engagement survey results were not fully disclosed, they might not accurately reflect nurses’ job satisfaction scores and the nurses’ level of engagement with the organization. Survey data also
included results from management and nurses who were not working at bedside, so results might not accurately reflect the perceptions of the intended population. Based on the limited data available, the evaluation may not be accurate or reliable to reflect whether implementation of the CLP has improved retention and morale at Hospital M.
DISCUSSION AND RECOMMENDATIONS

The purpose of this project—to develop a CLP for Hospital M based on the mid-range theoretical framework of Benner’s “Novice to Expert”—was accomplished by conducting an extensive review of the literature and through intraprofessional collaboration. Because this project did not reach the implementation phase, the many perceived benefits, such as enhanced RN retention, job satisfaction, empowerment through recognition, professional development, and patient care quality improvement, could not be evaluated (Korman & Eliades, 2010; Nelson & Cook, 2008; Riley et al., 2009; Winslow et al., 2011). Designing the CLP infrastructure and gaining approval are only the beginning steps toward implementation and to realizing the many changes to come for nursing practice in this community hospital. Every hospital is unique and will face different hurdles and challenges in implementation of changes. Important initiatives such as establishing a CLP for nursing within the shared governance structure is usually accomplished through a direct order from the facility’s CNE or one of the top executives who wants to change the hospital culture, enhance retention, improve employee work engagement, and augment patient care quality. Therefore, when upper management supports implementation of a new program, conception and implementation are easier. What makes this project unique is that the conception and planning was initiated by a nurse holding a middle-management position and the project represents a perspective that is not found in the current literature on clinical ladders. In this section, the lessons learned by promoting a CLP for nurses from a middle-management position are reported. Unique insights such as strategies used for campaigning to upper management, staff nurses, and colleagues to achieve buy-in are shared. Although no findings were
generated from designing a CLP for this community hospital, sharing first-hand insights gained in completing this project may assist and encourage other middle managers who work at similar facilities to facilitate implementation of a CLP for their units or facilities.

Lessons Learned: Administration Perspectives and Recommendations

In earlier sections of this report, potential barriers to implementation of the CLP were examined and this information was found to be relevant during the approval phase of the CLP when working with individuals at the executive level. Evidence suggests that financial incentives associated with the CLP were rated very high by most nurses when they joined the CLP (Riley et al., 2009). During the discussion of the CLP in the PDC meeting at Hospital M, every member stated that a financial reward associated with advancement in the CLP is key to ensure adequate participation. However, it was revealed that the financial implications generated by CLP implementation were of primary concern for those in upper management. The decision in this case was to place a hold on project implementation until the budget could accommodate the associated salary increases. To this end, before the hospital conducts a cost analysis to determine the financial impact versus benefits, it will be helpful to highlight several key points to these stakeholders. Networking and collaborating with CLP supporters to meet with members of upper nursing administration and executives can be worthwhile.

During this project, the author discovered that many important stakeholders had limited knowledge regarding the benefits that implementing a clinical ladder can bring to the organization. It is paramount that everyone on the executive level be aware that the CLP has potential and good track record for fostering professional development, strengthening the quality of nursing practice, and enhancing nurse retention and
performance, as supported by the literature (Pierson et al., 2010; Zimmer, 1972). The literature supports that all of these outcomes have financial benefits to the organization. Being proactive, persistent, and available in following up with the approval process is vital. It is also important that the initiator act as a CLP advocate by making appointments and presenting the knowledge supported by evidence to lobby for the change. Presenting key information by utilizing graphic presentations and newsletters can be effective in educating the executive team. It can be an eye-opening experience for the executive team when the presentation includes financial information from current research showing how other facilities have reaped long-term benefits of retention offered by CLPs as compared to the significant financial loss associated with a high RN turnover rates.

Adopting a CLP will come across as a relevant and logical option for the facility that suffers from high RN turnover rates and disengaged nurses. In addition, a CLP with high levels of participation provides means for nurses to be professionally recognized. Nurses who participate in CLPs expressed that recognition by peers and managers and the ability to advance up the ladder and to have more opportunities for professional growth are highly valued (Riley et al., 2009).

The study by Riley et al. (2009) supported the belief that CLPs provided opportunities for nurses to acquire clinical knowledge and skills in a systematic way, which ultimately led to better patient care outcomes. In addition, as nurses advance up the ladder, they are likely to experience a paradigm shift. The initial perception of financial incentive being on the top of their list will no longer hold true. Instead, nurses who are at the expert level will most likely consider the satisfaction gained from professional career advancement, and the part that they play in improving nursing and
patient practice outcomes will take precedence to monetary reward. When nurses are satisfied at their job, they are more likely to stay. It is vital for decision makers to understand these reported outcomes and realize that a CLP could eventually improve the turnover rate by increasing employee satisfaction, which could save money by not having to hiring and training new employees.

**Lessons Learned: Staff Perspectives and Recommendations**

During the PDC meeting at Hospital M, when the draft of the CLP was presented, many voting members expressed concerns described by the study conducted by Riley et al. (2009). They feared that the educational requirements associated with level advancement might discourage nurses from participating. The critical care unit representative was very vocal in expressing the opinion that years of experience should take precedence and that obtaining a higher degree should be secondary. According to the members of the PDC, many nurses on their units who had worked in this community hospital for an extended period of time expressed doubts and provided negative feedback regarding academic requirements associated with the CN IV level. A group of experienced critical care nurses expressed their opinion during a staff meeting visit that they should be grandfathered into the CN IV level based on their years of experience, dedication, and loyalty to the hospital. Newer nurses on units such as medical surgical and telemetry expressed excitement and positive feelings about the proposed CLP. Managers from various units reported that their nurses were motivated by the idea of CLP implementation and had decided to go back and obtain a bachelor’s degree in nursing.

The issue of valuing experience over academic development is not unique to this community hospital. Tetuan et al. (2013) indicated that nurses close to retirement age
were less likely to perceive the benefits of joining CLPs because most of them were already at the top of their pay scale. Younger nurses were more open to the idea but are concerned about time constraints, family commitments, and the ability to meet eligibility requirements (Tetuan et al., 2013).

Allowing representatives from each nursing unit to voice their opinion on behalf of their peers and timely follow-up with feedback can be helpful in handling this situation. Taking into consideration the age, academic background, and work experience of each potential participant can help the team in designing a meaningful CLP for the designated population.

During this project, one of the major changes involved making provisions to allow BSN-prepared nurses with national specialty certification to advance to the CN IV level. This accommodation proves that upper management values the voices of seasoned experience nurses. Simple modifications such as this can facilitate buy-in by staff.

Another strategy that worked well for this project was a CLP crusade. The crusade was a series of campaigns carried out by the author by visiting every nursing unit to meet with staff, often on a one-to-one basis, answering questions, and listening to suggestions. A succinct description of a CLP and what was proposed were delivered during staff meetings on each unit in the hospital. Although these visits were very time consuming, they were noteworthy because they provided a safe forum for employees to voice opinions as well as suggestions. In the same setting, important messages regarding CLP were delivered and clarified in real-time interaction between management and staff nurses.
The question of whether financial incentives will accompany clinical level advancement, and how much, arose in every CLP discussion. Representatives from several units shared that their colleagues see financial gain as a form of reward, which appears to be a vital piece of the CLP. With that in mind, the commitment by the executive level to provide financial incentives associated with CLP became the “deal breaker” for staff in deciding whether to participate in the CLP. Letting staff know that the CNE and CEO are receptive to financial reward and will make provisions in the 2016 budget to include funds that accompany the ladder advancement became very empowering to all nurses. Being transparent regarding decisions and information from administration is also relevant to staff. Transparency can be ensured by frequent and timely communication such as email, newsletter, and meeting discussions to keep everyone excited about the CLP coming live soon.

