Southern California CSU DNP Consortium
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CLINICAL LADDER
PROGRAM EVALUATION

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

By
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ABSTRACT

As early as the 1960s, nursing leaders have recognized the need for hospitals to have a mechanism to retain and recognize talented nurses at the bedside for patient safety, to improve patient outcomes, and for nurse retention and satisfaction. One method of accomplishing these outcomes is a clinical ladder program (CLP). The Medical Center first introduced the CLP to the nursing team in 2014. Of the 900 eligible nurses, only 174 submitted applications by the December 2014 deadline. In addition, reviews of the CLP application documents at the Medical Center revealed that of the 174 applicants, 33 applicants did not qualify for any level on the CLP. This low rate of successful applications warranted a formal program evaluation to determine barriers nurses perceived to making application to the CLP. The purpose of this project was to conduct a formal program evaluation of the Medical Center’s CLP by me, the Medical Center’s Chief Nursing Officer. The program evaluation was administered to all nurses deemed eligible to apply to the CLP. Qualitative and quantitative methods were used to gather data and the findings identified issues such as lack of management support, lack of time, money, recognition, and an inconsistent review process. The identified issues in presentation and implementation enabled the design committee, charged with developing and administering the CLP, to make changes in the program based on nurses’ feedback. Changes were made to the CLP prior to the 2015 fall enrollment period. In comparing
the fall application period of 2015 to that of the fall of 2014, there was an increase from 15% successful applications in 2014 to 22% successful applications in 2015.
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BACKGROUND

As early as the 1960s, nursing leaders have recognized the need for hospitals to have a mechanism to retain and recognize talented nurses at the bedside for patient safety, to improve patient outcomes, and to improve nurse retention and nurse satisfaction (Ward & Goodrich, 2007). One method of accomplishing these outcomes is a clinical ladder program (CLP). The goals of the CLP are to enhance professional development, improve nursing responsibility and commitment to organizations, and promote nursing excellence (Ward & Goodrich, 2007).

Since the opening of Hospital A (a pseudonym) in 1983 and the opening of Hospital B (a pseudonym) in 1991, both facilities (referred to as the Medical Center) have recognized the promotion of nurses through the traditional administrative track. This process had the potential to negatively influence patient care by taking the best and most talented nurses from the bedside. Nursing leaders at the Medical Center recognized the need to promote a higher standard of patient care and to recognize bedside nurses’ expertise.

The concept of the CLP for the Medical Center was introduced to the nurses in 2013. It was accepted by the nursing union during negotiations that same year. A committee was convened to develop the CLP. Members from each nursing unit were invited by the Chief Nursing Officer (CNO) to participate on the development committee. The nursing union and nursing leadership were each able to designate four members to participate on the committee.

The committee met for 6 months to develop the program. The committee work entailed program development, nursing eligibility guidelines, qualifications for each level
on the CLP, and development of the application process. The committee studied and was influenced by the work of Patricia Benner. Benner adapted the Dreyfus model of skill acquisition to the careers of nurses (Benner, 1982). After the committee felt they had developed a strong program, they presented it to the Medical Center’s nursing governance council for final approval. Nurse leaders, along with members of the development committee, then started to market the CLP to all eligible nurses. Eligible nurses had between October 1, 2014, and December 31, 2014, to submit an application by completing a portfolio with evidence of their professional accomplishments. Of the 900 eligible nurses, only 174 had submitted applications by the December 31, 2014, deadline. Thirty-three of the applicants did not qualify for any level on the CLP.

**Problem Statement**

CLPs were designed to enhance professional development, provide a reward system for quality clinical performance, promote quality nursing practice, and improve satisfaction among nurses and patients (Nelson & Cook, 2008). It was hoped that the CLP would accomplish some of these outcomes for the Medical Center. However, of the Medical Center’s 900 eligible nurses, only 15% successfully completed an application for the initial CLP. This low rate of successful applications, along with 50% of the Medical Center’s nursing units scoring less than the American Nurses Credential Center’s national benchmark on nursing sensitive indicators, warranted a more formal program evaluation.

**Purpose Statement**

The goal of this Doctorate of Nursing Practice project was to complete a program evaluation of the Medical Center’s CLP. The aims of this program evaluation were to help determine: (a) whether the program was meeting its goals of improving nurse
satisfaction, (b) the strengths and weakness of the existing program, (c) the nurse’s perceptions of the program and barriers to making application to the CLP, and (d) whether the program was having an impact on patient satisfaction goals.

**Significance of the Project**

The Medical Center is seeking Magnet status, which involves meeting a variety of benchmarks, including having 80% of the clinical nurses at a Bachelor of Science in Nursing (BSN) level, having clinical nurses involved in research, and increasing the number of certified nurses in the organization, all of which would be supported by a CLP. The Medical Center’s nursing leadership had campaigned for the CLP acceptance by the governing board and the nursing union, with the hopes of improving nursing engagement and satisfaction scores and rewarding and recognizing talented nurses at the bedside. The Medical Center has made a large financial investment of resources into planning and setting up the program. As the CNO of the Medical Center, it was important for me to understand why there was such a low rate of successful applications among the Medical Center’s 900 nurses. I believed a program evaluation would contribute to an understanding of the current weaknesses of the program so that these weaknesses could be adequately addressed prior to the window for 2015 applications opening.

**Program Evaluation Plan**

The plan was to begin this program evaluation by performing a review of the literature to determine a valid and reliable tool to be used. Once a tool was found, permission to use the tool was sought from the author. Two potential tools were located, the first developed by Nelson and Cook (2008) and a second developed by Korman and Eliades (2010). These tools were potentially useful in that Korman and Eliades (2010)
and Nelson and Cook (2008) have reported content validity and high reliability with the CLP evaluation tools. Another goal of this program evaluation was to gather and analyze data through the use of qualitative and quantitative methodology to help determine the reasons why some nurses chose not to apply to the CLP. The data gathered from this project were used to help modify the existing CLP. The goal was to complete these modifications before the next CLP enrollment period.

**Theoretical Framework**

The Institute for Healthcare Improvement model for improvement (Langley et al., 2009), was chosen to help guide this program evaluation (see Figure 1). Because this was a quality improvement project, the model for improvement was identified as a tool that could be used for accelerating improvement. The model uses the Plan-Do-Study-Act (PDSA) steps for documenting a test of change. This model tests change by developing a plan to test the change (Plan), carrying out the test (Do), observing and learning from the consequences (Study), and determining what modifications should be made to the test (Act; Holly, 2014). An additional benefit to using this is that it is a model currently being used at this Medical Center and is familiar to the clinical ladder development committee and the writer.

