# IMPACT OF MEANINGFUL RECOGNITION ON NURSES' WORK ENVIRONMENT IN ICU: A COMPARATIVE EXPLORATION OF NURSE LEADERS' AND STAFF NURSES' PERCEPTION

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## ABSTRACT

Usha Koshy Cherian: Impact of Meaningful Recognition on Nurses' Work Environment in ICU: A Comparative of Nurse Leaders' and Staff Nurses' Perception
(Under the direction of Gwen Sherwood)

**Purpose:** Meaningful Recognition (MR) for job performance, one of the six essential standards of a Healthy Work Environment (HWE), is central to nurses' satisfaction and retention, patient satisfaction and outcomes, and organizational outcomes (AACN, 2005). However, little evidence exists to guide clinical practices related to MR strategies that are most valued by clinical nurses. As a result, nurse managers and other leaders often provide recognition based on assumptions, traditions, and previous experiences, which may or may not be meaningful to their nursing staff members. The purpose of this project was to explore the perception of MR among staff nurses and nurse leaders, compare these perceptions, and identify innovative methods for recognizing nurse's contributions in ways that are valued by the individual, and make recommendations for implementing these methods to the Organizations' Nursing Practice Council.

**Design:** This DNP project used mixed method approach to explore the perception of MR among a convenience sample of nurse leaders and staff nurses working in the Intensive Care Units (ICU) of a large academic medical center, utilizing a mixed method approach. Twenty six nurses participated in seven focus group interview (FGI) sessions that were grouped by position, to obtain a cross sectional perspective. Ninety-five nurses participated in the Healthy Work Environment (HWE) survey and Recognition surveys administered via Qualtrics software.

**Results:** Thematic analysis of the focus group discussion yielded eight themes: what is MR; when to give MR, ways to give MR, who should give MR, who should receive MR, benefits of MR and barriers in providing MR. A lack of awareness about the concept of MR and unavailability of best practices to provide MR were the major reasons cited by staff nurses and nurse leaders for not providing MR. In addition, limited resources, institutional policies and the size and diversity of the nursing workforce were also barriers to providing MR to nurses. Survey results indicated that critical care staff nurses' perception of the current work environment and MR was 'good' based on the AACN's scoring guidelines for HWE survey. The results of the Recognition survey was similar to the focus group discussion theme 'ways to give MR', which confirmed that salary commensurate to performance scheduling flexibility, opportunities for growth, private verbal feedback and written and public recognition were the most meaningful methods of recognition.

**Conclusion:** The standard of MR should be given equal priority along with other five HWE standards. Nursing leadership needs to focus on developing strategies to provide MR in a consistent and systematic manner, so that every nurse will reap the benefits of MR. The art and science of providing MR should be added to leadership development programs and included as an essential competency for nurse leaders.

## DEDICATION

To all the nurses I had the privilege to work with and learn from.

To my mentors who taught the value of meaningful recognition.

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# CHAPTER 1. IMPACTING NURSES' WORK ENVIRONMENT THROUGH MEANINGFUL RECOGNITION

## Introduction

Nursing is a noble and rewarding but physically and emotionally exhausting profession. Nurses are expected to demonstrate mental composure, physical stamina, and alert intelligence (Robins, 2015) while working in a highly complex, interactive, and stressful healthcare environment. A Healthy Work Environment (HWE) is linked to patient safety, nurse retention and recruitment, and financial viability of the organization (AACN, 2013; Aiken, Clarke, Sloane, Lake, & Cheney, 2008; Djukic, Kovner, Brewer, Fatehi, & Greene, 2014; Kelly, Kutney-Lee, Lake, & Aiken, 2013). The 2004 Institute of Medicine (IOM) report *Keeping Patients Safe: Transforming the Work Environment of Nurses* inspired the American Association of Critical-Care Nurses (AACN) to implement the HWE initiative. The HWE framework consists of six evidence-based standards: skilled communication, true collaboration, effective decision-making, appropriate staffing, meaningful recognition, and authentic leadership (AACN 2005). The AACN has emphasized the interdependence of these standards and that when any standard is considered optional effective and sustainable outcomes cannot be achieved (AACN, 2005). Yet, even after a decade of publishing the HWE framework, the standard of Meaningful Recognition (MR) remains an underused, misunderstood and abstract concept. Surveys show that at a national level the MR survey results are declining (Ulrich et.al, 2014). At an institutional level, MR is often the lowest scoring item in the annual workforce engagement survey (WES). During discussions with leaders and staff nurses it was evident that at an individual level, MR remains as a vague concept. While searching the database of CINAHL and PubMed using the key words

'Meaningful Recognition' and 'Healthy Work Environment' research articles related to MR was scarce when compared to the number of research studies exploring the other five standards of HWE (staffing, communication, collaboration, decision-making, and leadership) proving that MR is not a widely studied subject in health care academia and research.

