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A global examination of clinical ladder programs –A synthesis of commonalities and opportunities for standardization

Nada Wakim
South Miami Hospital, nadaw@baptisthealth.net

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WORLDVIEWS ON EVIDENCE-BASED NURSING

A global examination of clinical ladder programs – A synthesis of commonalities and opportunities for standardization

Amanda Slagle MPH, MSN, RN, CPHQ[1] | **Nada Wakim PhD, RN, NE-BC**[2] | **Sarah E. Gray DNP, RN, CEN, FAEN**[3]

[1]Certified Global Nurse Consultant, Virginia, Dulles, USA

[2]South Miami Hospital, Miami, Florida, USA

[3]Sigma Theta Tau International Honor Society of Nursing, Indianapolis, Indiana, USA

Correspondence
Amanda Slagle, 6050 Amman Place, #201, Dulles, VA 20189, USA.
Email: ms.slagle@gmail.com

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Abstract

Background: Clinical ladder programs (CLPs) have been part of the nursing profession for nearly 4 decades. However, the structure and implementation of CLPs vary widely throughout healthcare systems. CLPs are a valuable factor in nurse retention and employee satisfaction initiatives, but globally replicating and measuring their impact is difficult due to lack of standardization.

Aim: To identify opportunities for global standardization of CLPs through a systematic review of published evidence and facility-sourced CLPs applications and program documents.

Method: This study used a systematic literature search and scan of existing programs from facilities within the United States (US), Lebanon, and Ghana obtained through professional ties and organizational membership.

Results: Seventy-nine articles were screened with 30 studies identified for inclusion, plus 20 CLPs from the US and international facilities. Identified commonalities were the lack of consistency in the number of clinical levels across the CLPs, eligibility requirements and application process, reward and recognition, lack of emphasis on technology and informatics, and missed opportunities to use CLPs to drive a culture of safety. The administrative burden of the programs and the time required by the nurse to complete the CLP application were rarely referenced.

Linking Evidence to Action: The lack of consistency between facilities and across the healthcare sectors limits the measurable impact CLPs have on the nursing profession. Recommendations for practice include developing a standardized professional development framework. A standardized framework will encourage adoption of a retention tool that will provide the profession with a measurable method to demonstrate the value it brings to patient care. Providing guidance to health care facilities in low- and middle-income countries on the implementation of a professional development framework will assist in closing the global gap of professional development opportunities for nurses.

KEYWORDS
bedside nurse retention, clinical ladder program, clinical ladder standardization, global nursing shortage, professional development, recruitment

INTRODUCTION

Clinical ladder programs (CLPs) are hailed as promoting best clinical practice, enhancing professional development, recognizing clinical expertise, and increasing nurse satisfaction and retention (Moore et al., 2019). Despite the evidence validating the use of CLPs as hallmarks of the professional nursing practice, there remains variation and lack of standardization in CLP structure.

The American Nurses Association (ANA, n.d.) has identified that more than one-fifth of registered nurses (RNs) have intent to retire over the next 5 years. According to the International Council of Nurses (2022), the global nursing shortage could increase from between 7 to 11 million. Given the positive impact that CLPs have on nurse retention and job satisfaction (Tetuan et al., 2013; Warman et al., 2016), identifying evidence-based commonalities amongst the myriad of CLPs currently in use would support healthcare leaders in propelling the development of the profession forward, while also retaining the nursing staff they have hired.

BACKGROUND

CLPs were developed in the early 1970s in response to a national nursing shortage (Pierson et al., 2010) and are utilized by healthcare organizations as a retention tool for nurses. Currently, CLPs are designed to reward nurses for actions taken within specific categories (or domains) like education, research, clinical, and leadership skills (Riley et al., 2009).