Some RNs in this community hospital shared similar perceived barriers, such as the tedious application process or unknown time commitment, as identified in the study of Riley et al. (2009). Being aware of these concerns, PDC members formed a peer review team early on to meet regularly to fine tune the application and credentialing procedures, as well as all documents associated with the program, in order to streamline the process.

Some RNs expressed concern regarding potential financial hardships associated with returning to school. This concern was brought to the CNE’s attention and was addressed. The CNE reached out to the dean of the nursing program at a local university in an attempt to support nurses who expressed interest in furthering their education. The result was that the university nursing BSN and MSN programs offered a 10% discount in
tuition for all nurses who were currently working at this community hospital. In addition, the foundation at Hospital M agreed to donate a portion of philanthropy funds for education reimbursement. Effective dissemination of this news to potential participants who are going back to school can be very encouraging.

Although the CLP concept was not entirely new to Hospital M, most nurses and managers were not familiar with its concept and structure. Before project implementation, a house-wide education initiative regarding the “what, how, and why of the CLP” would be recommended to enhance participation. All informational news related to CLP should be published and advertised on the hospital website to attract potential participants. Materials and documents associated with the program, such as the actual application, rules and regulations, letter of recommendation, and exemplar templates, should be readily available online. In addition, a document that addresses frequently asked questions regarding the CLP should be prepared and available on all units. This endeavor will require interdisciplinary collaboration among human resource, nursing, and information systems.

Most of the CLPs described in the literature underwent multiple revisions before they reached maturity. Decision makers and other stakeholders should understand that benefits from CLPs are not instantaneous. Improvement of retention, turnover rates, work engagement, patient satisfaction, and care quality occur over time, sometimes after multiple revisions. Ongoing evaluations and monitoring of turnover rate, employee engagement scores, and patient satisfaction results are relevant strategies to monitor the program progress. Utilizing a reliable and valid instrument such as the Clinical Ladder Assessment Tool by Strzelecki (1989) can provide valuable insights regarding how
Hospital M can improve the CLP. In the future, it will be appropriate to conduct further research if the lessons learned and described in the discussion section are beneficial in implementing the CLP in a community hospital setting.
REFERENCES


APPENDIX A

PERMISSION TO USE “NOVICE TO EXPERT” FRAMEWORK

---------- Forwarded message ----------
From: Benner, Patricia <Patricia.Benner@ucsf.edu>
Date: Sat, Mar 15, 2014 at 10:25 AM
Subject: RE: Asking permission to use Novice to Expert as the theoretical framework for a project
To: Anne Lee <anne.lee@csu.fullerton.edu>

Dear Anne,

Yes you may have permission to use the Novice to Expert framework so long as you credit its sources appropriately. Please do not do your work without reading the later works Educating Nurses: A call for radical transformation, Expertise in Clinical Practice, and Clinical Wisdom in acute and critical care. Please keep in mind that it would be impossible to graduate from nursing school and still be a novice...a common mistake. I am including a synthesis paper that may be useful to you. There is a whole section on clinical ladders in each of the above works, the most recent being Educating Nurses: A Call for radical transformation. Good luck on your work. Patricia Benner

From: Anne Lee [anne.lee@csu.fullerton.edu]
Sent: Friday, March 14, 2014 7:52 PM
To: Benner, Patricia; Anne Lee
Subject: Asking permission to use Novice to Expert as the theoretical framework for a project

Dear Dr. Patricia Benner,

My name is Anne Lee and I am a DNP student at California State University Fullerton. I am working on my DNP culminating project. This project has to do with constructing a clinical ladder for the hospital I am working at. After extensive research, your Novice to Expert framework will be a perfect fit for my project. I am respectfully writing this e mail to ask for permission to incorporate your framework of “Novice to Expert” in my clinical ladder project. Please let me know if permission is granted. Looking forward for your approval. Thank you for your time.

Anne Lee MSN NE-BC
Cell xxx-xxx-xxxx
e mail: anne.lee@csu.fullerton.edu

--
Anne Lee MSN NE-BC
<table>
<thead>
<tr>
<th>Hospital M Clinical Ladder Classification</th>
<th>Education and professional requirements</th>
<th>Job responsibility and clinical skills</th>
<th>Professional growth and development (leadership, teacher, advocate, and provider reflected by exemplars)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clinical Nurse I (CNI)</td>
<td>Diploma RN</td>
<td>Basic admission, initial assessment,</td>
<td>Select 1</td>
</tr>
<tr>
<td>(Benner’s Novice and Advanced Beginner)</td>
<td>ADN or higher</td>
<td>documentation according to department</td>
<td>□ Join unit-based committee</td>
</tr>
<tr>
<td></td>
<td>RN with Bachelor of Arts or Science</td>
<td>guidelines</td>
<td>□ Project negotiated with unit manager</td>
</tr>
<tr>
<td></td>
<td>RN with Master of Arts or Science</td>
<td>Aware of own limitations</td>
<td>□ Attend learning activities as assigned</td>
</tr>
<tr>
<td></td>
<td>New BSN or MSN graduate with &lt; 1 year</td>
<td>Able to ID patient S/S with similar dx</td>
<td>(nonmandatory in-services/classes)</td>
</tr>
<tr>
<td></td>
<td>work experience</td>
<td>based on standard of care with</td>
<td>□ Join a professional organization</td>
</tr>
<tr>
<td></td>
<td>&lt; 1 year experience as RN</td>
<td>assistance</td>
<td>□ Pursue education advancement (e.g., BSN)</td>
</tr>
<tr>
<td></td>
<td>New graduate nurses</td>
<td>Implement MD orders in accordance</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>with P&amp;P with assistance</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Administer/document medication and</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>therapies according to P&amp;P with</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>assistance</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Manage patient assignment</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Report patient problem and issues</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>to CN or supervisor</td>
<td></td>
</tr>
<tr>
<td>Clinical Nurse II (CNII)</td>
<td>Previous patient care non-RN experience can apply for CNII after transfer in 6 months</td>
<td>Show increased clinical judgment by integrating formal knowledge to differentiate patient changes</td>
<td>Select 2</td>
</tr>
<tr>
<td>(Benner’s Competent)</td>
<td>Diploma RN</td>
<td>Perform comprehensive admission and</td>
<td>□ Serve on a hospital or department committee or</td>
</tr>
<tr>
<td></td>
<td>ADN</td>
<td>initial assessment and reassessment</td>
<td>task force</td>
</tr>
<tr>
<td></td>
<td>RN with other Bachelor of Arts or Science</td>
<td>at regular intervals</td>
<td>□ Join a professional nursing organization</td>
</tr>
<tr>
<td></td>
<td>RN with other Master of Arts or Science</td>
<td>ID area of concern and investigate</td>
<td>□ Obtain national certification</td>
</tr>
<tr>
<td></td>
<td>BSN</td>
<td>appropriately</td>
<td>□ Advanced Specialty Instructor (i.e., ACLS,</td>
</tr>
<tr>
<td></td>
<td>MSN</td>
<td>Recognize S/S of patient need for</td>
<td>BLS instructor)</td>
</tr>
<tr>
<td></td>
<td>&gt; 1 year in specialty area</td>
<td>intervention and document</td>
<td>□ Participate in community health service</td>
</tr>
<tr>
<td></td>
<td>8 contact hours (in own specialty) in</td>
<td>appropriately</td>
<td>project (can be a volunteer)</td>
</tr>
<tr>
<td></td>
<td>past 12 months</td>
<td>Communicate data to team members,</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>physicians, and CN</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Prioritize problems: patient-family</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>centered</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Document and plan discharge/transfer</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>instructions</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>ID nursing actions to meet patient’s needs</td>
<td></td>
</tr>
<tr>
<td>Hospital M Clinical Ladder Classification</td>
<td>Education and professional requirements</td>
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<td>Professional growth and development (leadership, teacher, advocate, and provider reflected by exemplars)</td>
</tr>
<tr>
<td>----------------------------------------</td>
<td>------------------------------------------</td>
<td>--------------------------------------</td>
<td>---------------------------------------------------</td>
</tr>
</tbody>
</table>
| Clinical Nurse III (CN III) (Benner’s Proficient) | • Diploma RN or ADN + National cert + 6 years of experience in acute care. (at least 3 years @ Hospital M)  
• BSN (3 years in specialty experience/1 year @ Hospital M + FT or 2 years PT)  
• MSN (3 years in specialty experience + 1) | • Utilize advanced assessment skills to anticipate and correlate similarly diagnosed patients  
• Anticipate concerns and needs of patient and family  
• ID strategies, evaluate standards, and incorporate strategies to plan care  
• Involve interdisciplinary team in care plan  
• Participate in unit routine in development of protocols, care plans, pathways  
• Serve as a primary preceptor, role model, | • Conduct staff meeting or unit-based inservice (15-min. minimum) on evidence-based practice  
• Participate in a health support group  
• Chair or participate actively in unit-based committee  
• Chair or participate actively in unit-based task force  
• Negotiate project with unit manager  
• Serve as active unit preceptor  
• Serve as CN  
• Serve as Relief Charge (>24 times annually) |