To compound this issue, the definition of MR remains unclear for many nurses and nurse leaders. Prior reesearch studies on MR conducted in health care and nursing field (Blegen, 1992; Abualrub & Al-Zaru, 2008) and in other industries (Ventrice, 2013) state that monetary benefits are a major form of recognition. However the recent data from AACN (2013) survey suggests that MR for nurses is not based on monetary rewards but involves RNs in leadership positions acknowledging the value that nurses bring to the organization. The majority of RNs who responded to the AACN survey ranked acknowledgement from patients as the most meaningful recognition (51.4%), followed by recognition from fellow RNs (21.3%) and, lastly, recognition from frontline nurse managers (11.5%) (Ulrich et.al, 2014). This indicates that there is an urgent need to explore the concept of MR and increase awareness among nurse leaders of about the importance of MR and equip the leaders with tools to provide MR to staff and thereby create and sustain a HWE (Ulrich et.al, 2014**).**

## Problem Statement

Meaningful Recognition (MR) for job performance is one of the six essential standards of Healthy Work Environment (HWE) and is central to nurses' satisfaction and retention, patient satisfaction and patient and organizational outcomes. The process of MR acknowledges an individual's behavior and the impact their actions have on others, and ensures that the feedback is relevant to the recognized situation and is equal to the person's contributions (AACN, 2005). The lack of recognition contributes to dissatisfaction, poor morale, high turnover, reduced productivity, and poor performance among nursing staff, which may result in suboptimal patient

outcomes (Lefton and aBreugger, 2009). However, there is little evidence to guide clinical practices related to MR strategies that are most valued by nurses. As a result, nurse managers and other leaders often provide recognition based on assumptions, traditions, and previous experiences, which may or may not be meaningful to nursing staff (Cronin & Becherer, 1999) and may negatively affect the health of the work environment.

Therefore, exploring effective methods of recognizing staff contributions that are valued by the recipient within specific work environments and settings may provide valuable information for developing effective MR interventions. In addition, the information gathered through this project may be used in leadership training to increase awareness among the nurse leaders about MR and its potential benefits such as improved patient satisfaction and outcomes.

## Purpose of the DNP Scholarly Project

This DNP scholarly project will focus on the MR component of the HWE. The aims of the project are to (a) examine the understanding of nurse leaders and staff nurses who work in adult critical care units about the concept of MR and its importance in shaping an HWE; (b) identify strategies to efficiently and effectively provide MR in the critical care units; and c) propose a sustainable plan for educating nurse leaders and nurses on establishing and maintaining the process of MR in the critical care units.

## Clinical Question

What are the practical and effective ways in which nurses and nurse leaders can provide Meaningful Recognition (MR) to nurses so as to contribute to a Healthy Work Environment (HWE) in the Critical Care Units of University of North Carolina Hospitals (UNCH)?

### Specific questions to guide the project.

1. How do staff nurses working in the adult critical care units rate their work environment and what is the reported level of MR as measured by the HWE survey?

2. How do nurses and nurse leaders from adult critical care units perceive Meaningful Recognition (MR)?

3. Are there differences in perception of HWE and MR based on the critical care staff nurses' level of education, position in the institution, age group, gender, years of service in the unit, years of experience in the institution, and years of experience in nursing?

4. What are adult critical care staff nurses' preferred ways of being recognized as measured by the Recognition Questionnaire?

5. Are there differences in preferred ways of recognition based on the critical care staff nurses' level of education, position in the institution, age group, gender, years of service in the unit, years of experience in the institution, and years of experience in nursing?

## CHAPTER 2. LITERATURE REVIEW

Meaningful recognition (MR) is the process of acknowledging one's behaviors and the impact these actions have on others, ensuring the feedback is relevant to the recognized situation and is equal to the person's contributions (AACN, 2005). MR has the following characteristics: it is ongoing and builds on itself, relevant to the person being recognized, congruent with the person being recognized, occurs in response to the value they add, is a fundamental human need, and is an essential requisite to personal and professional development (AACN, 2005). According to AACN (2005), providing meaningful recognition is essential for effective and sustainable outcomes of healthy work environment to emerge.

MR leads to higher job satisfaction, a stronger commitment to the organization and profession, better delivery of quality patient care, and stronger workgroup cohesion and collaboration (Grochow, 2012). Lack of MR causes people to feel invisible, undervalued, unmotivated, and disrespected (AACN, 2005), all of which will result in a poor work environment. The impact of nurses' work environments on patient outcomes, nurse outcomes, and organizational outcomes is well documented in the literature (Aiken, Clarke, Sloane, Lake, & Cheney, 2008; Djukic, Kovner, Brewer, Fatehi, & Greene, 2014; Institute Of Medicine (IOM), 2004; Kelly, Kutney-Lee, Lake, & Aiken, 2013). Less than optimal work environments affect the quality of healthcare delivery, the attractiveness of the organization for customers (patients & healthcare workers), and the financial well being of the organization (low reimbursements, poor staff retention, and high staff turnover).