The effectiveness of CLPs has been reported in many countries, however, the adoption has not been universal, even in the United States (Ko & Yu, 2014). Developing a CLP is not easy, and the success of the CLP is dependent on supportive nursing leadership that is committed to the program's success (Knoche & Meucci, 2015; Warman et al., 2016). With a global nursing shortage predicted, it is timely to identify tools that will guide healthcare organizations in the United States and around the globe on retaining nurses at the bedside. A standardized professional nursing development framework that enables healthcare leaders to demonstrate the measurable impact that nurses have on patient care is one key strategic tool. The aim of this systematic literature review was to identify opportunities for standardization of CLPs to improve the ability to measure the impact CLPs have on the nursing profession and delivery of patient care, globally.

METHODS

A systematic search of published evidence and facility-sourced CLP applications was conducted to identify the structure of CLPs. The database search included CINAHL, MEDLINE, the Sigma Repository, and free open-source platforms, including EBSCO and PubMed. The search criteria were not restricted to specific dates since CLPs date back to the 1970s, and the authors felt it was beneficial to identify historical context and shifting trends in CLP structure. One article was determined as a principal article (Moore et al., 2019), Thus, the search used the principal article's key subject headings: job satisfaction, personnel retention, and professional recognition.

The search was conducted using EBSCO's automated "SmartTextsearch" and yielded 600 articles. The results included articles that referred to program structure, implementation, design, and redesign. Articles that referred to "effectiveness" or "willingness to participate" in an existing program were excluded from the initial results. These articles were outside the scope of this study as they related to the individual perception of a CLP and not the structure. Other excluded articles referred to clinical ladder alternatives, one healthcare setting, or one specific nursing area.

Initially, 79 articles were screened with an interrater reliability of 93%. Consensus building utilizing the exclusion criteria resulted in a total of 30 studies. Contributing to the literature review and enhancing the perspective of the paper's findings was the review of 20 current CLPs. To the authors' knowledge, this is the first-time current CLPs were reviewed alongside published evidence. These CLPs, sourced through the authors' professional ties in the United States, Lebanon, and Ghana, added contextual and operational insight often absent from traditional literature reviews.

An attempt was made to obtain CLPs from a non-biased source, a Google search, but this result yielded only three programs and only two were dated. Therefore, the authors leveraged professional and organizational ties to identify current CLPs. At times, facilities were unwilling to provide the CLP documents, citing concerns of proprietorship and privacy. As many facilities did not give permission for their CLP to be published, this paper does not cite the specific facility-sourced CLPs. Ultimately, two CLPs from a Google search, plus 18 CLPs from healthcare facilities were included in the review.

FINDINGS

Eighteen of the 30 articles reviewed focused on program structure, design or redesign, factors of successful CLPs, and nurses' satisfaction with CLPs. Seven were quantitative, one was qualitative, and four were mixed method research studies. The systematic review observed the evolution of CLPs since their inception, the earliest article was from 1983. Most of the studies were led in the United States except for one study conducted in South Korea.

Of the twenty facility-sourced CLPs, eighteen were from facilities and organizations located across several states including California, Florida, Louisiana, Washington, New Hampshire, Virginia, Texas, and Iowa. Two CLPs were from Ghana and Lebanon. The remaining two CLPs were found through an internet search.

From this global review, findings regarding CLPs commonalities and variations were discovered. The commonalities and variations were congregated into 6 overarching themes.

Framework

All studies reported that the CLP used was grounded in the Benner Model, except for one grounded on Carper's Fundamental Patterns of Knowing in Nursing (Schmidt et al., 2003). Four facility-sourced CLPs referenced Benner, one stated the CLP was grounded on the ANA standards of practice and three cited the Magnet model as the foundation for the CLP. The majority of frameworks in the studies and the facility-sourced CLPs were constructed as an application using a point system that allowed participants to accumulate points from several sections of the facility's application. Many CLPs referred to the application sections differently such as categories, domains, tracks, components, criteria, competencies, and one referred to them as standards (Merian-Tresch, 1997). One article noted that its CLP was founded on an exemplars model (Pierson et al., 2010). Facility-sourced CLPs that did not categorize clinical activities or behaviors were confusing and hard to follow. These CLPs tended to have a laundry list of activities which led the authors to interpret that the nurse could choose from the list without following a particular development plan. Worthy of note is that only two facility-sourced CLPs, including one international CLP and one article (Burke et al., 2017), referenced the use of technology as a domain or a clinical activity.