Select 4  
• CN responsibilities  
• Peer performance evaluation  
• Unit preceptor/mentor  
• Chair/active participant in unit-based council*  
• Chair/active participant in unit-based task force*  
• Mini expert*
<table>
<thead>
<tr>
<th>Hospital M Clinical Ladder Classification</th>
<th>Education and professional requirements</th>
<th>Job responsibility and clinical skills</th>
<th>Professional growth and development (leadership, teacher, advocate, and provider reflected by exemplars)</th>
</tr>
</thead>
<tbody>
<tr>
<td>review committee.</td>
<td>year @ Hospital M + FT or 2 years PT</td>
<td>and/or mentor</td>
<td>□ Cross training*</td>
</tr>
<tr>
<td>• Review for approval</td>
<td>• Other requirements refer to Portfolio Checklist (Appendix H)</td>
<td>• Demonstrate all-inclusive charge responsibility</td>
<td>□ Serve on department or hospital committee*</td>
</tr>
<tr>
<td>• Option to withdraw at any time</td>
<td>• Non-BSN must enroll in an accredited BSN/MSN program</td>
<td>• Independently recognize need for consult to assist other staff</td>
<td>□ Serve on department or hospital task force*</td>
</tr>
<tr>
<td>• Denial with rationale to manager and applicant or approval or promotion communicated to manager and applicant</td>
<td>• 16 contact hours (12 in own specialty) in past 12 months</td>
<td>• Orient employees and students by manager or supervisor</td>
<td>□ Negotiate activity or project with manager or director*</td>
</tr>
<tr>
<td>• CLP peer review committee sends list of approved employees to HR</td>
<td>• Present 4 exemplars</td>
<td>• Delegate task to licensed and unlicensed providers</td>
<td>□ Obtain national certification (CN IV—required but can count additional other than in specify)*</td>
</tr>
<tr>
<td>• Validation every year</td>
<td></td>
<td>• Be chair/active participant in unit-based committee</td>
<td>□ Serve as advanced specialty instructor (BLS, ACLS, PALS)*</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>□ Participate in community health service or project*</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>□ Coordinate community health activities/events*</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>□ Participate in community health activity/event*</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>□ Participate in community health education activity/event*</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>□ Participate in education activity*</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>□ Participation regularly as a volunteer*</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>□ Conduct family and patient education</td>
</tr>
<tr>
<td><strong>Hospital M Clinical Ladder Classification</strong></td>
<td><strong>Education and professional requirements</strong></td>
<td><strong>Job responsibility and clinical skills</strong></td>
<td><strong>Professional growth and development (leadership, teacher, advocate, and provider reflected by exemplars)</strong></td>
</tr>
<tr>
<td>---------------------------------------------</td>
<td>---------------------------------------------</td>
<td>-------------------------------------------</td>
<td>-----------------------------------------------------------------------------------</td>
</tr>
</tbody>
</table>
| Clinical Nurse IV (CN IV) (Benner’s Expert) | • BSN + national nursing specialty certification + > 10 years in specialty area + FT (this will not be applicable after 2020) | • Anticipates patient outcomes based on pattern | • Facilitate a health support group*  
• Make professional or health-related presentation*  
• Publish professional or health-related articles*  
• Conduct evidence-based practice/PI/research-related project *  
• Join professional nursing organization*  
• Serve as officer or committee member in a professional nursing organization*  
• Make professional or health-related presentation* |
| | • MSN or higher + national nursing specialty certification + > 6 years in specialty area + FT | • Revises/recommends changes in policies based on clinical observation | |
| | • Other requirements refer | • Teaches patient problem identification and how to document patient problems/needs/diagnosis | |
| | | • Demonstrates use of consistent language in problem statements | |
| | | • Teaches others to use problem statements | |
| | Select 6 | | • CN responsibilities  
• Peer performance evaluation  
• Unit preceptor/mentor  
• Chair/active participant in unit-based council*  
• Chair/active participant in unit-based task force*  
• Mini expert* |
<table>
<thead>
<tr>
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<th>Job responsibility and clinical skills</th>
<th>Professional growth and development (leadership, teacher, advocate, and provider reflected by exemplars)</th>
</tr>
</thead>
</table>
| • Completed portfolio forwarded to CLP peer review committee  
• Review for approval  
• Option to withdraw at any time  
• Denial with rationale to manager and applicant  
• Approval or promotion communicated to manager and applicant  
• CLP peer review committee sends list of approved employees to HR  
• Validation every year | to Portfolio Checklist (Appendix H)  
• 24 contact hours (12 in own specialty) in past 12 months  
• Present 5 exemplars | • Collaborate in effort to lower LOS and reduce hospital cost  
• Assist in evaluation of hospital cost-effective strategies  
• Initiate and implement cost-effective project  
• Collect data, monitor, and evaluate to participate in variance analyses or changes in practices  
• Implement pilot of proposed changes  
• Track and evaluate data collected  
• Orient peers to preceptor role  
• Orient peers to the CN role  
• Mentor role  
• Conduct advanced PI/research activities  
• Initiate changes based on PI  
• Utilize nursing research to assist with change in nursing practice  
• Initiate research/PI project | □ Cross training*  
□ Serve on department or hospital committee*  
□ Serve on department or hospital task force*  
□ Negotiate activity or project with manager or director*  
□ Obtain national certification (CN IV—required but can count additional other than in specialty)*  
□ Serve as advanced specialty instructor (BLS, ACLS, PALS)*  
□ Participate in community health service or project*  
□ Coordinate community health activities/events*  
□ Participate in community health activity/event*  
□ Participate in community health education activity/event*  
□ Conduct education activity*  
□ Participate regularly as a volunteer*  
□ Develop family and patient education materials/programs* |
<table>
<thead>
<tr>
<th>Hospital M Clinical Ladder Classification</th>
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</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td>□ Facilitate a health support group*</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>□ Make professional or health-related presentation*</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>□ Publish professional or health-related articles*</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>□ Conduct evidence-based practice/PI/research-related project*</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>□ Join a professional nursing organization*</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>□ Serve as officer or committee member in a professional nursing organization*</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>□ Make professional or health-related presentation or posters at conferences*</td>
</tr>
</tbody>
</table>