Inadequate leadership support that stems from deficient leader education and leaders' lack of understanding about HWE are cited as contributory factors for poor work environments (Ulrich et al., 2014). The monetary value attached to human components such as recognizing staff to improve the work environment is invisible to administrators because the revenue they generate cannot be easily tracked and the energy they create is intangible (Homisak, 2015). Strong nurse leaders who recognize the value of MR at all levels of the organization, especially at the patient care unit level, are essential to establish a HWE (Shirey, 2006). Kramer, Maguire, and Brewer (2011) conducted a study of work environments among 12,233 nurses who worked in magnet-designated hospitals. The findings of this study confirm that development of healthy unit work environments is a professional responsibility and this is possible through partnership between organizational and nurse leadership and the clinical professional staff at the unit level. Promoting and advocating for a culture that encourages recognition at workplace might help in retaining staff and thus enhance the quality of nursing care (Abualrub & Al-Zaru, 2008)

## Effect of MR and HWE on Patient Outcomes

The review of literature did not yield any studies that specifically explored the relation between MR and patient care outcomes. However evidence suggests that meaningful recognition is associated with positive self esteem, which fuels psychological capital factors such as self-efficacy, optimism, and resiliency; perceived organizational support; organizational commitment; job embeddedness; and job satisfaction (Lefton, 2012). In addition, many studies have explored the effect of HWE as a whole or the specific components of the HWE on patient care outcomes. One thing is clear—awareness about job satisfaction and burnout is important because this may affect quality of patient care and high staff turnover rates (Myhren, Ekeberg, & Stokland, 2013)

Intensive Care Units (ICUs) are highly stressful healthcare settings that require high standards of nursing skills and competences that can lead to high job stress and less job satisfaction for nurses working in the ICUs (Myhren, Ekeberg, & Stokland, 2013) and thereby pose many challenges to maintain a healthy work environment. Bai (2015) reports that although the unique nature of nursing practice in ICUs may lead to higher job stress and less job satisfaction for nurses, an HWE can facilitate nurse's job satisfaction, retention rate, quality of patient care, and patient care outcomes. The findings of a study done among 706 nurses to investigate the mediating effect of nurse job satisfaction on the relationship between a healthy work environment and nurse-reported quality of care (QC) in Chinese intensive care units supported the conclusion that a healthy work environment could improve nurse job satisfaction and nurse-reported QC in the ICUs (Bai, 2015). In a study to explore the relationships between nursing practice environments and medication error interception in acute care hospitals among 686 staff nurses, researchers found that better practice environments were positively and significantly associated with error interception (Flynn, Liang, Dickson, Xie, & Suh, 2012).

Patients' quality of care suffers when nurses' work environments are unhealthy because an HWE is essential for the nurse to effectively coordinate and integrate the multiple aspects of care and bring about positive outcomes for patients (Mitchell, 2008). The U.S. Department of Health and Human Service (DHHS) reported that a poor nursing work environment had negative consequences on hospitalized Medicare beneficiaries such as adverse events, prolonged hospital stay, and death (Kurtzman & Fauteux, 2014). Researchers has reported statistically significant association between higher staffing levels (HWE standard) and decreased hospital-associated infections (HAI) (Stone, Pogorzelska, Kunches, & Hirschhorn, 2008). However, it is important to note that improving one component of HWE alone has no effect on the patient outcome.

Researchers report that decreasing the nurse workload by 1 patient per nurse lowered mortality by 9% in hospitals with the best work environments and by 4% in hospitals with average work environments but had virtually no effect in hospitals with poor work environments (Aiken et al., 2012).

## Effect of MR on Nurse Outcomes

Nurse outcomes are measured in terms of autonomy, self-efficacy, job satisfaction, commitment to the organization, and retention. Nurses with an increase in autonomy and self-efficacy in the workplace are more satisfied in their job and have an increased commitment to the organization (Huddleston, 2014). Kelly, McHugh, and Aiken (2011) conducted a secondary analysis of data from a four-state survey of 26,276 nurses in 567 acute care hospitals to evaluate differences in work environments and nurse outcomes in magnet and non-magnet hospitals. They reported that magnet hospitals had significantly better work environments ($t = -5.29$, $P < .001$), more highly educated nurses ($t = -2.27$, $P < .001$), and nurses were 18% less likely to be dissatisfied with their job ($P < .05$) and 13% less likely to report high burnout ($P < .05$). The study of work environments in nine countries found that hospitals with poor work environments were associated with negative outcomes for nurses (burnout, job dissatisfaction) and patients (lower-quality care, not prepared for discharge) (Aiken, Sloane, & Clarke, 2011). The 2013 AACN survey stated that about 50% of the nurses who responded to the survey had the intention to leave within the next 3 years (21.3% within 12 months and 29.2% within 3 years). However the respondents were willing to reconsider the plans to leave if leadership and respect from administration improved (Ulrich et al., 2014). This is a great example of the far-reaching effects of MR on nurse outcomes. Creating awareness about MR and developing MR skills in nurse leaders is essential to maintain a stable registered nurses' work force in the organization.

## Effect of MR and HWE on Organizational Outcomes

Organizational outcomes, which are measured in terms of employee productivity, employee retention, and attainment of organizational goals, are the direct results of nurse and patient outcomes (Huddleston, 2014). Organizational outcomes are a major factor in determining the financial health of the organization.