The authors found that even amongst facilities connected by umbrella health systems, the CLP framework differed, including categories used in the framework and the points allocated to clinical activities. Even the name facilities used for CLPs differed (Table 1). In addition to name and evaluation methodology, CLPs differed in the number of clinical levels available to participants. The average number of clinical levels was four but ranged from three to eight.

TABLE 1 Clinical ladder programs nomenclature

Different names used to describe CLPs
Clinical Ladder
Career Ladder
Career Development Program
Clinical Advancement Program
Performance Based Clinical Achievement Program
Professional Nurse Advancement Program

Eligibility and application processes

There was a wide variation in the CLP application processes, eligibility requirements, portfolio documentation, methods of submission, and review and appeal processes. A synthesis of the various eligibility requirements is listed in Table 2.

Application cycles and frequency differed between organizations. Often, nurses would enter the CLP voluntarily or be required to enter at clinical level I when hired and then apply to advance to higher clinical levels. One article reported that the CLP application was submitted on an employee's anniversary hire date (Day & Scidmore, 1995). Most facility-sourced CLPs followed an initial annual application submission process. Two articles reported that nurses could apply four times a year (Guerrero & Hansen, 1993; Pettno, 1998).

The application review process varied. Either a committee, peers, or leaders performed the reviews. Usually, a portfolio designating a participant's achievement was required. Some facilities used scoring grids to facilitate committee review.

Two articles mentioned the administrative burden time for nurses and the review committee and the amount of documentation and work required from the individual nurse (Jordan, 2015; Tetuan et al., 2013). At least one facility-sourced CLP had separate documents detailing the requirements for clinical level III and IV to maintain their level and additional direction for advancing in the facility's ladder. Another CLP detailed the requirements for submitting the CLP application, specifying the need to use a 3-ring binder and divider pages.

Most articles and facility-sourced CLPs varied in the eligibility requirements to advance on the ladder and did not mention how long a nurse needed to remain at one level before advancing. One facility-sourced CLP mentioned that advancing from level I to level II in succession was recommended but not required, and a nurse could enter at level II if requirements were met. Another allowed advancement after a 90-day probationary period, two required 12 months, another allowed 6 months, and another explicitly stated that advancement was only permitted after two years in each clinical level. Several CLPs stated that point systems and peer and management references were included in the advancement decision.

Education, tenure, years of experience, and certification

CLPs have long been regarded as a useful tool for hospital administrators to recruit and retain nursing staff and encourage nurses to obtain higher levels of nursing education (Tetuan et al., 2013). Most articles and facility-sourced CLPs used a point system to provide a quantitative method for evaluating the nurse's ability to progress on the ladder. However, the similarities in how a CLP may value or assign weight to education, years of experience, and tenure varied greatly. Table 3 illustrates six facility-sourced programs and the different requirements each had for reaching a clinical level regarding

TABLE 2 Eligibility requirements across 50 CLPs

CLP Eligibility
Minimum employment period
Letter of support, attestation, or cover letter from Nurse Manager
Professional goals and objectives for upcoming year
Letters of recommendations from peers working in the same unit
Submission of a statement of purpose
Experience in acute care or specialty area
Educational requirement
Attendance and/or performance evaluation
Use of unscheduled leave time
Commitment to BSN requirement
CEUs earned
Proof of completion of role development classes
Certification in specialty
Minimum level of employment ranged from 90 days to 12 months
Corrective action recorded
Full time or part time status
Minimum required points

education, years of experience, tenure, and certification. For the purposes of comparison, clinical level II and IV for each CLP (when available) are displayed.