*Note. ADN = Associated Degree Nurse, BSN = Bachelor of Science Nurse, MSN = Master of Science Nurse, CL = Clinical level, ID = identify, S/S = signs and symptoms, Dx = diagnosis, P&P = policy and procedure, CN = charge nurse, FT = full time, PT = part time, LOS = Length of stay PI = performance improvement; * = may repeat x 1. Adapted from Clinical Ladder and Peer Review Program by Georgia Health Science Health System (2012).
APPENDIX C

CLP PARTICIPANT AGREEMENT FORM

Date: _____________

I, _______________________________________, am applying for / maintaining my
Clinical Nurse Level _________ in Hospital M Clinical Ladder Program in nursing. I am
aware of and in agreement with the following terms and conditions:

1. I am participating in this program by my own choice and understand that I am solely
   responsible to meet all requirements associate with my level.
2. I am responsible for obtaining document and signatures as required, and maintain any
   other information that might be needed.
3. I understand that in order to maintain or advance my level in clinical ladder program,
   I must meet annual requirements as listed in the program.
4. I have checked my portfolio for completeness including dates and signatures. All
   contents reflect activities in the past twelve months.
5. I understand if any required item listed on the check list is missing from my portfolio,
   maintenance or advancement of level will be denied and I will not be eligible to
   appeal this decision.

The Professional development council review committee will review the portfolio and
make recommendations based on council’s interpretation of the portfolio for my
advancement within the Clinical Ladder Program.

Signature: _______________________________          Date: ______________________
Name (Print): ____________________________        Unit: _____________________
Chair / Co-Chair / Designee signature: ______________________________________
Date: ____________________________

Adapted from Clinical Ladder and Peer Review Program by Georgia Health Science Health System (2012).
I recommend ______________________________ for promotion / maintenance of CN III / IV without reservation. He / she has demonstrated an exceptional level of consistent performance in all of the following areas:

Job performance:

Communication skills:

Mentoring:

Teamwork:

Positive leadership during change:

Leadership with unit /department:

______________________________________ ____________________
Name of Peers Date

______________________________________           ___________________
Nurse Manager                                                                          Date

Please return completed supporting letter to unit Manager.

Adapted from Clinical Ladder and Peer Review Program by Georgia Health Science Health System (2012).
APPENDIX E

CLINICAL LADDER ASSESSMENT TOOL

Dear Participant:

This questionnaire is designed to measure the effectiveness of clinical ladder programs. By completing this instrument you will provide information that will help determine the outcomes of CLP. Your responses will be kept confidential. Please complete the questionnaire and return it in the envelope provided.

Definition

Please consider the following definition when completing the questionnaire. CLP is a system which recognize clinical expertise and which enables nurses to develop their potential and to be challenged by future learning possibilities, and which attracts and retains qualified nurses in clinical practice.

Instructions

Please complete the general information. Complete your assessment of clinical ladder program by checking the response including the status of the CLP in your hospital.

General Information

Circle the items that best describe your hospital:

Location: Urban Suburban Rural

Size: 400+ 200-399 100-199 1-99

Type: Teaching Hospital Medical Center Community Hospital

Circle the item that describes your clinical area of nursing practice:

Adult medical surgical Adult critical care Emergency
Obstetrics/ gynecology Pediatrics Operating room

Circle the number of steps in the clinical ladder at your hospital:

Two Three Four Five

Circle the item that best describes your position on the clinical ladder:

Entry/ beginner First step Second step Third step- Top of the ladder

Circle your current level of education:

Diploma Associate degree Bachelor of Science, Nursing Master of Science, Nursing

__________ others

Years of experience in nursing ______________________________
<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.1</td>
<td>The clinical ladder expectations were reviewed at my orientation so that I can clearly understand what was expected of me</td>
</tr>
<tr>
<td>1.2</td>
<td>I know exactly what is expected of me at my stage in the clinical ladder program (CLP).</td>
</tr>
<tr>
<td>1.3</td>
<td>I know exactly what I need to do in order to advance on CLP.</td>
</tr>
<tr>
<td>1.4</td>
<td>Each level of the CLP builds upon the skills gained and refined at the previous level.</td>
</tr>
<tr>
<td>1.5</td>
<td>Successful integration of education, practice and research is secondary and optional as I advance in the clinical ladder.</td>
</tr>
<tr>
<td>1.6</td>
<td>I know that my nursing practice is critically examined and validated according to define standards before advancement in the CLP occurs.</td>
</tr>
<tr>
<td>1.7</td>
<td>As I advance in the clinical ladder I will be expected to provide care to patients with greater complexity and intensity of nursing needs.</td>
</tr>
<tr>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>2.1</td>
<td>The CLP allows me to choose the level of involvement that I want to maintain in nursing activities.</td>
</tr>
<tr>
<td>2.2</td>
<td>I believe that the environment created by the CLP encourage me to accept responsibility for the level of sophistication of my clinical skills.</td>
</tr>
<tr>
<td>2.3</td>
<td>The CLP increases my awareness of the need to describe the rationale for my nursing care.</td>
</tr>
<tr>
<td>2.4</td>
<td>The clinical ladder effectively stimulates me to be involved in activities that directly affect patient care.</td>
</tr>
<tr>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>3.1</td>
<td>The job expectations for my respective level in the clinical ladder clearly and accurately describe the work I do</td>
</tr>
<tr>
<td>3.2</td>
<td>The CLP evaluation review provides me with feedback on how well I am doing.</td>
</tr>
<tr>
<td>3.3</td>
<td>The CLP review process increase my awareness of my specific learning needs based on current nursing standards.</td>
</tr>
<tr>
<td>3.4</td>
<td>I have a clear understanding of how expectations for each level of the clinical ladder fits into the overall standards of professional nursing practice.</td>
</tr>
<tr>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>-----</td>
<td>----</td>
</tr>
<tr>
<td>4.1</td>
<td></td>
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<tr>
<td>4.2</td>
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<td>4.3</td>
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<td>4.4</td>
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<td>4.5</td>
<td></td>
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<tr>
<td>4.6</td>
<td></td>
</tr>
<tr>
<td>4.7</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
<th>5. Rewards and benefits are commensurate with levels of practice</th>
</tr>
</thead>
<tbody>
<tr>
<td>5.1</td>
<td></td>
<td>I know the rewards and benefits related to each step in the clinical ladder.</td>
</tr>
<tr>
<td>5.2</td>
<td></td>
<td>I am satisfied with the rewards and benefits associated with advancement in the clinical ladder.</td>
</tr>
<tr>
<td>5.3</td>
<td></td>
<td>I believe that the differentiation of the rewards and benefits incentives for advancing in the clinical ladder are fair and equitable.</td>
</tr>
<tr>
<td>5.4</td>
<td></td>
<td>My advancement in the CLP is accompanied by public and formal recognition within the hospital.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
<th>6. Job satisfaction through recognition for clinical practice</th>
</tr>
</thead>
<tbody>
<tr>
<td>6.1</td>
<td></td>
<td>For me, advancement in the CLP provides a sense of accomplishment and professional satisfaction about my work and choice of a career.</td>
</tr>
<tr>
<td>6.2</td>
<td></td>
<td>A major factor in my continuing employment at this hospital in the CLP.</td>
</tr>
<tr>
<td>6.3</td>
<td></td>
<td>I would not consider employment in a setting that does not have a CLP.</td>
</tr>
<tr>
<td>6.4</td>
<td></td>
<td>When seeking employment one of my priorities would be a hospital with a CLP.</td>
</tr>
<tr>
<td>Yes</td>
<td>No</td>
<td><strong>7. Provide for increased levels of autonomy and decision making</strong></td>
</tr>
<tr>
<td>-----</td>
<td>----</td>
<td>------------------------------------------------------------------</td>
</tr>
<tr>
<td></td>
<td></td>
<td>7.1 Advancement in the clinical ladder will increase my responsibility and decision making as defined by criteria for each level.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>7.2 Advancement in the clinical ladder encourages me to use my personal initiative and judgment in providing nursing care.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>7.3 Increased opportunity for independence and freedom in how I provide patient care are omitted as component of the CLP.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>7.4 Advancement in the clinical ladder encourages me to utilize an increased knowledge base and sophisticated nursing skills.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>7.5 Advancement in the CLP encourages me to be a role model for new nursing staff</td>
</tr>
<tr>
<td></td>
<td></td>
<td>7.6 Advancement in the CLP encourages me to apply advanced clinical practice concepts to improve the quality of nursing care I provide.</td>
</tr>
</tbody>
</table>
APPENDIX F