The first step of this model is *Plan*. This included a literature review of best practices of CLP evaluations and completion of a table of evidence. The second step of this model is *Do*. This involved a program evaluation tool being administered to the Medical Center’s nurses to determine barriers they faced in making application. The third step of this model is *Study*. Data analysis from the evaluation tool was shared with the clinical ladder design team for discussion and action planning. The fourth step of the
Figure 1. Model for improvement.
model is Act. Program modifications were made to the clinical ladder based on data analysis review. The revised clinical ladder was presented to the Medical Center’s nurses in the fall of 2015. The application period for 2015 opened on October 1, 2015, and remained open until December 31, 2015.
REVIEW OF LITERATURE

To assure a complete review of the literature, a professional librarian was consulted from the Medical Center’s medical library. The literature review for this project was conducted utilizing the Cumulative Index to Nursing and Allied Health (CINAHL), PubMed, Medline, Cochrane Library, and Google Scholar. The databases were accessed via the Pollak Library at California State University, Fullerton, and the Medical Center’s library. The search strategy used the following terms and combinations: clinical ladder, program evaluation, Magnet, nursing unions, foreign trained nurses, mentorship, job satisfaction, clinical competence, professional development, career advancement, intent to stay, personnel retention, career mobility, professional portfolio, professional autonomy, and shared governance. The search was limited to peer-reviewed articles written in the English language in the last 10 years. Studies were also searched by using reference lists and bibliographies.

Analysis of the literature for CLPs and their evaluations was found to be primarily descriptive rather than evaluative. Authors would use clinical ladder and career ladder interchangeably. These descriptive studies encompassed the following categories: examination of nurse satisfaction, barriers to application, and benefits of gaining professional recognition. In addition, the following themes were found: Patricia Benner, Plan-Do-Check-Act (PDCA) model, program evaluation, and international trained nurses.

Nurse Satisfaction

Korman and Eliades (2010) reported a relationship between nurse satisfaction scores and higher advancement on the clinical ladder. Respondents agreed that advancement on the CLP provided a sense of accomplishment and professional
satisfaction. Their quantitative study described nurse satisfaction in a CLP comprised of clinical, education, and management tracks. They asserted that clinical ladders are one mechanism in creating an organizational climate that encourages retention of registered nurses. Nelson and Cook (2008) described finding higher satisfaction rates among specialty trained nurses and no significant difference in job satisfaction between primary care career ladder nurses and noncareer ladder primary care nurses with at least 1 year of experience on the job. Bjørk, Hansen, Samdal, Tørstad, and Hamilton (2007) reported nurses’ intent to stay at their current employment increased as they moved upward on the CLP. Uncertainty about staying at the hospital was greatest among level 1 nurses. The literature supports the belief that nurses who participate in a CLP are generally more satisfied with their jobs than nonparticipants, which has implications for long-term retention of experienced nurses.

**Barriers to Application**

Zehler, Covert, Seiler, Lewis, and Beery (2015) reported barriers to application as lack of time due to family obligations, personal education goals, and time away from patient care. Nurses in their study also reported money as a barrier. Nurses felt the amount of time required in pursuing the clinical ladder was not reflected in the additional pay they would receive. It was also noted in this study that nurses felt the process for application was confusing and lacked clarity. In addition, several nurses criticized their managers for not supporting their application, showing lack of engagement in the process and not providing coverage for the nurse to attend required committee meetings. Another barrier identified in the study of Ward and Goodrich (2007) was nurses having too many
personal time constraints to make application to the CLP. The participants in this study also shared the perception that the advancement process itself was intimidating.

**Professional Recognition**

Analysis of the literature regarding professional recognition emerged as an important factor in determining how likely nurses would be to apply to a CLP. In their study, Ward and Goodrich (2007) reported that peer recognition surfaced as an important factor for making application to the CLP and to pursue advancement. Korman and Eliades (2010) reported that their study respondents believed that advancement on the clinical ladder was not valued by their peers, as evidenced by a low satisfaction score for this item on the survey used in this study, thus becoming a targeted area for performance by the committee responsible for the CLP at the Medical Center conducting the study. Zehler et al. (2015) discussed nurses in their study feeling eager to share supportive attitudes offered by their peers and nurse leaders when pursuing the CLP. Many were encouraged by peers and their nurse leaders to apply for advancement and described peer support as crucial for success.

**Patricia Benner**

Many studies found on the CLP, especially evaluation studies on CLPs, reference Patricia Benner’s work (Bjørk et al., 2007; Goodrich & Ward, 2004; Nelson & Cook, 2008; Riley & Rolband, 2009). Benner became renowned in 1984 with her publication of *Novice to Expert* (Altmann, 2007). She was the author and project director of a federally funded grant titled Achieving Methods of Intraprofessional Consensus, Assessment and Evaluation Project (Altmann, 2007). Brenner adapted the Dreyfus model of skill acquisition to the careers of nurses (Benner, 1982). The Dreyfus model explains that in
the acquisition and development of a skill, one passes through five levels of proficiency: novice, advanced beginner, competent, proficient, and expert (Benner, 1982). Benner posited that the Dreyfus model of skill acquisition applied to nursing and combined with an interpretive approach to describing nursing practices offers guidelines for career and for knowledge development in clinical nursing practice (Benner, 1982). Benner’s theory, based on qualitative research, describes a five-stage career trajectory from novice nurse to expert, a framework that many clinical ladders are based upon today. Benner’s work and research has progressed from theory to a useful practice (Altmann, 2007).

Benner (1982) explained that recognition, reward, and retention of the experienced nurse in positions of direct clinical care practice are the first steps in improving the quality of patient care. Patricia Benner’s work supports the importance of the clinical ladders within the clinical nursing practice and adds to the understanding of the need for acceptance of the emergence of clinicians and clinical specialists in the patient care settings and retaining these talented nurses at the bedside.

Goodrich and Ward (2004) described a self-paced program that encouraged individual nurses to define their practice and assume personal responsibility for career advancement based on Benner’s work. The hospital in their study utilized four levels of practice, which were outlined by criteria that required an increased demonstration of competency at each successive level.

The committee in Korman and Eliades’ (2010) study was influenced by Benner when creating their CLP. They designed their ladder having five levels measuring the capabilities of a novice, advanced beginner, competent, proficient, and expert. Each level
had a specific set of criteria in which education, leadership, and research were integrally threaded.

The PDCA Model

Many study authors stated that the purpose for their program evaluation was for a quality improvement project (Goodrich & Ward, 2004; Nelson & Cook, 2008; Riley & Rolband, 2009). The quality improvement model used was PDCA, also known as PDSA, which is a commonly used quality improvement methodology in healthcare. The PDCA model was originally introduced by Shewart and Deming (Seidl & Newhouse, 2012) as a model for continuous quality improvement in business. It gained popularity in healthcare when the Institute for Healthcare Improvement recommended its use as the model for improvement and accelerating change (Seidl & Newhouse, 2012). This model tests change by developing a plan to test the change (Plan), carrying out the test (Do), observing and learning from consequences (Study), and determining what modifications should be made to the test (Act).