Often the BSN, MSN, and PhD degrees were awarded different points. Most of the facility-sourced CLPs required a nurse to have a BSN before applying for a clinical level II position, although one indicated that a nurse could advance to clinical level IV with only a BSN.

CLPs are frequently designed to reward nursing experience as years of practice because it commensurates with professional maturity (Day & Scidmore, 1995). However, it was often unclear if facility-sourced CLPs distinguished between tenure at the facility or considered total years of experience as a nurse. For example, one facility stated a clinical level I participant was someone who had an LPN or RN license, while others did not specify years of experience or tenure and rather focused on educational requirements.

Certification was also an element that many programs required before a nurse could advance in the clinical ladder (Watts, 2010). While some programs made certification a requirement, others did not.

Reward and recognition

Monetary

A cross sectional survey study found that the top reasons for participation in a CLP were personal reward, monetary reward, professional growth, and professional recognition (Tetuan et al., 2013). However, the reward and recognition within CLPs was another identified area of variation. Program compensation varied from additional hourly rates to various bonus structures. In the facility-sourced CLPs, monetary rewards ranged between 2% to 5% or from $500 up to $6240 depending on the facility, the hours worked (i.e., full-time equivalent [FTE]), and the clinical ladder level attained. All the facility-sourced CLPs used an hourly rate increase, or a bonus structure based on FTE and clinical level. One healthcare system reimbursed their RNs for all hours worked on the portfolio.

Non-monetary

In the studies reviewed, variations existed with non-monetary recognition methods, as well. The rewards varied between one-time events such as a lunch or recognition ceremony with certificate and name badge change, or more tangible rewards such as educational reimbursement, days off, or research scholarship. Non-monetary rewards were not addressed in the facility-sourced CLPs.

Professional and leadership engagement

Continuous professional development is central to enhancing the ability to function and contribute to a rapidly changing healthcare environment (ANA Leadership Institute Competency Model, 2013). Given the emphasis placed on leadership development of the bedside nurse, it is no surprise that most CLPs designated a separate category, or several activities related to leadership.

All articles included activities related to leadership and seven listed leadership as a separate domain. Most articles' CLPs outlined leadership activities and competencies at higher clinical levels that participants had to complete to meet criteria for advancement. Eight facility-sourced CLPs listed leadership as a separate competency including the international facility sourced CLPs. Leadership activities included precepting, serving as a committee officer or work group leader, or as a charge nurse (Day & Scidmore, 1995; Guerrero & Hansen, 1993; Krugman et al., 2000; Monarch, 1994; Pierson et al., 2010; Schmidt et al., 2003). Additionally, facility-sourced CLPs' leadership activities included being a super user or champion, participating in or conducting research projects, developing and presenting continuing education, writing Magnet® documents, and serving as a peer interview panelist or competency validator.

Community service

Equally prominent in many of the CLPs' frameworks was the emphasis on community service. One article noted that community activities were one way to satisfy the point requirements for non-direct patient care professional activities (Day & Scidmore, 1995). Community service was cited to focus the nurse's professional development in the work setting and to provide impetus for staff to give back to the facility and the community (Tetuan et al., 2013). Seven of the twenty facility-sourced CLPs had a separate domain or specific activities for community service, including volunteer work

TABLE 3 Comparison of six-facility-sourced clinical ladder programs (CLPs)