CLP: PORTFOLIO CHECKLIST FOR CN III AND CN IV

Name: _____________________________ Employee number: ________________

Hospital e mail address: _____________________________ Shift: ______________

Hire date: _________________ Contact phone number: ______________________

School of nursing attended: _________________________ Date graduate: _________

Clinical Nurse Level application and portfolio type

- [ ] CN III  - [ ] CN IV  - [ ] Application  - [ ] Maintenance

Nurse Manager/Director: _____________________________ Unit: ________________

**Application components:** Submit all requirements listed in portfolio. Check appropriate portfolio. Any required items missing in the portfolio will be denied.

**Advancement Portfolio required items**
- [ ] Signed copy of agreement form
- [ ] Resume
- [ ] Job responsibility (supported by examples)
- [ ] A.D.N. with national certification, BSN, MSN
- [ ] Nurse manager /director letter of recommendation (see Appendix I)
- [ ] Peer support letters (2) (see Appendix J)
- [ ] Contact hours (CN III -16, CN IV- 24) within 12 months
- [ ] Exemplar (CN III - 4, CN IV - 5)
- [ ] Human resource verification of at least part-time commitment (one year for CN III, 2 year for CN IV)
- [ ] National certification (Required for CN IV)
- [ ] Leadership activities (listed below)

**Maintenance Portfolio required items**
- [ ] Signed copy of agreement
- [ ] Signed and dated manager/ director letter of recommendation (may reuse with updated signature and date)
- [ ] Contact hours (CN III -16, CN IV- 24) within 12 months
- [ ] Exemplar
- [ ] National certification (Required for CN IV)
- [ ] Leadership activities (listed below)
Leadership activities (CN III- 4, CN IV-6)

- Charge Nurse responsibilities
- Peer performance evaluation
- Unit preceptor/mentor
- Chair/active participant in unit based council
- Chair/active participant in unit based taskforce
- Mini expert
- Cross training
- Serve on department or hospital committee
- Serve on department or hospital taskforce
- Activity or project negotiated with manager or director
- National certification (CN IV requirement)
- Advance specialty instructors (BLS, ACLS, PALS)
- Participate in a community health service or project
- Coordinate Community Health activity/events
- Participation in community health activity/event
- Participate in a community health education activity/event
- Education activity
- On-going participation as a volunteer
- Family and patient education materials/program
- Facilitate a health support group
- Professional or health related presentation
- Publish professional or health related articles
- Evidence based practice/PI/research related project
- Membership of professional nursing organization
- Officer or committee position in a professional Nursing Organization
- Professional or health related presentation or posters in conferences

*Denotes activity that may be repeated for this application.

Adapted from Clinical Ladder and Peer Review Program by Georgia Health Science Health System (2012).
APPENDIX G