Riley and Rolband (2009) described using the PDCA model to determine the low rate of participation with their nurses’ involvement in the CLP. The committee developed a questionnaire, after reviewing the literature, to be given to CLP participants, with the goal of identifying satisfiers and barriers for participation. Members of the committee reviewed data from the study and made revisions to their program. Incentives identified were personal satisfaction, professional growth, and financial rewards. The redesigned program furthered interest and participation in the CLP. The study authors noted the need for continued evaluation of the CLP being essential to identify areas of improvement and strengthening the existing program benefits.
Goodrich and Ward (2004) conducted an evaluation of the CLP in a community hospital to identify the perceived lack of interest in pursuing promotion on the clinical ladder. This first evaluation prompted changes in the advancement criteria and the application and interview process. They then repeated their study in 2007 (Ward & Goodrich, 2007). This was the check step of the PDCA model. The changes made to the CLP resulted in approximately double the number of nurses advancing on the CLP.

**Program Evaluation**

A program evaluation is the process of collecting, analyzing, and using data to measure the impact of a program using reliable methods to examine the process (Holly, 2014). Program evaluations include assessing the program need, the plan, performance, impact, and the effectiveness (Moran, Burson, & Conrad, 2014). Formative evaluation is structured to provide information for project improvement (Holly, 2014). It differs from other types of evaluations as it is ongoing and involves informed judgment on the part of the evaluators to determine if the program will meet its intend goals (Holly, 2014). Program evaluations demonstrate how successful a program is. It is equally important to understand why some aspects of the program did not work (Holly, 2014).

Common themes arose from several program evaluations using descriptive studies. Motivators for nurses to apply to clinical ladders were empowerment, support from manager and peers, professionalism, and monetary awards (Bjørk et al., 2007; Korman & Eliades, 2010; Nelson & Cook, 2008; Riley & Rolband, 2009; Ward & Goodrich, 2007; Zehler et al., 2015). The same studies found that lack of manager and peer support, lack of time, poor monetary rewards, personal obligations, and lack of knowledge on how to complete an application and criteria for the review process were
found as barriers. Personal time constraints were cited as a frequent barrier to making a commitment in making application to advancement on CLPs. Time away from patient care was also identified as a barrier, as nurses need to be allowed professional time in meeting the requirements for the CLP application, attending shared governance meetings, and performing research in their organizations. Support from nursing leadership was noted as an advantage in all studies. Leadership does matter and all nurses deserve a knowledgeable nurse leader to mentor and guide them through the process (Zehler et al., 2015).

Korman and Eliades (2010) reported that being valued by peers is an important factor in making application to the CLP. Many respondents reported that peers not valuing the clinical ladder process was a barrier to making the application. The authors found this is a potential opportunity for nursing leadership to target and address. Career ladders are one mechanism in creating an organizational climate that promotes and encourages clinical excellence in registered nurses.

The literature on program evaluation makes it clear that nurses and nurse leaders use CLPs to accomplish a variety of outcomes. Among those outcomes are using the CLP to grow professionally, to make quality improvement changes on their units, and to increase the level of expectation for professionalism (Zehler et al., 2015). Nurse engagement scores along with patient satisfaction scores have been shown to rise in hospitals where CLPs are in existence (Zehler et al., 2015).

**Internationally Trained Nurses**

Very little has been found in the literature regarding internationally trained nurses and their advancement on clinical ladders. Two studies (Adeniran, Smith-Glasgow, &
Bhattacharya, 2013; Bruyneel et al., 2013) found that internationally trained nurses do not progress through the career advancement ladders at an equal pace with their U.S.-educated counterparts. Nursing leadership needs to have an understanding of this to better support and mentor internationally trained nurses. It was also noted that internationally trained nurses from developing countries were more likely than domestically trained nurses to perform tasks below their skill level. This is thought to be because internationally trained nurses were more task oriented and brought customs and roles of nursing from their home countries (Polsky, Ross, Brush, & Sochalski, 2007).

Research is limited in studies reviewing clinical ladder evaluations and foreign-trained nurses advancing on clinical ladders. This study author has been able to find only two studies to date.

The findings from this review of literature support many of the same themes that this project’s author had heard verbally from the Medical Center nurses. This anecdotal data supports the belief that motivators for nurses to apply to CLPs were empowerment, manager support, professionalism, and monetary awards. Possible barriers to applying were lack of manager support, lack of time, poor monetary rewards, and personal obligations. A formal program evaluation was needed to determine whether the motivators and barriers to application to a CLP found in the literature were shared by the majority of the nursing workforce regarding the CLP at the Medical Center.

**Project Goals and Objectives**

The main objective of this quality improvement project was to perform a program evaluation on the CLP at the Medical Center. As the CNO of the Medical Center, I wanted to learn from this evaluation what actions were needed to increase nurses’
participation in the CLP by at least 25% (225 nurses making application) during the next application cycle.

The primary objective of this project was to evaluate the CLP at the Medical Center to better understand the low application rate to the program in the application period for 2014. A secondary objective was to evaluate participant satisfaction with the CLP and the CLP application process for registered nurses. To achieve these objectives, quantitative and qualitative methods were employed to develop and analyze the results of a program evaluation questionnaire administered to the staff.
METHODS

The goals of this project were to identify barriers to the CLP for the nursing staff at the Medical Center and to identify ways to decrease those barriers for future application cycles. I determined the best way to accomplish those goals was to employ a mixed-methods approach in gathering and analyzing data. To facilitate this approach, the following steps were taken:

1. Met with key stakeholders, the clinical ladder committee, and nursing leadership and discussed the evaluation tool and the methods to administer the evaluation questionnaire via Survey Monkey in the fall of 2015. The evaluation tool was sent to those nurses who were eligible to make application to the CLP in 2014.

2. Collaborated with the clinical ladder committee and nursing leadership to share all findings and data collected from the evaluation questionnaire administered during the fall of 2015.

3. Reviewed data from the evaluation questionnaire with the clinical ladder committee and nursing leadership. Data collection was completed October of 2015.

4. Developed an action plan and timeline to address improvement opportunities identified by the nurses who answered the evaluation questionnaire.