### Nurse-Related Financial Outcomes

The shortage of nurses is projected to be 285,000 RNs by 2020 and approximately 500,000 RNs by 2025 (Buerhaus et al., 2009). In the 2013 AACN survey, nurses who were dissatisfied with their current position had plans to leave the organization (32.3%) or the work unit (16.5%) (Ulrich et al.,2014). Considering the average salary is $64,690 for an RN, the approximate cost to replace one medical-surgical nurse is $92,442 and the cost to replace a specialty practice nurse is estimated at $145,000 (Huddleston, 2014). In addition to the direct costs, there are hidden costs such as advertisement, hiring process, orientation, and training. High turnover rate and shortage of nurses will place greater demands on nurses providing direct patient care, which will further affect nurse satisfaction. From the author's observation a high turn over rate also heavily affects the stability of the nursing work force. In some instances when one or more key members leave the work force it can have a ripple effect on the rest of the work force, resulting in a mass exodus of nurses from the unit or organization. As the nurse turnover continues to creep up, managing retention may become a strategic imperative; therefore including programs that build relationships, commitment, and confidence early on in the employment cycle may prove essential (Colosi, 2014). St. Lucie Medical Center implemented an MR program targeted toward personal growth and clinical advancement of staff nurses that increased nurse satisfaction and contributed to an HWE (Sherman, Edwards, Giovengo, & Hilton, 2009). Similarly, Clevenger (2009) reports that an MR program that recognized the

preceptors in the operating room reinforced positive behaviors and improved preceptor morale, ongoing education, enhanced bonding, and served as a source of fun.

It is interesting to note that other industries such as information technology companies are also concentrating on the area of MR to improve HWE. MR boosts engagement, productivity, and profits, whereas ineffective recognition is a waste of both money and time (Ventrice, 2013). However leaders should keep in mid that recognition has meaning only when it is relevant to the person being recognized. Ventrice (2013) points out that employees are motivated by recognition more than rewards. The most meaningful recognition is best done by individually acknowledging the team members when they are doing right and communicating with them. Recognition that is not congruent with a person's contributions or comes in tandem with emotionally charged organizational change is often perceived as disrespectful tokenism (Barnes & Lefton, 2013).

**Patient-Related Financial Outcomes**

Financial stability of health care organizations heavily depends on the reimbursements from third-party payers, which in turn is based on patient outcome and satisfaction. In the literature there was no evidence of direct relationship between MR and patient outcomes. However, MR being a component of the overall HWE, the author is making a safe assumption that MR being a part of the HWE has an indirect influence on patients' outcomes that are affected by HWE.

The Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) is a widespread measure of hospital's patient-centered care and patient experience and is significantly influenced by the quality of nurses' work environments. For every 10% of nurses who reported dissatisfaction with their jobs, there was a 2% decrease in the percentage of patients who would definitely recommend the hospital (Ulrich et al., 2014). Poor HCAHPS

scores can result in a 2% reduction in payment from Center for Medicare and Medicaid Services (CMS) (Mattox, 2014) and may affect the organization's financial health.

Rate of readmissions is a measure of organizations' quality of care. Kramer, Maguire, and Brewer (2011) studied 12,233 experienced nurses from 717 clinical units in 34 magnet hospitals and reported that nurses' ratings of quality of patient care directly correlated to quality of work environment. In an unhealthy work environment discharge planning is done less often (Ulrich et al., 2014), which causes high readmissions. In 2013 Medicare levied $227 million in fines for excess readmissions (Ulrich et al., 2014). Because hospitals are not reimbursed for readmissions, this cost (estimated to be about $11,200 per readmission) has to be absorbed by the hospitals (Ulrich et al., 2014). In addition CMS will penalize the organization a 3% readmission penalty in fiscal year 2015 (Ulrich et al., 2014).

Hospital-acquired conditions (HAC) are expensive and are no longer reimbursed by third-party payers. Therefore healthcare organizations are encouraged to identify the circumstances that lead to HACs and develop preventative strategies to reduce the incidence of HAC (Nero, Lipp, & Callahan, 2011). The cost of preventable harm to hospitalized Medicare beneficiaries in 2010 is estimated to be $324 million (Kurtzman & Fauteux, 2014). The estimated mean direct cost per hospital-associated infections (HAI) is $15,275. An average of 10 cases of HAIs are reported every month, which will cost the organization $1,833,000 (Rizzo, 2013). Researchers who investigated the relationships between critical care work environments and nurse-reported healthcare-associated infections (HAIs), using a sample of 3,217 critical care nurses in 32 hospitals reported that nurse-reported HAIs were less likely to occur in an HWE (Kelly, Kutney-Lee, Lake, & Aiken, 2013). Agarwal, Sands, and Schneider (2010) calculated that more than $12 billion a year is wasted due to inefficiency in communication (an element of

HWE) among care providers in U.S. hospitals. Re-designing of the work environment can optimize the nurses' work environment and improve nurses' job satisfaction, reduce nurses' turnover, and avoid CMS penalties for poor nurse-sensitive outcomes (Djukic, Kovner, Brewer, Fatehi, & Greene, 2014).

## Conceptual and Theoretical Framework

The concept of MR can be explored on the basis that (a) MR is a basic human need and (b) organizational culture has a unique role in valuing MR and shaping a HWE.

This project used theory of Human Motivation (Hierarchy of Needs) by Abraham Maslow *and* the theory of organizational culture developed by Edgar Schein as a theoretical framework.