TABLES OF EVIDENCE
## Evidence Quantitative Studies

<table>
<thead>
<tr>
<th>Purpose (Author(s), Year)</th>
<th>Design &amp; Key Variables</th>
<th>Sample &amp; Setting</th>
<th>Measurements, Operational Definitions of Variables</th>
<th>Result or Findings</th>
<th>Authors' conclusions; limitations</th>
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<tr>
<td>Determine whether CLP and non-CLP RNs differ on: job satisfaction, role engagement, and to understand barriers to CLP participation. (Nelson &amp; Cook 2008)</td>
<td>Quantitative Descriptive. IV : CLP DV: Job Satisfaction, role engagement, leadership activities, PI activities, preceptorship activities, knowledge and attitude regarding CLP. Benner’s novice to expert framework.</td>
<td>45 CLP RNs (average age 51) (average year of service 12.9). 23 non-CLP RNs (average year of service 9.5). Sample matched to control confounding job role. EC-year of service &lt; 1 year. Primary care 25%, specialty area 29%, case managers 38%, others 7%. Setting: KPCO</td>
<td>Anonymous survey with a 5-point Likert-type scale (validated by expert consensus) via Survey Monkey. Factor analysis establishes the survey’s construct validity. (p. 355) Measure job satisfaction, role engagement, leadership, PI, preceptorship activities &amp; knowledge &amp; attitude toward CLP.</td>
<td>CLP not associated with job satisfaction: p = 0.16. CLP affects Leadership activities: p = .02. PI activities: p = .02. Preceptorship activities: p = 0.001. CLP is associated with ↑ knowledge of CLP: p &lt; 0.001 → positive attitude toward CLP. p &lt; .001. CLP not associated with manager support. (P. 357)</td>
<td>NS difference in job satisfaction between CLP and non-CLP RN in the same job role. CLP RNs more involved in leadership, PI and preceptorship activities. CLP RNs have stronger beliefs in the CLP philosophy, knowledge and perceived benefits. CLP participation not correlated with nurse manager support. Limitations: Self-report using new instrument with untested reliability and validity. Survey sent via e-mail; nurses might not check or read. Note: Job satisfaction is not affected by CLP. Union-facility. AC unit.</td>
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<td>Evaluate satisfaction with a CLP for RN in 3 distinct tracks: education, clinical &amp; management. (Korman &amp; Eliades 2011)</td>
<td>Quantitative descriptive survey design. IV: 3 track CLP: educational, clinical, management. Educational level, level of advancement. DV: Participant satisfaction &amp; retention. Benner’s Novice to expert framework.</td>
<td>174 RNs who participated in the C.A.R.E. Ladder. ACH</td>
<td>UEXCEL evaluation questionnaire survey with 22 items in a Likert-type scale measure job satisfaction, retention. Content validity and high reliability (p. 262) Revised (name change) instrument (p. 263)</td>
<td>78% surveys return, rate. 66.9% are BSN or higher, 68.4% are on clinical track, 60.3% CLIII. NS difference in education / track level. Satisfaction score = 83.5 / 100 Overall satisfaction on each item = 3.6 / 5 (somewhat agree) Sense of accomplishment score = 4.16 / 5 NS difference in overall satisfaction score related to nursing education degree (p=NA). NS difference in CL (only looked at III &amp; IV) advancement related to satisfaction. RN in educational track had highest satisfaction scores regardless to CL advancement as compared to RNs in clinical/management track (p = .03).</td>
<td>RNs satisfied with the three tracks CLP. CLP provides opportunities to acquire knowledge, skills lead to recognition. Provide a sense of career accomplishment &amp; satisfaction. CLP RNs view program positively regardless of education preparation, level of advancement, or selected track. Limitations: possible researcher bias (researchers worked at ACH). Generalize ability may be limited due to response rate. Note: NS difference of satisfaction except MSN (p=.03). Did not look at non CLP RN. Financial information: ($730 budgeted /CLP RN / year but replacing an RN is about $ 82K-88K) - importance to retain.</td>
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</table>
| Purpose (Author(s), Year) | Design & Key Variables | Sample & Setting | Measurements, Operational Definitions of Variables | Result or Findings | Authors’ conclusions; limitations
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<td>Measure RNs perceptions of current CLP &amp; identify satisfiers to ↑ participation (Riley et al., 2009)</td>
<td>Quantitative, descriptive, non-experimental. IV: 3 levels CLP with 4 tracks-clinical, leadership, education &amp; research. (Benner’s Model) DV: level of satisfaction related to accountability, clinical performance, rewards, professional growth, job satisfaction, autonomy, and decision making. Benner’s Novice to expert framework</td>
<td>1,850 CLP RNs, 94% female, from 43 clinical + specialty units. IC: Bedside RN 800-bed, tertiary care, teaching hospital in southern US.</td>
<td>Modified Strzelecki CLP assessment questionnaire (anonymous) 5-point Likert measures RNs’ perception on CLP: recognition, satisfaction, professional growth &amp; financial gain, autonomy, decision making, accountability, recognition, ID incentive &amp; barriers</td>
<td>41% response rate. High participation from specialty area (CL II &amp; III). 42% respondents are BSN. 47% ADN. 28.5% 1-5 years of experience, 25% 6-10 years. 85.75% RNs know pay ↑ as CL advances. CLP RNs rated salary incentives with ↑CL (mean, 4.2 on 5 point Likert scale). The availability of CLP was not a major factor in continued employment (range, 2.62-2.85 on a 5 point Likert scale). Recognition by peers on their unit rated (range, 3.73-3.96 on a 5 point Likert scale) ID barrier of CLP is described as “unknown time commitment beyond scheduled work” rated (mean, 3.72 on a 5 point Likert scale) (p. 184-185).</td>
<td>CLP RNs perceived satisfiers: overall peer recognition, professional growth, money &amp; own satisfaction. Perceived barrier: time investment beyond work is needed. Limitation: Participation varies across units. Variability – managers giving out &amp; collecting surveys- inconsistency in participation. Note: Good insights on construct of CLP, No Statistical power to support. Transferability uncertain. Bedside RN only. Mostly BSN. Manager plays a role. Financial incentive rated high. Recognition rated high. Both associated with final satisfaction.</td>
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<td>Evaluate reasons, experiences &amp; benefits associated with CLP. (Bjork et al., 2007)</td>
<td>Quantitative Cross-sectional survey design. Data analyzed by descriptive &amp; inferential statistics. IV: CLP DV: perceived benefits such as job satisfaction, recognition, retention &amp; better care.</td>
<td>Purposive sampling RNs that are or had participated in CLP. 541 RNs at 4 hospitals that had CLP in place in Norway.</td>
<td>Survey questionnaire measures demographic, background. Index for Work Satisfaction part A &amp; B (24 items) measure job satisfaction &amp; clinical decision making (results include non-CLP participants). CLP Experts constructed evaluative questions based on a 2004 study to address retention, use of competence &amp; benefits. Rate 12 reasons for joining by Likert scales with +/- response.</td>
<td>26 % return rate 40% engaged in some form of continuing education for the past 6 month to 1.5 years. Self-motivations &gt; external motivations. Organized unit participation is important ($p \leq .01$). ↑ CL; ↑ value organization, ↑ Personal &amp; professional benefit ($p &lt; .001$). ↑ Competency ($p &lt; .001$). ↑ Patient care quality ($p &lt; .001$). ↑ Initiate nursing activities ($p &lt; .001$) ↑ Look up databases ($p &lt; .01$). ↑ Collaborate with other units ($p &lt; .01$). ↑ PI activities ($p &lt; .005$). ↑ Coaching &amp; precepting ($p &lt; .05$ - .005) ↑ Resource for supervisor ($p &lt; .05$) ↑ Willing to stay &gt;1 year only in CL 2 ($p = NA$) (p. 92-93).</td>
<td>RNs intrinsic motivation drives professional development. Managers – important role to facilitate &amp; support. CLP RNs perceive the importance of better patient care. ↑ CL, ↑ learning effect and use of competence. Longer in the CLP → ↑ retention. CLP ↑ motivation in work. CLP provides professional &amp; personal benefits for participants. Perceive themselves as more engaged &amp; proactive. Limitations: new instrument reliability. Note: construct validity weaken by instrument. Population may be generalizable in my setting. Findings are similar to the States.</td>
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<td>Assess CLP &amp; non-CLP RNs’ attitudes toward the CLP.</td>
<td>Quantitative</td>
<td>130 CLP RNs-219 Non-CLP</td>
<td>PNCL Instrument: 25-item modified Likert scale measure attitude</td>
<td>CLP participants: experienced, day shift and FT RNs. NS differences found in education level or degrees, RNs close to retirement age do not perceive benefits of CLP. CLP RNs have ↑positive attitude + ↑knowledge toward program ($p &lt; .001$) (p. 6) Benefits: financial incentives &amp; professional recognition lead to retention. Barriers: Time constraints, family commitments &amp; eligibility requirements.</td>
<td>Evidence: Most RNs- positive attitude toward CLP. CLP participants &amp; non participant responded positively job satisfaction (83%) and retention indicators (68%). Limitations: convenience sample with modest response rate (39% + not all questions answered). Note: + response toward job satisfaction + retention. Turnover rate drop from 8.33% (2007) to 1.96% (2012) after implementation.</td>
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<td>Examine: 1. Perceived barriers &amp; benefits 2. Relationships between participation, job satisfaction, retention 3. Determine predictors of participation. (Tetuan et al., 2013)</td>
<td>Cross-sectional study IV-3-levels CLP DV-perceived benefits &amp; barriers. Job satisfaction, retention. Benner’s Novice to expert framework</td>
<td>586-bed acute care hospital and the clinic in northeast Kansas. Data collected 11/15/2008 to 12/19/2008</td>
<td>(Cronbach’s $\alpha = .961$) (p. 6) 8-item modified Likert scale measure job satisfaction (Cronbach’s $\alpha = .899$) (p. 6) 1-item measure retention 24-items measure benefits &amp; barriers 8-items measure organization purpose 9-items measure demographic data</td>
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<td>Explore relationship between RN job satisfaction/CLP/intent to stay. (Bjork et al., 2007)</td>
<td>Quantitative Cross-sectional survey design. IV: CLP, further education, time for professional development. DV: Job satisfaction Intent to stay</td>
<td>4650 Clinical RNs IC- must be at least part time employee 4 Hospitals in Norway (had established CLP before year 2000).</td>
<td>A questionnaire – 4 sections: Demographic, background variables. IWS-7 Likert scale (Cronbach’s α=.86 to measure pay) (Cronbach’s α=.44 for professional status), all other subscale 0.66-0.78) measure satisfaction + intent to stay. 24 items question measures clinical decision Measure the perception + evaluate of the CLP</td>
<td>RNs mean age 37.5 (range 21-72); male (7.9%); married with children (46.8%); avg. year of experience 8.5; with continuous education (47.1%), 28.3% participate in CLP. Significant differences in job satisfaction ↑RN to RN interaction (p = .03) or &gt; 1 day of professional development (p = .002) Table 3. Comparing which is rank # 1 that affects job satisfaction: #1 is pay # 2 autonomy. NS differences between CLP with satisfaction. Older RNs ↑ education satisfaction, RN going for professional development will ↑ intention to stay.</td>
<td>Participate in CLP did not ↑ job satisfaction. CLP promotes professional development and ↑ retention. Limitations: internal consistence &amp; reliability on the IWS subscale. Factor analysis 45.5% response rate also noted Note: authors compare findings with 10 studies (1992-2005) &amp; found similar result. (Table 3 on p. 753). CLP is indirectly related to job satisfaction but ↑ professional growth &amp; ↑ retention.</td>
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*Note. ACH = Akron Children’s Hospital; ADN = Associate Degree Nurses; BSN = Baccalaureate-prepared Nurses; C.A.R.E. = Career Achievement and Recognition of Excellence; CL = clinical level; CLP = clinical ladder program; DV = dependent variable. EC = exclusion criteria; EOM = Essentials of Magnetism; FT = full time. IC = inclusion criteria; ID = identify; IRB = Institutional Review Board; IV = independent variables; IWS = the Index of Work Satisfaction; KPCO = Kaiser Permanente of Colorado; MSN = Master prepared Nurses; NA = not available; NS = not significant; PI = performance improvement; PNCL = Professional Nurse Contribution Ladder; RN = registered nurses; SG = shared governance. UEXCEL = University Hospital’s Focus on Nursing Excellence in Clinical Care, Education & Leadership.*
### Evidence Qualitative, Quantitative (Mixed-Methods) Studies