5. Shared action plan and timeline with the clinical ladder committee for adoption in the fall of 2015.

6. Shared clinical ladder improvement opportunities with the nursing union for acceptance and adoption in the fall of 2015.
**Setting**

This CLP evaluation took place at the Medical Center. The Medical Center consists of a 461-bed acute care facility located in the Western region of the United States. It is an academic Medical Center owned for the past 6 years by a university. The Medical Center is comprised of an acute care hospital, a cancer hospital, an acute care medical group, and its affiliated licensed clinics throughout the community. The Medical Center is committed to fulfilling its mission of becoming a recognized top-tier academic Medical Center by delivering personalized, compassionate, and innovative care.

The Medical Center has 900 nurses eligible for application to the CLP. The nurses vary in age and educational background; 60% of the nurses are BSN prepared or higher and 26% hold a certification in their specialty. Many of the nurses are foreign trained. The majority of the nurses are represented by a nursing union.

**Population**

The population studied was the acute care registered nurses who were eligible to submit an application to the CLP between October 1, 2014, and December 31, 2014, at the Medical Center. Informed consent was acknowledged by the nurses when accepting to take the program evaluation survey. All participants are employed by the Medical Center and are fluent in English.

**Ethics and Institutional Review Board**

This project author started the Institutional Review Board (IRB) process by completing training on the protection of human subjects. Approval for the project was obtained from both the Medical Center IRB and the university IRB.
Project Enrollment

Subsequent to IRB approval, study respondents, all eligible registered nurses in the Medical Center’s CLP, were sent an email invitation with the link to the survey (see Appendix A). Nurses were notified that survey responses would not be linked to their names and that I, the project coordinator, would only receive nameless data from Survey Monkey. Survey data were collected over a 1-month timeframe during the fall of 2015. An incentive of a gift certificate of $5 to the hospital coffee cart was provided electronically at the completion of the survey. De-identified data were filed in a password-protected database and then emailed to the biostatistician for analysis.

Collection of Data

I requested permission to use the study instrument University Hospital’s Focus on Nursing Excellence in Clinical Care, Education and Leadership (UEXCEL) evaluation questionnaire survey (Korman & Eliades, 2010). Korman and Eliades (2010) reported that this instrument has been shown to have high validity and high reliability. Permission was not obtained and therefore I worked with a biostatistician to create a Likert-type scale questionnaire with 18 questions. I reviewed several studies pertaining to evaluation of CLPs (Bjørk et al., 2007, Korman & Eliades, 2010, Nelson & Cook, 2008; Riley & Rolband, 2009; Ward & Goodrich, 2007; Zehler et al., 2015). Information for a new questionnaire was developed from the above noted studies looking at the degree to which nurses endorsed various views of the CLP. The newly developed questionnaire included demographic and background variables. Questions included hours worked in a week, hours spent as an outside caregiver, number of jobs held, where initial nursing training was obtained, and evaluative questions for clinical ladder participants to answer.
pertaining to potential barriers to making application. Nurses were given a choice not to answer a question and move on to the next (see Appendix B). Face and content validity along with internal consistency were established with the assistance of the biostatistician; however, reliability was not addressed through test-retest or alternate forms.
ANALYSIS

A mixed-methods approach was used in data collection in this study to address related questions. This approach allowed me to analyze the data from more than one perspective. Polit and Beck (2012) defined mixed-methods design as research in which both qualitative and quantitative data are collected and analyzed to address different but related questions. Both methods were used in the data analysis to follow.

Thematic Analysis of Qualitative Data

Polit and Beck (2012) described thematic analysis as recurring regularity emerging from analysis of qualitative data. I determined the most effective way to analyze the qualitative data gathered for this project was to complete a thematic analysis. To begin, I read each nurse’s written comments and then coded each of them. Codes were merged to identify and create themes. Common themes arising from the nurses’ written comments found in the write-in section of the CLP evaluation tool regarding barriers to making application were as follows: difficult program requirements; lack of management support; lack of time, money, and recognition; and an inconsistent review process. These themes were also reviewed and corroborated by my project chair and other members of my project committee.

Program Requirements and Lack of Management Support

Two of the prevailing themes identified in this study were program requirements and lack of support by nursing leadership and management. Several nurses wrote comments regarding feeling confused by the application process and the program requirements. Directions were confusing and the process not clear. Lack of manager knowledge of the process was also noted as a barrier. One nurse reported “lack of
encouragement and motivation from charge nurse and manager.” Another nurse reported, “The management and submanagement team are unsupportive of the clinical ladder participation often loudly expressing negative comments and the unworthiness of the clinical ladder system.” Several nurses wrote in comments about requirements being too difficult. Not enough credit for years of experience and too much focus on BSN degrees were noted in several comments.

Resentment also came out in several nurses’ comments, as represented by this nurse:

Clinical ladder program should focus on beside nurses and need to acknowledge what we have been doing for our patients. We don’t feel we are being acknowledged for what we do. Bedside nurses do not have time to put in extra hours after our shifts. We barely get rest when we have our days off. We should be rewarded and acknowledged on how we take care of our patients and not volunteering outside of our shift hours.

**Time, Money, and Lack of Recognition as Barriers**

Several nurses reflected in their comments about not having enough time for application, monetary rewards not being sufficient enough, and lack of recognition as barriers. Family obligations along with personal educational goals were noted as barriers. “Currently in school, too time consuming” was noted by one nurse. Finding the time to be involved in committees outside of bedside assignments was noted as being difficult by several nurses as well as finding coverage for themselves by a qualified coworker. Another nurse wrote, “Finding time and opportunities to participate in activities that qualify for clinical ladder points is difficult.”

Several nurses reflected in their comments that the monetary bonus offered was not worth the time spent in making the application to the clinical ladder. They noted that picking up one to two extra shifts would be the same amount of pay as the clinical ladder
bonus. One nurse reflected in his or her comments the following sentiment, “Should result in a pay raise not a bonus. An extra shift sometimes can equate to the payment of a clinical ladder bonus.”

There were several comments regarding lack of clinical ladder recognition. One nurse noted,

There was no recognition of receipt of my clinical ladder award aside from a simple email congratulating me and my name huddled during the shift. My patients will never know I obtained a level on the clinical ladder nor will anyone else that was not part of the huddle. I completed above and beyond what is expected from a staff nurse, but there is no everyday reminder of that.

**Inconsistent Review Process**

There were several written comments regarding the committee process for awarding points. One nurse noted,

I noticed that there were discrepancies on how the committee members awarded points. Some were more organized in identifying the points achieved on the clinical ladder form and others did not; therefore, there were inconsistencies. It was hard to find out whether points were granted or not per section when the evaluator did not write anything on the sheet. Every evaluator should provide comments/points consistently.

There were several comments noting that reviewers had not received enough training in how to evaluate the portfolios.