**Theory of Human Motivation (Hierarchy of Needs).** (Appendix M Image A1)

The basic human need for MR can be explained using Maslow's theory of human motivation (Maslow, 1943), commonly known as Maslow's *Hierarchy of Needs*. According to Maslow, individuals are motivated to act on the basis of their needs, where the most basic needs (e.g., food, water) must be met before higher-order needs are pursued (e.g., to know, to understand) (Maslow, 1943). The two human needs that correlate with the concept of MR are the need to belong to a group and be accepted (*belonging and love)* and the need to be competent, achieve mastery of tasks, and receive attention and praise for having attained competency (*esteem*). Attainment of these two levels allows the person to reach the highest level of human needs, self-actualization, which offers peace with surroundings and satisfaction with one's career and life (Carter, 2012).

According to AACN (2005), recognition of the value and meaningfulness of one's contribution to an organization's work is a fundamental human need and an essential requisite to personal and professional development. When the basic needs are not met, it may result in

dissatisfaction and burnout, which is a psychological response to long-term emotional and interpersonal stressors, usually in the work context (Myhren, Ekeberg, & Stokland, 2013). Evidence links six work-life issues that cause burnout. These include: work overload, lack of control, lack of reward, lack of community, lack of fairness, and value conflict (Paris & Terhaar, 2011), many of which are experienced by nurses. Applying Maslow's hierarchy to nursing practice suggests that when the self-esteem needs are not met, nurses will be less motivated and less likely to progress to the higher-level function of self-actualization in the practice environment (Paris & Terhaar, 2011).

***Limitations***: Maslow's theory is well known and appealing to common sense, there is no empirical evidence to support its hierarchical aspect. This theory fails to take into account the cultural and individual differences and thus it may not be generalizable across all populations.

**Theory of Organizational Culture** (Appendix M Image A2)

Meaningful recognition is not an event but a process that must be ongoing and built over time, thus becoming a norm within the work culture (Barnes & Lefton, 2013). Schein (2010) defined culture as a "pattern of shared basic assumptions learned by a group as it solved its problems of external adaptation and internal integration which has worked well enough to be considered valid and therefore to be taught to new members as the correct way to perceive, think, and feel in the relation to those problems" (p. 18.). Each organization's culture is relatively unique, malleable, and subject to continual change, thereby creating the potential to maximize service, quality, and outcomes for both healthcare providers and patients (Bellot, 2011).

Edgar Schein's (1992) organizational cultural model has three elements—artifacts, espoused values, and basic assumptions. Artifacts are readily visible aspects of culture including technology and behavioral patterns and may have multiple cultural meanings. Espoused values

are observable patterns of meanings that are testable in the physical environment and by social consensus. Basic assumptions, however, are shared values that are not readily observable but have to be inferred from the observations of the culture. According to Schein (1992), "to learn something new in this realm requires us to resurrect, reexamine and possibly change some of the more stable portions of our cognitive structure (double loop learning or frame breaking). Such learning is intrinsically difficult because reexamination of basic assumptions temporarily destabilizes our cognitive and interpersonal world releasing large quantities of basic anxiety"(p. 22). However, there is hope that the culture in systems can be created, embedded, evolved, and ultimately manipulated by leaders. Schein (1992) stated that the dynamic process of culture creation and management are the essence of leadership and thus leadership and culture are fundamentally intertwined and become two sides of the same coin.

Changing culture requires leaders with vision as well as the appropriate management tools to engage personnel in embracing a positive change for a healthier and more productive workplace (Brunges & Foley-Brinza, 2014). Thus the need for organizational acceptance of programs that provides MR as a part of creating a favorable environment can be explained using organizational culture theory. This theory guided the author to develop the ultimate goals of this project—to understand the culture of the facility and develop appropriate tools to provide meaningful recognition to nurses.

***Limitations:*** This theory is broad and abstract. The MR standard of HWE does not fit well into the traditional quality improvement approach of diagnosing and correcting problems. In addition, Nurses, as a group, may have an overdeveloped sense of humility, which makes them reluctant to say what works well (Havens, 2006), and influence a change in the organizational culture.

# CHAPTER 3. METHODOLOGY

This DNP project, an exploratory, descriptive, correlational study, was completed using mixed methodology techniques. The aim of this design was to explore the perception of MR among nurses using results from the Healthy Work Environment (HWE) and Meaningful Recognition (MR), identify the types of recognition most meaningful for nurses working in the critical care units of University of North Carolina Hospitals (UNCH) and explore differences in the perceptions of the HWE and MR based on the various demographic characteristics of the participants. Qualitative data was collected through Focus Group Interviews (FGI) of 26 staff nurses and nurse leaders from the adult critical care units of UNCH. Following the FGI, a survey was administered to all the nurses and nurse leaders of the adult critical care units at UNCH.