<table>
<thead>
<tr>
<th>Statement of Problem, Aims &amp; Research Questions (Author(s), Year)</th>
<th>Design, Variables or Conceptual Theoretical Underpinnings</th>
<th>Sample &amp; Setting</th>
<th>Data Collection Process, Data Management &amp; Analysis</th>
<th>Result or Findings</th>
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<td>Determine characteristics &amp; components of a viable SG structures that allow RN to control practice which will enhance practice, work environments, nurse satisfaction and retention &amp; quality of patient care. (Kramer et al. 2008)</td>
<td>Qualitative – predominantly. Non-experimental descriptive design (Mixed methods). Grounded theory of CNP utilized. (Kramer &amp; Schmalenberg, 2003, 2004). Shared Governance Model as infrastructure. Qualitative-DV-empowerment IV-CNP</td>
<td>Strategic sampling for identification of high-scoring clinical units. 55% of all RNs, 60% BSN, 23% managers, 59% MSN or higher. 206 units from 8 highest scoring magnet hospitals of the country.</td>
<td>Qualitative: Tape-recorded semi structured interviews using “Consensus of expert” interviews + open ended questions 26 Observations of the participants by primary investigators @ departments and meetings. Constant comparative analysis of interview + observations. Quantitative-CWEQII empowerment tool-19 items measure (5 point Likert) structure attributes that lead to empowerment. EOM tool measures input rating &amp; decision making that reflect CNP</td>
<td>Themes ID: SG &amp; CLP enables CNP. Allows access to power, participation, recognition, accomplishment &amp; EBP initiatives. Viable SG with CLP leads to CNP facilitation. Advancement on the CLP promotes CNP by offering professional recognition per leaderships &amp; RNs. Pertinent quantitative result: Be able to access to line of power (empowerment) which indirectly relate to job satisfaction is significantly higher in an integrated SG model with CLP structure (p ≤ .001) (p.551)</td>
<td>Viable SG (meaning the SG system is integrated throughout the hospital) &amp; CLP enhance CNP. Limitation: not discussed. Note: all 8 magnet hospitals had SG and CLP that promote CNP. Professional recognition is associated with CLP &amp; valued by CLP RNs. This will be useful for my facility since the CNO’s vision is toward Magnet status.</td>
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<td>Determine if CLP meets the needs of participants; if the process supports professional practice, and assess needs for revision. (Ward &amp; Goodrich, 2007).</td>
<td>Qualitative, Descriptive study to evaluate current CLP. CLP-4 levels based on Benner’s Novice to expert framework.</td>
<td>Convenience sample 960 RNs in CLP. Diploma RNs (54%), CL II (55.6%), Community hospital in central Virginia.</td>
<td>Anonymous survey: The Clinical Ladder Assessment Tool (SPSS descriptive analysis) with Likert scales + open ended questions to measure effectiveness of CLP, area of practice, CL, years of experience, clinical competence, accountability, professional growth, reward/benefits, job satisfaction, recognition, autonomy &amp; decision making. Reasons to motivate advancement.</td>
<td>CLP stimulate ↑ accountability &amp; responsibility ↑ CL ↑ professional view. ↑ Decision making opportunity. 90% CL III &amp; IV RN perceive CLP encourages them to become role model &amp; mentor for new RN. 80% CL III &amp; 78% CL IV RN perceive CLP ↑ care quality, ↑ accountability. 75% agree CLP ↑ Professional satisfaction 100% respondent ID financial incentive as #1 most important factor for seeking advancement &amp; recognition as #2. Barriers: Time constraint, tedious process &amp; lack management support.</td>
<td>Needs education for CLP, r/t advancement &amp; criteria. Department reference manual, on line power point education for applicants &amp; e-instruction on how to access-helpful. Manager’s support staff’s application-key. Formal recognition requested. Limitations: unreliable delivery of survey. ↓ Response: due to anonymity issues. Note: CLP-process and criteria need to be clear and easily accessible. Management support - key!</td>
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<td>ID satisfiers &amp; dissatisfiers of RNs, determine barriers accessing the advancement process, and modify the infrastructure to encourage more activity on CLP &amp; retention. (Goodrich &amp; Ward, 2004)</td>
<td>Mixed method: Quantitative &amp; qualitative IV – CLP DV- Satisfaction, attitude, pay, autonomy, task requirements, policies, interaction &amp; professional status.</td>
<td>Quantitative-convenience sample of 1,021 RNs with 282 responders. Qualitative-purposive sample of CLP RNs in CL II, III, IV + managers Non-profit healthcare system (2 acute care hospitals + 2 long term care facilities) in Virginia, USA.</td>
<td>Quantitative- Descriptive statistics was utilized. IWS instrument (mail, anonymous) to evaluate level of RNs work satisfaction with 7 component-Likert scale measure attitude + 15 items providing information regarding salary, autonomy, task requirements, policies, interaction &amp; professional status. 4 open ended questions regarding advancement process of CLP Qualitative- 6 open ended questionnaire by A. W. Schultz 1991. Taped interviews.</td>
<td>55% diploma RNs. 32% BSN, 9% ADN, 4% MSN. &lt; 1% doctorate. 1% CL I. 70% CL II, 21% CL III, 1% CL IV. IWS results- Rating of importance: 1. ↑ Paid = ↑ satisfaction, 2. Autonomy, 3. Professional status. Common themes: the process is overwhelming, pay ≠ ↑ responsibilities, personal obligation is a barrier, revision is needed for the process, CLP advancement ≠ patient care delivery improvement, and CL III &amp; IV need to share expertise across the organization.</td>
<td>Evaluate the CLP advancement process regularly. CLP advancement criteria should have measurable outcomes. Leaders-essential facilitators Limitations: Researchers work in the organization → researcher bias. ↓ Response rate (28%) Note: have similar sample population as my facility. Financial incentive &amp; recognition is KEY! Administration support needed for success.</td>
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Note. CLP = Clinical Ladder Program; CL = Clinical Level; CNO = Chief Nursing Officer. CNP = control of nursing practice. COO = Chief Operating Officer. DV = dependent variable; EOM = Essentials of Magnetism; ID = identify; IRB = Institutional Review Board; IV = independent variable; IWS = the Index of Work Satisfaction; MD = medical doctor. MSN = Master prepared nurses, RN = Registered Nurse; SG = shared governance.
### Individual Evidence Summary