Education, certification & years of experience identified from six different CLPs						
	CLP 1	**CLP 2**	**CLP 3**	**CLP 4**	**CLP 5**	**CLP 6**
Clinical Level II	• RN with greater than one year of nursing experience • Nursing education includes Diploma, ADN, BSN, MSN, or health-related Master's • National certification is required for the Diploma and ADN nurse	• At least 3 years RN at facility • Part time or full time • BSN Required • Certification required	• All RN's who have a minimum of 1-year	One of the following: • BSN degree required • Nursing Licensure with ANCC recognized certification	• 13–24 months at facility • BSN degree required	• 1 year experience in practice • 1 year employed at the facility • Successful completion of unit-based orientation
Label	Competent	Advanced Proficient	Clinical Colleague	[a]	[a]	Competent
Clinical Level IV	• RN with greater than 5 years nursing experience • Nursing education includes BSN, MSN, or health-related Master's, and Doctorate • National certification is required for BSN and MSN prepared nurses	• At least 5 years RN at facility • MSN or Masters approved • Certification maintained for 5 years prior required	• 3 Years of experience • BSN • Certification in specialty	One of the following: • BSN with a master's degree in a health-related field and ANCC recognized certification • MSN with an ANCC recognized certification • Doctorate/ PhD in a health- related field • DNP/PhD in Nursing	• 37–59 months at facility • BSN • ANCC certification in related area of practice	• 3 years' experience in practice • 1 year employed at facility • Successful completion of Level 3 in previous year (consecutive advancement) • Level 4 must have a minimum of a bachelor's degree (in any field).
Label	Expert	Expert/Clinical *Level III is the highest level for CLP*	Clinical Leader	[a]	[a]	[a]

[a]Indicates information was not provided.

and advocacy. Frequently, the facility-sourced CLPs linked the community service back to the organization's mission. One facility CLP stated that community service was required to maintain the nurse's current clinical level. Another facility broke down the point allocation for the community service by hours served.

Research, quality improvement, & patient safety

The Institute of Medicine (IOM) has highlighted the need for health care providers and systems to evolve to meet the increasingly complex needs of patients, families, and populations (IOM, 2004). In line with the IOM recommendations, CLPs must evolve to support the nursing profession. Competencies in quality improvement and patient safety are identified as critical for nurse education to address the professions' need to improve the delivery of health care, and it has been perceived that the integration of these competencies is limited in the practice setting (Burke et al., 2017).

This review revealed that CLPs consistently provide credit, and often require that nurses perform research, which may be categorized as an evidence-based project (EBP), quality improvement or performance improvement activity (QI/PI). Similarly, many of the facility-sourced programs required nurses to participate in research activities, such as a journal club, reviewing a clinical protocol, or completing an EBP/QI/PI project. At the higher clinical ladder levels, nurses were expected to submit research for publication or present at a professional conference to obtain a promotion in the clinical ladder. Another similarity noted between the facility-sourced programs and peer-reviewed literature was using a self-written exemplar or submitting written feedback from the patient or family member to demonstrate the delivery of quality patient care.

Despite CLPs recognition of QI and support for nurses to utilize EBP and advance research, notably absent in the peer-reviewed literature and facility-sourced programs was a prioritization of patient safety. The topic of patient safety did not emerge in the CLP peer-reviewed literature until 2017 after the IOM report on Quality and Safety in Education for Nurses (QSEN) project (Burke et al., 2017). More surprisingly, out of the 20 facility-sourced programs, only one program elevated safety in its CLP framework via the domain named “Quality & Safety.” Of the 50 CLPs reviewed, none referenced the use of an auditing tool or other standardized method for determining the delivery of quality care in line with the facility's clinical protocols.

Clinical setting

Most CLPs reviewed were designated for direct patient care or bedside RNs. Several facility-sourced programs included eligibility criteria that a nurse must hold a clinical role or provide direct care. One facility-sourced CLP stated a percentage of time that must be directed toward patient care to be eligible for the CLP.

While it was difficult to ascertain the target population for many of the facility-sourced CLPs, two programs did state that the CLP was inclusive of home care, outpatient, and acute care settings. The peer-reviewed literature was largely geared toward the acute care side, although several studies indicated that the CLPs were used in the ambulatory (Tetuan et al., 2013), rehabilitation (Monarch, 1994) or homecare settings (Winslow et al., 2011).

Linking evidence to action

It has been 40 years since CLPs erupted, yet variation is predominant in their structure, format, application, and implementation process. CLPs that meet the needs of clinical nurses could improve patient outcomes and delivery of care, nurse retention, and employee satisfaction. Yet, the variation between CLPs inhibits the opportunity to measure the impact of CLPs on the profession and the measurement of an individual nurse's competency across the clinical levels. Table 4 highlights recommendations for strengthening CLPs ability to demonstrate utility to the profession.