**Quantitative Analysis on Demographic Composition of Sample**

Quantitative data were gathered to complete an analysis in the following areas: training settings, psychometrics, nurses’ attitudes towards the CLP, and barriers to applying to the CLP. To help accomplish a thorough analysis of the data, a biostatistician was employed to conduct a quantitative analysis. Polit and Beck (2012) defined quantitative analysis as the manipulation of numeric data through statistical procedures for the purpose of describing phenomena or assessing the magnitude and reliability of
relationships among them. A series of chi-square tests of independence, a statistical test to assess differences in proportions (Polit & Beck, 2012), were conducted to explore the overall demographic composition of the sample and to compare the characteristics of the nurses trained within and outside of the United States (see Table 1).

Examination of the data revealed that nurses trained outside of the United States were significantly more likely than expected to work long hours, with one in 10 reporting working more than 72 hours in a typical week compared to U.S.-trained nurses, of whom only approximately one in 100 reported working this long. In addition, it was discovered that nurses trained outside of the United States tended to have BSN or higher degrees, with less than one in 10 reporting having only obtained an Associate of Arts/Associate of Science (AA/AS) degree, statistically fewer than what was expected.

**Psychometrics**

As the CNO of the Medical Center, I was interested in learning more about the nurses’ attitudes towards the Medical Center’s CLP. As described previously in this paper, I did not receive permission to use a preexisting survey of attitudes and barriers towards a CLP. In working with a biostatistician, we created our own 12-item attitudinal scale to assess the degree to which nurses endorsed various views of the CLP based on the goals and objectives of this study and what was identified in the literature as having been useful in other similar studies. In conducting a principal components analysis (PCA), a factor extraction method (Polit & Beck, 2012), the scale created showed three types of questions and was comprised of three subscales: (a) the CLP’s impact on nurses’ practices, (b) logistics related to enrolling in and completing the program, and (c) opportunities for education to meet program requirements.
Table 1

Training Settings

<table>
<thead>
<tr>
<th>Training Setting</th>
<th>Within United States</th>
<th>Outside United States</th>
<th>(p^*)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of jobs</td>
<td></td>
<td></td>
<td>.63</td>
</tr>
<tr>
<td>1</td>
<td>123 (83.1%)</td>
<td>36 (80.0%)</td>
<td></td>
</tr>
<tr>
<td>More than 1</td>
<td>25 (16.9%)</td>
<td>9 (20%)</td>
<td></td>
</tr>
<tr>
<td>Hours worked, per week</td>
<td></td>
<td></td>
<td>.03</td>
</tr>
<tr>
<td>&lt; 24</td>
<td>3 (2.0%)</td>
<td>1 (2.2%)</td>
<td></td>
</tr>
<tr>
<td>24-36</td>
<td>35 (23.6%)</td>
<td>7 (15.6%)</td>
<td></td>
</tr>
<tr>
<td>36-48</td>
<td>87 (58.8%)</td>
<td>28 (62.2%)</td>
<td></td>
</tr>
<tr>
<td>48-72</td>
<td>21 (14.2%)</td>
<td>4 (8.9%)</td>
<td></td>
</tr>
<tr>
<td>&gt; 72</td>
<td>2 (1.4%)</td>
<td>5 (11.1%)</td>
<td></td>
</tr>
<tr>
<td>Hours spent as a caregiver, per week</td>
<td></td>
<td></td>
<td>.65</td>
</tr>
<tr>
<td>0-10</td>
<td>81 (55.1%)</td>
<td>27 (60.0%)</td>
<td></td>
</tr>
<tr>
<td>11-20</td>
<td>22 (15.0%)</td>
<td>6 (13.3%)</td>
<td></td>
</tr>
<tr>
<td>21-30</td>
<td>9 (6.1%)</td>
<td>5 (11.1%)</td>
<td></td>
</tr>
<tr>
<td>31-40</td>
<td>10 (6.8%)</td>
<td>2 (4.4%)</td>
<td></td>
</tr>
<tr>
<td>&gt; 40</td>
<td>25 (17.0%)</td>
<td>5 (11.1%)</td>
<td></td>
</tr>
<tr>
<td>Highest degree attained</td>
<td></td>
<td></td>
<td>.04</td>
</tr>
<tr>
<td>AA/AS</td>
<td>38 (25.7%)</td>
<td>4 (8.9%)</td>
<td></td>
</tr>
<tr>
<td>BSN</td>
<td>82 (55.4%)</td>
<td>32 (71.1%)</td>
<td></td>
</tr>
<tr>
<td>MSN (Master of Science in Nursing)</td>
<td>25 (16.9%)</td>
<td>6 (13.3%)</td>
<td></td>
</tr>
<tr>
<td>Master’s degree, outside of nursing</td>
<td>3 (2.0%)</td>
<td>3 (6.7%)</td>
<td></td>
</tr>
</tbody>
</table>

Each of these will be treated as it owns subscale in my analyses. A Cronbach’s alpha analysis was used to examine the internal consistency of the survey; results are found in Table 2.

A battery of 12 items regarding nurses’ attitudes toward the CLP was examined. A PCA, an extraction method using orthogonal rotation (varimax), was conducted to explore the underlying factors in the scale, as these survey questions were developed from scratch for this study (Polit & Beck, 2012). In addition, the decision was made to
Table 2

*Three Factors, Cronbach’s Alpha, and Individual Factor Loadings From PCA With Varimax Rotation (n = 109)*

| Factor 1: Impact on Practice (α = .90) |  
|--------------------------------------|--- |
| I believe involvement in the clinical ladder program encourages me to accept responsibility and accountability for my clinical practice. | .64 |
| The clinical ladder stimulates me to be more involved in Shared Governance activities that directly impact patient care. | .78 |
| Advancement on the clinical ladder encourages me to be a role model by applying advanced clinical practice concepts to improve the quality of nursing care I provide. | .81 |
| The clinical ladder is an effective way for my nursing expertise to be recognized. | .65 |
| I believe that advancement on the clinical ladder is valued by my nursing colleagues. | .85 |

| Factor 2: Implementation Logistics (α = .83) |  
|---------------------------------------------|--- |
| My nurse leader was knowledgeable of my clinical ladder application. | .80 |
| My nurse leader was supportive of my clinical ladder application. | .81 |
| Criteria for the clinical ladder applications were reviewed with me so that I clearly understood what was expected of me. | .62 |
| My portfolio evaluation for the clinical ladder program was fair and equitable | .65 |
| I know exactly what I need to do to make an application or advance to the next level of the clinical ladder. | .73 |

| Factor 3: Opportunities for Training (α = .88) |  
|-----------------------------------------------|--- |
| The Medical Center offers opportunities for me to acquire the knowledge to advance on the clinical ladder. | .85 |
| The Medical Center offers opportunities for me to participate in activities to advance on the clinical ladder. | .83 |
examine the internal consistency of the total 12-item scale as well as any identified subscales by calculating Cronbach’s alpha. Cronbach’s alpha was examined to determine if any of the questions should be removed from the scale (and analyzed as stand-alone items in subsequent analyses).