<table>
<thead>
<tr>
<th>Titles (Author(s), Year)</th>
<th>Key Findings</th>
<th>Authors’ conclusions NOTE</th>
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<tr>
<td><strong>Benner Framework for CLP</strong></td>
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<td>From Novice to Expert (Benner, P. 1982)</td>
<td>5 levels of proficiency: Novice, advance beginner, competent, proficient and expert. Using Dreyfus model of acquisition as her framework. Describe skills acquisition of each stage.</td>
<td>Dreyfus model of skill acquisition, applied to nursing + an interpretive approach describing nursing practices, offers guidelines for career and for knowledge development</td>
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<td>Using the Dreyfus Model of Skill Acquisition to Describe and Interpret Skill Acquisition and Clinical Judgment in Nursing Practice and Education. (Benner, P. 2004)</td>
<td>Further delineate the understanding of novice to expert. Nurses with a range of experience and reported skillfulness were interviewed. Studies using nurses’ narrative accounts of actual clinical situations + observation and interviews. The skill of involvement + moral agency development are linked with the expertise development and change as the nurse becomes more skillful. Nurses do not progress to expert level when: difficulty with understanding the true meaning of practice/ difficulty with interpersonal skills/ difficulty with problem engagement.</td>
<td>Allows further understanding how the Dreyfus model operates under complex and fast-paced organizations. The Dreyfus model is useful for understanding the learning needs and learning styles at different levels of skill acquisition.</td>
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| **Goals and Objectives** | Literature review globally of CLP  
History of CLP.  
Theoretical underpinnings: Benner’s Novice to Expert Model (worldwide).  
Use of CLP: reward RNs, improve recruitment, retention and productivity.  
Most hospitals utilizing 3 or 4-level (majority) CLP.  
Key number of measures in CLP: educational attainment, professional experience and leadership skills.  
Most Hospitals place heavy emphasis on participation in continuing education, clinical expertise, communication skills and participation in research and peer evaluation.  
CLP increases job satisfaction for nurses on CL II to IV.  
CLP enhances retention; improvement of patient care reported by patients.  
Most hospitals use an evaluation committee (managers and clinicians) to assess progression; peer review is often emphasized as a major element in the assessment process.  
Evaluation focus on retention rate and job satisfaction by survey. | Hospital uses CLP after structure or personnel reform.  
The main claimed benefits of using CLP include improved retention, productivity, and job satisfaction worldwide.  
Recommendations: review or revise design of CLP after a period of implementation.  
Note: Nice comparison and synthesis of CLP in different countries. |
| **Twenty years of experience with a Clinical Ladder: a tool for professional growth, evidence-based practice, recruitment, and retention (Pierson et al., 2010)** | Institute a CLP in a 257-bed hospital 20 years ago and track its progress.  
CLP goals are to enhance recruitment and retention, professional development, and evidence-based practice initiatives.  
Theoretical underpinnings: Benner’s Novice to Expert Model  
CLP-5 CL.  
Six major categories essential to the program: Education, experience, professional and leader, provider, teacher & advocate + exemplars.  
Using point system to rate education level.  
Align CLP with Magnet. | CLP participants express a sense of professional accomplishment + personal satisfaction → confidence to reach out other ways professionally. Effective tool in succession planning.  
Note: Magnet + point system |
| **Job Satisfaction / Retention** | Job satisfaction related to retention  
Definition of job satisfaction included + related theories  
Sources of satisfaction identified: related to CLP – pay, education and professional development, recognition, autonomy, leadership. | More research is required.  
Satisfied job = Retention  
Job satisfaction is related with rewards.  
Job satisfaction related to unfulfilled expectations @ work. No effective evidence-based proof that model or framework can improve nurses’ job satisfaction.  
Note: useful during literature review. |

*Note: CLP = Clinical Ladder Program; CL = Clinical Level*
APPENDIX H

PERMISSION TO USE CLINICAL LADDER ASSESSMENT TOOL

From: Strzelecki, Sarah [mailto:Sally_Strzelecki@chs.net]
Sent: Wednesday, April 09, 2014 4:10 PM
To: Lee, Anne
Subject: RE: Permission to use

Anne, you have my permission to use the Clinical Ladder Assessment Tool in your research. Please share your findings with me after you complete the implementation. As agreed I have attached a scanned copy of the original document. Best wishes with your research.

Sarah Strzelecki | Chief Nursing Officer | Assistant Facility Privacy Officer | Phoenixville Hospital | 140 Nutt Road | Phoenixville, PA 19460 | Tel: 610-983-1299 | Fax: 610-983-1296 | Sally_Strzelecki@chs.net

From: Lee, Anne [mailto:Anne.Lee@methodisthospital.org]
Sent: Wednesday, April 09, 2014 7:06 PM
To: Strzelecki, Sarah
Subject: Permission to use

Dr. Strzelecki,

Thank you for talking to me on the phone. My name is Anne Lee and I am a student attending the DNP program at California State University, Fullerton. My culminating project is to develop a clinical ladder program for the hospital I am working in. In the project, I recommend using the Clinical Ladder Assessment Tool as an evaluation tool one year after implementation. This e-mail is to ask for your permission so I can use this tool. Thank you for your time.

Anne Lee MSN, RN, NE-BC
Manager, Cardiac Services.
Cell xxx-xxx-xxxx
APPENDIX I

NURSE MANAGER SUPPORT LETTER TEMPLATE

I recommend ______________________________ for promotion/maintenance of CN III/IV without reservation. He / she has demonstrated an exceptional level of consistent performance in all of the following areas:

Job performance:

Communication skills:

Mentoring:

Teamwork:

Positive leadership during change:

Leadership with unit/department:

________________________________________  ___________________
Nurse Manager  Date

Adapted from Clinical Ladder and Peer Review Program, by Georgia Health Science Health System, 2012, retrieved from http://connection.georgiahealth.edu
APPENDIX J

CLINICAL LADDER IMPLEMENTATION TIMELINE

<table>
<thead>
<tr>
<th>Year</th>
<th>Event</th>
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<tr>
<td>2016</td>
<td>Dec</td>
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- **Formation of PDC. CLP conception**
- **Submit for Budget approval Fiscal 2016**
- **Present proposal to Nursing executive, other executive team and board of directors for approval. (CLP on hold)**
- **House-wide educating staff regarding CLP.**
- **PDC review committee credentialing process team credentialing**

- **PDC Select Benner’s framework for CLP**
- **4 clinical levels CLP finalized. PDC review committee formation. Present to Advisory Council**
- **Agreement, Portfolio, Hand-book in place. Ready for staff.**
- **Implement CLP Accepting application**
- **Program evaluation**