## Project Setting

This project was conducted among the nurses and nurse leaders from the adult critical care units at the University of North Carolina Hospitals (UNCH). The University of North Carolina Health Care System (UNC Health Care), based in Chapel Hill, is a level III trauma center and a not-for-profit integrated healthcare system. UNCH is owned by the state of North Carolina and is affiliated with the UNC School of Medicine. UNCH has a total of 803 beds, which includes 11 critical care units with a combined total of 150 beds (UNCH, 2015). The adult critical care areas are managed by surgery services, medicine services, and cardiovascular services.

## Sample

A voluntary convenience sample of registered nurses from five adult intensive care units at UNCH participated in this project. All levels of Registered Nurses (RN), including Staff Clinical Nurse I, II, III and IV, nurse managers, nurse directors, and nurse educators from the five critical care units were invited to participate in this project to ensure a representative sample of units and nurse positions (see Table 1 for the details of Focus Group Interview participants and Table 2 for the potential sample pool of nurses to whom the survey was administered). Clinical Nurse I is a new graduate, with no clinical experience as an RN. After 1 year of clinical experience, the RN is transitioned to Clinical Nurse II. This is the largest group of nurses at UNCH and includes nurses with experience ranging from 1 year to over 30 years. Clinical Nurse IIs are promoted to a Clinical Nurse III by submitting a portfolio of their leadership abilities and extra clinical activities and projects and with the approval from the managers. Clinical III positions are limited in number; representing approximately ten percentage of the total staff nurse positions. Clinical Nurse IVs have a dual role as a clinical expert and assistant manager of the units. Clinical Nurse IVs performs administrative functions such as scheduling, payment of salary as well as performing clinical duties. Managers oversee all CNs and the overall administration of the unit. Educators organize and execute continuing education of the staff nurses. Directors oversee a service line with many patient care units. All directors directly report to the Chief Nursing Officer. The participants were categorized into two groups, leaders and staff nurses, based on their hierarchical position in the organization and salary status. Managers, directors, and educators were categorized as leaders due to their position and decision-making capacity over staff nurses and the monthly salary status. Clinical nurses I, II, III and IV, were grouped into the staff category because they were direct caregivers at the bedside and were paid on an hourly basis with lesser decision-making capacity. Although clinical nurse level 1V

performs some amount of managerial function, their role gravitates more to being clinical experts at bedside than as a manger.

The PI obtained written permission from the respective directors and nurse managers of the critical care units before recruiting the participants for FGI and the surveys (Appendix A). Cardiothoracic Intensive Care Unit was exempted from the project due to leadership transition, as requested by the director of the cardiovascular services.

The director, managers, and educators were individually invited through email to participate in the project. Staff nurses were invited to participate in the FGI through an e-mail send out by the managers of the respective critical care units participating in the study. In addition, fliers were posted on the bulletin boards in the bathrooms and break rooms of the participating critical care units to inform the participants about the different timings of FGI and ensure participation from all the units. The participants were selected on a first come-first served basis to fulfill stratification for representation of all four levels of staff nurses in the critical care units (Table 1).

Table 2. Details of Sample for Focus Group Interview

| | Job category | Units/Services | Number of attendees |
|---|---|---|---|
| FGI of Staff #1, #2 and #3 and #4 | Clinical Nurse (CN) 1,11,111 and 1V | Intensive Care Units | Focus Group #1 =3<br>Focus Group #2 =4<br>Focus Group #3 =3<br>Focus Group #4 =6<br>Total =16 |
| Focus Group #5 | Managers | Intensive Care Units | Total =4 |
| Focus Group #6 | Directors | Adult Intensive Care Units and Continuing Education | Total =3 |
| Focus Group #7 | Educators | Intensive Care Units | Total =3 |
| | | | Total FGI participants = 26 |

Table 3. Potential and Actual Sample Pool Based on Registered Nurses Employed in the Adult Intensive Care Units (ICU)

| Intensive Care Units (ICU) | Director | Nurse Manager | Nurse Educator | Clinical Nurse IV | Clinical Nurse III | Clinical Nurse II | Clinical Nurse1 |
|---|---|---|---|---|---|---|---|
| Surgery | 1 | 1 | 1 | 3 | 10 | 45 | 1 |
| Neurosurgery | | 1 | | 2 | 5 | 35 | 2 |
| Burns | | 1 | | 2 | 5 | 35 | 4 |
| Cardiothoracic (exempted) | 1 | NA | | NA | NA | NA | NA |
| Cardiology | | 1 | 1 | 2 | 4 | 20 | 2 |
| Medicine | 1 | 1 | 1 | 2 | 5 | 35 | 4 |
| Survey was send out to 230 Registered Nurses | 3 | 5 | 3 | 11 | 26 | 170 | 12 |
| Actual N=93. (2 of the participating nurses did not indicate their title) | 0 | 2 | 0 | 7 | 17 | 63 | 2 |

## Protection of Human Subjects

This DNP project proposal was submitted to the University of North Carolina's (UNC) Institutional Review Board (IRB) and was considered exempt under the non-biomedical category (IRB #15-2052) on October 20, 2015 (Appendix G). This project was also reviewed and approved by the UNCH Nursing Research Council (NRC) on September 23, 2015 (Appendix F). Prior to the Focus Group Interview, the primary investigator (PI) explained the details of the project from the project information sheet (Appendix H, Item 1) and obtained an informed consent from each participant. Prior to administering the surveys in Qualtrics, the participants were instructed to read the information document and reminded that participation in the survey was considered as their consent (Appendix J, Item 1). This document also provided information about the approximate time needed to participate in the project and the voluntary nature of the participation in the project.