The Kaiser-Meyer-Olkin (Polit & Beck, 2012) measure revealed that the sample size in the study was suitable for PCA analysis (KMO = .85). In addition, Bartlett’s test of sphericity (Polit & Beck, 2012) indicated that the correlations between the individual survey questions were high enough to warrant examination using a PCA approach, $\chi^2(66) = 866.69, p \leq 0.001$.

Prior to rotation, eigenvalues of the unrotated matrix were calculated, producing three factors with eigenvalues of greater than 1. Visual examination of inflexion with a scree plot further supported a three-factor solution. The resulting three-factor solution explained 73.01% of the observed variance in subjects’ scores on attitudes towards the clinical ladder tool. A total of two items cross-loaded onto two factors (component loading $\geq .50$) and were placed on the scale that made the most theoretical sense. The factors revealed and individual factor loading are presented in Table 2.

Cronbach’s alpha for the total score ($\infty = 0.91$) and each of the three subscales ($\infty = 0.83-0.90$; see Table 2) was found to be acceptable, with single-item deletions making negligible improvements to the scales’ internal consistency. Based on these data, it was determined that no questions needed to be revised or deleted from this survey (Polit & Beck, 2012).
Attitudes Towards the CLP

Nurses’ attitudes towards the CLP were assessed by 12 questions, each scored on a 5-point Likert-type scale where higher scores reflect more positive attitudes. Examination of descriptive statistics for 12 questions revealed generally neutral attitudes towards the CLP, with mean scores for the majority of items falling near 3.0, the neutral “Neither Agree nor Disagree” score, as demonstrated in Figure 2.

Nurses’ perceptions of the CLP being valued by their peers scored low at 3.3, lending support to the perception that their peers do not value the CLP. This score and the score from “criteria being reviewed,” which scored at 2.9, are two of the lowest scores from this part of the survey, warranting further study by myself and the design committee.

![Figure 2. Nurses’ attitudes of the CLP.](image-url)
Two of the attitudinal items emerged as significantly different between nurses trained in the United States and those trained abroad. For those trained outside of the United States, it appears from the data that the CLP is valued as a means of recognizing expertise. Those nurses trained abroad also reported higher knowledge of the next steps required to apply or advance to the next level of the ladder. Please see results in Table 3.

Table 3

*Summary of Independent Samples t Tests Comparing Attitudes Towards the CLP by Educational Setting (n = 114-120)*

<table>
<thead>
<tr>
<th></th>
<th>Educated Within United States</th>
<th>Educated Outside of United States</th>
<th>p</th>
</tr>
</thead>
<tbody>
<tr>
<td>Impact on Practice</td>
<td>17.77</td>
<td>18.68</td>
<td>.38</td>
</tr>
<tr>
<td>Valued by peers</td>
<td>3.24</td>
<td>3.50</td>
<td>.32</td>
</tr>
<tr>
<td>Involvement in shared governance</td>
<td>3.54</td>
<td>3.83</td>
<td>.23</td>
</tr>
<tr>
<td>Role modeling</td>
<td>3.61</td>
<td>3.79</td>
<td>.45</td>
</tr>
<tr>
<td>Recognition of expertise</td>
<td>3.61</td>
<td>4.04</td>
<td>.05</td>
</tr>
<tr>
<td>Responsibility and accountability</td>
<td>3.77</td>
<td>3.96</td>
<td>.32</td>
</tr>
<tr>
<td>Implementation Logistics</td>
<td>16.73</td>
<td>17.82</td>
<td>.27</td>
</tr>
<tr>
<td>Criteria reviewed</td>
<td>2.83</td>
<td>3.30</td>
<td>.10</td>
</tr>
<tr>
<td>Nurse knowledge of criteria</td>
<td>3.17</td>
<td>3.70</td>
<td>.03</td>
</tr>
<tr>
<td>Fair review</td>
<td>3.39</td>
<td>3.41</td>
<td>.95</td>
</tr>
<tr>
<td>Leader knowledge</td>
<td>3.57</td>
<td>3.70</td>
<td>.61</td>
</tr>
<tr>
<td>Leader support</td>
<td>3.79</td>
<td>3.65</td>
<td>.59</td>
</tr>
<tr>
<td>Opportunities for Training</td>
<td>7.26</td>
<td>7.58</td>
<td>.45</td>
</tr>
<tr>
<td>Learning opportunities</td>
<td>3.57</td>
<td>3.83</td>
<td>.25</td>
</tr>
<tr>
<td>Practice opportunities</td>
<td>3.68</td>
<td>3.75</td>
<td>.76</td>
</tr>
</tbody>
</table>

**Barriers to Applying to the CLP**

In order to identify barriers to participation in the CLP, five questions were posed to participants, four scaled numerically and a single open-ended item designed for nurses to write any additional comments they felt were important. For the purpose of analysis,
all numeric scales were collapsed into two categories (barrier vs. not a barrier). For the open-ended question, any response given was recorded into barrier in order to quantify the number of other barriers identified by participants. A summary of the results to Questions 1-6 is presented in Figure 3.

**Figure 3.** Perceived barriers to participation in the CLP.

Time and commitment to succeed and time to apply were the leading barriers found in this part of the analysis. Lack of awareness of the program was also noted as a strong barrier. These barriers were also found in the qualitative results noted earlier in this paper. Nurses felt like time and guidance were major barriers to participation. Insufficient payment, while not negligible, seemed to be a less important barrier, as it was mentioned by less than half of the respondents.
In order to better understand barriers to participation in the CLP, while taking into account the differing perspectives of nurses educated within or outside of the United States, a series of chi-square tests of independence were conducted. As shown in Table 4, a difference in the importance of monetary rewards as a barrier to participation was found to be statistically significant, with insufficient monetary reward serving as a stronger barrier for nurses trained outside of the United States. While no other comparisons revealed statistically significant differences, overall lack of awareness and time emerged as important barriers identified by the majority of respondents.

Table 4

*Perceived Barriers to the CLP for Nurses Educated Within or Outside the United States (N = 192)*

<table>
<thead>
<tr>
<th>Barrier</th>
<th>Within United States</th>
<th>Outside United States</th>
<th>p*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lack of awareness</td>
<td>74.3%</td>
<td>78.9%</td>
<td>.79</td>
</tr>
<tr>
<td>Insufficient monetary reward</td>
<td>54.0%</td>
<td>73.7%</td>
<td>.03</td>
</tr>
<tr>
<td>Time to apply</td>
<td>85.1%</td>
<td>86.8%</td>
<td>.79</td>
</tr>
<tr>
<td>Time and commitment to succeed</td>
<td>85.8%</td>
<td>86.8%</td>
<td>.88</td>
</tr>
<tr>
<td>Other barriers</td>
<td>34.5%</td>
<td>31.6%</td>
<td>.74</td>
</tr>
</tbody>
</table>

*aConducted for chi-square tests of independence.