A generalized finding for all CLPs was the absence of measuring patient outcomes and the nurse’ demonstrated value to patient care as it pertained to the non-direct patient activities. Every CLP placed an emphasis on non-direct patient care activities, such as community service, participating in committees, presenting at conferences, and developing an EBP/QI project. Often these non-direct patient care activities were a requirement for advancing on the ladder. However, the process in which these non-direct patient activities were tracked to demonstrate the impact on patient outcomes, delivery of patient services, and the nurse's professional development remains unknown.

CLPs reward nurses for non-direct patient care activities, but these activities pull nurses away from the bedside. These activities are relatively difficult to complete for a clinical bedside nurse due to time constraints and patient care responsibilities. CLPs should provide equal opportunities for nurses to promote their clinical leadership skills while performing nursing at the bedside. By using a

TABLE 4 Linking evidence to action

CLPs must
Be standardized across healthcare sectors and utilize a framework that is competency based;
Equalize recognition for direct and non-direct patient care actions to ensure nurses are rewarded for clinical leadership at the bedside;
Utilize nurse-directed auditing tools, rather than narrative statements, to measure delivery of effective patient care;
Drive a culture of safety and measure patient outcomes to demonstrate value of nursing care;
Incorporate population-focused metrics and be utilized in outpatient facilities and private practices; and
Connect the use of technology with care delivery and patient outcomes.

standardized, competency-based CLP, nurses can demonstrate their clinical acumen and leadership through the outcomes of their patient care.

CLPs could be used as a platform for demonstrating the value nurses bring to patient care, but the current format is geared toward utilizing CLPs as a retention tool rather than an opportunity to stimulate professional growth and development and improve patient outcomes. CLPS should be based on nurse competencies, driving the use of evidence and research into practice. By having a standardized CLP based on nurse competencies, facilities could measure the impact of nursing care on patient outcomes. Standardizing the framework will facilitate adoption of CLPs globally and support comparative measures within the profession across borders.

CLPs have an opportunity to steer the nursing profession to lead from the front on patient safety. However, it appears that healthcare facilities have missed the opportunity to harness the power of CLPs to drive a culture of safety. Using a standardized template, such as an auditing tool based on clinical protocols, rather than self-written exemplars would enable nurses to demonstrate measured proof of value and safe delivery of care.

Nurses play a vital role in supporting the advancement of population health and are integral to achieving the 2030 Sustainable Development Goals (World Health Organization, 2020). The use of CLPs must be expanded to outpatient and ambulatory care settings and realign the focus of clinical leadership at the primary and preventative care levels. In academia, the nursing profession is striving to adopt a holistic view of patient care by incorporating population-based competencies in the nursing education curriculum (National Academies of Sciences, Engineering, and Medicine, 2021). It is essential that clinical practice align with these changes and grow beyond the traditional mindset of limiting nursing's greatest achievements to the facility-level of care.

The role technology plays in health care continues to grow, but the CLPs reviewed did not recognize the value of nurses' use or adaptation of technology in their clinical practice. Technology plays a vital role in improving efficiency and safety in health care, and nurses are critical to ensuring that the technology employed improves the delivery of patient care. CLPs should incorporate clinical activities that elevate the role of technology in nursing practice.

CONCLUSION

There is a lack of standardization in CLPs across health systems and borders. Facilities may struggle to identify current or innovative trends in CLP design if these programs remain proprietary and private, which may lead to continued methods of trial and error for program development and refinement. To demonstrate value for the investment in nurses' professional development, patient care outcomes, and time spent away from direct patient care, it is essential that data be collected using standardized tools. A standardized CLP has the potential to be a method to accomplish this goal.

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CONFLICT OF INTEREST

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ORCID

Amanda Slagle https://orcid.org/0000-0003-3954-6046

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