## Confidentiality

To reassure the participants about the confidentiality of the data collected through the focus group interviews and the surveys, informed consent included statements such as (I) data collected will only be used for research purposes, (ii) PI will not ask you for your name or any other identifiers, (iii) your responses in the FGI /Survey will be anonymous, and (iv) all information you provide will be combined with the group's responses, any unit data will only be reported as group data.

## Data Security

Only the PI had access to the FGI recordings and the transcripts. Access to the electronic data was limited to the PI, the PI's advisor, and the statistician appointed by school faculty. The PI stored digitally recorded data from the FGI securely and only the PI handled the raw data. Only de-identified data were securely, electronically transferred for transcription and only the PI and the transcriptionist could access this data. Survey data was stored in Qualtrics software on the PI's personal computer, which was password secured. All data related to the study in paper or electronic form will be stored securely for a maximum of 5 years and then destroyed. The ultimate ownership of the data will remain with the PI and will not be shared without an ethical review.

## Data Collection

Data collection for the project was implemented using both Focus Group Interviews and Surveys using two instruments. Both approaches collected demographic data from participants.

### Step 1. Focus Group Interviews

The purpose of the Focus Group Interviews (FGI) was to elicit perceptions, information, attitudes, and ideas about the importance of Meaningful Recognition (MR) in creating an HWE across the different levels of nurses (directors, managers, educators, and staff nurses). Evidence

indicates that smaller group interaction is productive and nurses enjoy the opportunity to have their ideas and opinions heard (Brunges & Foley-Brinza, 2014). Publically expressed statements of disagreement, conflict, and conviction may add to the richness of the data as well as power and meaning of the study findings.

Focus Group Interviews (FGI) prompts were formulated on the basis of an Appreciative Inquiry (AI) 4 D (Discovery, Dream, Design, Delivery) framework to explore the concept of MR and its perceived importance in creating and maintaining an HWE among nurses in the critical care units (Table 3).

Table 4. Appreciative Inquiry Framework for FGI

| |
|---|
| Appreciative inquiry is an organizational development intervention developed by Cooperrider in 1986 based on affirmation, appreciation, and dialogue that searches for the best in people and organization, actively acknowledges and celebrates their successes, shifts the focus from a problem to possibilities and thus enhances organizational growth (Trajkovski, Schmied, Vickers, & Jackson, 2013).<br>The four key phases of AI process (4-D cycle) occur in sequence:<br>***Discovery phase*** explores the chosen topic area interviews, storytelling, and discussions groups (Trajkovski et.al., 2013).<br>***Dream phase*** is where participants work together to develop assertive statements of what the organization hopes to achieve (Trajkovski et.al. 2013) and expand on the key positive theme generated during the AI interviews to create compelling positive vision (Havens, 2006).<br>***Design Phase*** invites people to examine and to determine which committee structures, policies, procedures, recognition methods and communication links best facilitate the dream (Havens, 2006).<br>***Delivery Phase*** focus on sustaining the envisioned future and transforming the new vision into a daily practice (Trajkovski, et.al., 2013), making it a habit to seek the positive, build relationships and continue to redesign processes (Havens, 2006). |

The FGI prompts were prepared based on the literature about MR and HWE and were clearly phrased, appropriately sequenced, and explicitly aligned with the AI framework so that the response elicited addressed the topic of effectively and efficiently providing MR for nurses in intensive care units. The prompts were reviewed and validated by the DNP project committee members. These prompts encouraged the nurses to explore the value of MR for them, recall the most valued MR they received, and identify ways to provide and receive MR in a consistent and systematic manner.

Volunteer participants for FGIs received an email reminder of the venue and time 7–10 days prior to the FGI sessions. A reminder email was sent out 3 days before and one day before the actual FGI. A medium-sized conference room was used for each FGI to enhance the acoustic quality of recording. At the beginning of each FGI, the PI discussed the consent to participate in the project with the participants, introduced the topic of FGI, provided a short definition of HWE and MR, and requested the participants to fill out a demographic questionnaire (see Appendix H for the complete FGI packet).

Table 5. Focus Group Interview Questions

| |
|---|
| **Introduction:**<br>This session will use appreciative approach using Appreciative Inquiry (AI) framework and focus on the positives and values on what would be meaningful recognition. |
| **FGI Prompts** |
| 1.What is your understanding of Meaningful Recognition and Healthy Work Environment? |
| 2.Think of the times in your nursing career when you felt rewarded. What is the most meaningful recognition you've received as a nurse? (Personal anecdotes). Who provided the most meaningful recognition for you? |
| 3. If you could dream most valuable way of providing MR what would it be? (What are examples of MR that you value)? |
| 4.What are considerations in providing MR among nurses in our organization? |
| 5.How would you design an efficient and effective process to implement MR among nurses? |

FGI with leaders (directors, managers, and educators) was conducted by the PI and was assisted by facilitated by the nurse researcher at UNCH, who also served as a committee member for this DNP project and the staff nurses' (Clinical nurse I, II, III, and IV) interviews were conducted by the PI alone.