**Project Outcomes**

The data analysis was shared with the Medical Center’s clinical ladder design committee for discussion and action. The clinical ladder design committee discussed the common themes that were noted as barriers to making application from both the qualitative and the quantitative analyses and made the following changes to the CLP in an effort to reduce perceived barriers to making application:
1. Revised and clarified the application document by adding the Clinical Ladder Statement of Intent. The purpose of this Statement of Intent is to provide clarity to committee members as to what level the nurse was applying for, which would eliminate confusion for committee members reviewing the portfolio.

2. Added points for nurses who developed new forms for the Medical Center.

3. Added points for nurses who assisted in skills validation.

4. The clinical ladder design committee hosted 10 mentoring sessions for nurses who wanted to learn more about making application to the CLP. Along with the mentoring sessions, nurses were given paid time to complete their portfolios during the mentoring session.

5. Revisions were made to the scoring sheet and all members of the clinical ladder design team were given instructions on how to use the new tool. Committee members were asked to review three portfolios and score them. This was done to test interrater reliability. Members were also asked for a three meeting commitment to review portfolios in January. The goal for this change was to seek consistency in having trained committee members to review portfolios in an equitable manner and eliminate inconsistency of the portfolio review process.

6. The clinical ladder design committee hosted a workshop for nursing leadership at the Medical Center to explain the application process and explain leadership roles in supporting eligible nurses in making application.
7. All forms for making application along with instructions on how to apply were posted on the Medical Center’s nursing portal.

The above modifications were taken to the Shared Governance Council for discussion and approval. The nurses attending the Shared Governance Council asked for additional modifications to be made to the CLP; their requests were granted and the following modifications were also made:

1. Added points for secretaries of councils/committees.
2. Points for the attainment of chemotherapy provider cards.
3. Points for Bone Marrow Therapy certification.
4. Points for Daisy awardees. The Medical Center is in a partnership with the Daisy Foundation. This award recognition program honors nurses for the care they provide to their patients.
5. Points for nurses who had been awarded the Medical Center’s employee of the month.
6. Points for nurses pursuing a doctorate in nursing.

**Fall 2015 Results**

After making modifications to the CLP that were noted earlier in this project paper, the CLP was once again offered to the Medical Center’s nurses in the fall of 2015. In comparing the fall application period of 2015 to that of 2014, there was an increase from 15% successful applications in 2014 to 22% successful applications in 2015. Along with an increase in successful applications, the Medical Center now has greater than 51% of its nursing units scoring better than the American Nurses Credential Center’s national benchmark in nursing quality sensitive indicators and patient satisfaction. These results
reflect the importance of keeping talented nurses at the bedside, with an increase in quality indicators and a decrease in patient harm. As this is a quality improvement project, I have the goal, along with the design committee and the nursing governance council, to repeat this evaluation in the spring of 2016 and further enhance this CLP for the Medical Center.
DISCUSSION AND IMPLICATIONS FOR NURSING

Organizational benefits of CLP participation in the healthcare environment have been demonstrated in the literature and more is being written about barriers to application to CLPs. This program evaluation contributes further to nursing knowledge by using both quantitative and qualitative analyses to identify the following themes to barriers to application:

1. Time and commitment to apply and succeed. Nurses noting not being in a position to go back to school due to the large investment in tuition and family restraints. Many nurses noted in the demographic section being caregivers at home and having multiple jobs.

2. Lack of awareness about the CLP. Nurses noting they were not aware of the program or found the application requirements too difficult to understand or follow.

3. Insufficient monetary rewards. Nurses noting they felt the time completing the required portfolio was not worth the monetary reward received.

4. Lack of support from nursing leaders and peers was noted as a strong barrier.

The clinical ladder design committee reviewed the data from the program evaluation analysis. The design committee worked hard to improve the structure and process for application to help eliminate barriers to professional advancement. Actions taken to modify and improve the CLP were discussed in the outcomes section of this paper. The design committee took much effort in communicating new changes to the CLP as they were cognizant of confusion created by each change. Changes were
reflected on the Medical’s Center’s nursing web page and found in the nurses’ portal. Nurse leaders shared changes to the CLP at shift huddles and in weekly updates.

**Leadership**

Leadership does matter in the CLP application process. Several nurses noted lack of leadership support as a barrier to their application. In order for nurses to achieve successful application to the CLP and advancement, nurse leaders require the same level of understanding and knowledge of the program goals (Zehler et al., 2015). The Medical Center’s nursing leadership team participated in an in-depth training program so that they could better support their nurses through the application process. As the CNO of the Medical Center, I felt strongly that I needed to make clear my expectations of the nurse leaders, and this was done in the training program. Nurse leaders must be full partners with the clinical staff, encouraging them and allowing protected time away from patient care to work on projects and to attend meetings. By not collaborating with nurses and using their advancing competence, managers lose opportunities to address unmet clinical needs or neglected areas of practice on their own units (Bjørk et al., 2007). Nurse leaders were allowed to budget nonproductive time for their nurses to be away from bedside care and participate in council work, research, and quality improvement projects. As the CNO, I am encouraging new managers to ask for mentorship from more senior managers who have high numbers of nurses on the CLP. As a CNO, I feel strongly that my nurse leaders must be full partners with their clinical nurses, encouraging them and allowing them protected time away from the bedside to work on projects and attend meetings.
Monetary Support

Several nurses noted insufficient monetary rewards as a barrier to application. The Medical Center’s senior leadership team, in 2015, approved additional budget funds for nurses to have protective time away from direct patient care for research, work on quality improvement projects, and attend shared governance meetings. These additional budgeted funds support the importance of the CLP and those nurses attempting to advance on it. Paid mentoring sessions were also provided to nurses in 2015 to support portfolio completion with the assistance of mentors. Lack of time and monetary support were noted as major barriers by the nurses completing the evaluation tool. Due to the amount of award given to CLP participants being negotiated with the nursing union, this amount cannot be changed until the next window of contract negotiations opens. This was noted as a barrier by nurses feeling the amount of the reward was not worth their time filling out the portfolio. The Medical Center has also budgeted for registered nurse (RN) to BSN program reimbursement for all nurses with seniority of 4 or more years. This was done in an effort to support nurses with tuition and not cause additional burden on their families. The Medical Center is currently partnered with a nursing school hosting an RN to BSN program on campus.

Foreign-Trained Nurses

Two of the attitudinal items emerged as significantly different between nurses trained in the United States and foreign-trained nurses. For foreign-trained nurses, it appears from the data that the CLP is valued as a means of recognizing expertise. Foreign-trained nurses also reported higher knowledge of next steps required to apply or advance to the next level of the ladder. In reviewing monetary awards as a barrier to
participation, it was found to be statistically significant, with insufficient monetary reward serving as a stronger barrier for foreign-trained nurses. As the CNO of the Medical Center, I want to study these differences further to better understand the needs of our foreign-trained nurses and how to better support them.

**Clinical Ladder Recognition**

Nurses remained neutral on their response to advancement on the CLP being valued by their nursing colleagues. In the thematic analysis, several nurses noted that they did not feel their colleagues valued advancement on the CLP. The design committee reflected on this information and decided to recognize nurses who advance on the CLP at the Medical Center’s town hall meetings. Along with recognition at the town halls, a plaque would be hung in the nurse’s unit with his or her name and picture on it. The nurse would also be recognized at a unit huddle in front of his or her peers. The design committee is currently designing a name badge for those nurses who have advanced on the ladder reflecting what level they have been awarded. The design committee is also honoring all clinical ladder awardees at a breakfast in their honor during nurses’ week.
CONCLUSION

The results from this study support the fact that nurse leaders need to continue to examine CLPs in their respective institutions. This is an effort to keep talented nurses at the bedside. This project paper was written from the perspective of a CNO of a major academic medical center. Results from this study are applicable to CNOs of medical centers in their efforts to reduce nurses’ barriers in making applications to their CLPs. One strong recommendation is to make the application process as simple as possible. If the process is too cumbersome or difficult, nurses report that application to the CLP is not worth their time. Providing recognition, mentoring, and nursing leadership support is key to meeting the expectations of the clinical nurse. Many of the benefits from participating in a CLP align with the Medical Center’s goal of improving patient care quality.

One major limitation identified in this project is that permission was not obtained to use the validated evaluation tool desired from the author of the tool. Because of this, I, with the assistance of a biostatistician, created an evaluation questionnaire to be used for this project. This new instrument was untested for reliability and validity.

A second possible limitation to this project was the level of computer literacy of the nurse participants. This is a possible limitation because computer skills were required to fill out the online survey tool. Although anonymity was assured, some participants may have been reluctant to return a completed survey; however, to minimize this, clear direction and guidance on whom to call for support was given to participants.
REFERENCES


Dear Nurses,

Please find enclosed a program evaluation tool being used to assess for motivators and barriers to making application to our clinical ladder program. Your feedback is very important to us; please take the time to fill out this survey. The information will be reviewed by the clinical ladder design team. It is our goal to strengthen the program and to increase participation in this year’s enrollment. But we can only meet this goal if you provide us with your feedback.

Please know that this information is being used for a Quality Improvement project.

Please know by completing this online tool, that the information provided is de-identified and cannot be traced back to you. By completing this survey you are giving consent to have your answers used in this Quality Improvement project.

Thank you in advance for your time in completing this survey.

The Clinical Ladder Design Team
APPENDIX B

CLINICAL LADDER EVALUATION TOOL

This evaluation tool was developed to help the Medical Center determine the effectiveness of the Clinical Ladder Program.

Please select the best answer that represents you.

1. On average, how many hours a week do you work
   - □ less than 24
   - □ 24-36
   - □ 36-48
   - □ 48-72
   - □ greater than 72

2. On average, how many hours a week do you spend as a caregiver outside of work
   - □ 0-10
   - □ 11-20
   - □ 21-30
   - □ 31-40
   - □ greater than 40

3. How many jobs do you currently hold
   - □ 1
   - □ 2
   - □ greater than 2

4. Where did you receive your initial training
   - □ United States
   - □ Outside of the United States

5. What is the highest degree obtained
   - □ Diploma
   - □ AA/AS
   - □ BSN
   - □ MSN
   - □ PhD.
   - □ DNP
   - □ Master’s Degree outside of Nursing

Please select the answer that best represents your opinion of the program.

<table>
<thead>
<tr>
<th>Strongly Disagree</th>
<th>Disagree</th>
<th>Neither Agree nor Disagree</th>
<th>Agree</th>
<th>Strongly Agree</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
</tbody>
</table>

6. The clinical ladder is an effective way for my nursing expertise to be recognized.
   - □ 1
   - □ 2
   - □ 3
   - □ 4
   - □ 5

7. Medical Center offers opportunities for me to acquire the knowledge, skills and involvement in activities to advance on the clinical ladder.
   - □ 1
   - □ 2
   - □ 3
   - □ 4
   - □ 5
8. I believe involvement in the clinical ladder program encourages me to accept responsibility and accountability for my clinical practice.

☐ 1  ☐ 2  ☐ 3  ☐ 4  ☐ 5

9. My nurse leader was knowledgeable and supportive of my clinical ladder application.

☐ 1  ☐ 2  ☐ 3  ☐ 4  ☐ 5

10. The clinical ladder stimulates me to be more involved in Shared Governance activities that directly impact patient care.

☐ 1  ☐ 2  ☐ 3  ☐ 4  ☐ 5

11. Criteria for the clinical ladder applications were reviewed with me so that I clearly understood what was expected of me.

☐ 1  ☐ 2  ☐ 3  ☐ 4  ☐ 5

12. My portfolio evaluation for the clinical ladder program was fair and equitable.

☐ 1  ☐ 2  ☐ 3  ☐ 4  ☐ 5  ☐ NA

13. I know exactly what I need to do to make an application or advance to the next level of the clinical ladder.

☐ 1  ☐ 2  ☐ 3  ☐ 4  ☐ 5

14. I believe that advancement on the clinical ladder is valued by my nursing colleagues.

☐ 1  ☐ 2  ☐ 3  ☐ 4  ☐ 5

15. Advancement on the clinical ladder encourages me to be a role model by applying advanced clinical practice concepts to improve the quality of nursing care I provide.

☐ 1  ☐ 2  ☐ 3  ☐ 4  ☐ 5
*If you did not apply to the Clinical Ladder, please complete the following section*

Please rate how much the following factors act as barriers to applying to the Clinical Ladder Program

<table>
<thead>
<tr>
<th></th>
<th>Not a Barrier</th>
<th>Somewhat a Barrier</th>
<th>Strong Barrier</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
</tbody>
</table>

1. The lack of awareness about the program.
   - 1
   - 2
   - 3
2. The time it takes to write the application.
   - 1
   - 2
   - 3
3. Insufficient monetary reward.
   - 1
   - 2
   - 3

Thank you for taking the time to complete this tool.