All the interviews were audio-recorded using Olympus VN-722 PC voice recorder and cell phone recording was used as back up. For additional clarity and richness of data, the PI documented informal notes during the FGI sessions, requested the participants to clarify their responses, and prompted in depth discussion of certain topics by using phrases like, "did I understand it right," "is this what you meant," "could you explain it further?"

**Step 2: Surveys**

The surveys administered to the nurses and nurse leaders had three parts—The Healthy Work Environment (HWE) Survey (AACN, 2005) and Recognition Survey (Blegen, 1992) and Demographic Survey. The purpose of HWE survey was to obtain quantitative data on nurses' perception of the health of their work environment and the meaningful recognition they received. The purpose of Recognition Survey was to obtain data on the methods of recognition that are meaningful to nurses. The purpose of Demographic Survey was to obtain the demographic features of the nurses who participated in the survey.

**Survey Instruments**

**1. Healthy Work Environment (HWE)** survey (Appendix D), developed by the American Association of Critical-Care Nurses (AACN) in 2005, is a tool for the preliminary assessment of work environment.

The HWE assessment tool has a total of 18 questions; each of the six HWE standard is assessed using three unique questions (Table 5). Survey participants were asked to rate each individual item on a 5-point Likert scale, where 1 = strongly disagree and 5 = is strongly agree,

the highest score possible. An aggregate HWE mean score for all 18 items and a mean scale for each subscale were calculated. AACN's scoring guidelines were used to interpret the mean scores for the entire assessment and for the six HWE standards: 1.00–2.99 = Needs Improvement; 3.00–3.99 = Good; 4.00–5.00 = Excellent.

Table 6. Six Domains of Healthy Work Environment and Subscale Survey Item Numbers

| HWE Standard domains | Explanation | Survey items |
|---|---|---|
| Skilled Communication | Equally proficient in communication and clinical skills | 1, 6, 14 |
| True Collaboration | Relentless in pursuing and fostering true collaboration. | 2,10, 15 |
| Effective Decision making | Valued and committed partners in making policy, directing and | 7, 11,16 |
| Appropriate staffing | Effective match between patients' needs and nurse competencies. | 3, 8, 12 |
| Meaningful recognition | Must be recognized and must recognize others for the value each brings to the work of the organization. | 4, 9, 17 |
| Authentic Leadership | Nurse leaders must embrace, live and engage others in the achievement of a healthy work environment | 5, 13, 18 |

The questions and scales have been reviewed for face validity and administered to two groups of 250 subjects each (AACN, 20015). Both samples were tested for reliability and showed internal consistency with identical factor structures and Cronbach's Alpha scores of 0.80 or better (AACN, 2015). Permission to use the HWE assessment tool was obtained from the AACN in September 2015 (Appendix A, item #1).

**2. Recognition Questionnaire** (Appendix E) developed by Blegen and colleagues (1992) is used widely to measure nurses' perception of managers' recognition behaviors and to determine what types of recognition is meaningful to nurses. Content validity was established by a panel of 16 nursing experts with an extensive review of the literature. Initially the authors identified 65 behaviors that acknowledged staff nurses' performance and achievement. Later on

the list was reduced to 30 behaviors that were categorized under six factors: monetary rewards commensurate with performance (salary), private verbal feedback, written acknowledgement, public acknowledgement, schedule adjustment, and opportunities for growth and development (Table 6). I added one more item under factor 3, to see if the charge nurse responsibilities were perceived as recognition, thus taking the final recognition survey to a 31-item instrument. Each individual item in the survey is scored on a 5-point Likert scale, where I = not at all or 5 = great.

Table 7. Six Factors of Recognition Behaviors

| | |
|---|---|
| Factor 1: Opportunities for growth and development | • Spend a day with the supervisor<br>• Participate in unit planning<br>• Develop booklet describing services<br>• Support for career goals<br>• Recommended as expert speaker<br>• Time to work on special project<br>• Opportunity for peer review<br>• Set criteria for reward fairness<br>• Represent unit at hospital meetings<br>• Consulted on important decisions<br>• Discuss patient care and management<br>• Encouraged to develop expertise<br>• Encouraged to participate in state and national activities |
| Factor 2: Written acknowledgment | • Letter about performance to file<br>• Letter about extra hours to file<br>• Letter about performance to Director |
| Factor 3: Private verbal feedback | • Private verbal feedback<br>• On the job feedback<br>• Selected as a charge nurse on a rotation basis.<br>• Selected as preceptor |
| Factor 4: Public acknowledgment | • Congratulates in front of peers<br>• Patient evaluations posted<br>• Patient evaluation copy to the director<br>• Head nurse brags about staff nurses<br>• Celebration for years of service |
| Factor 5: Schedule | • Preference for selection of hours<br>• Priority to stay home with low census<br>• Day off with pay for workshop |
| Factor 6:Salary | • Salary increases are commensurate with level of performance |

Blegen and colleagues (1992) conducted a factor analysis using varimax rotation procedure to establish construct validity. Cronbach's alpha coefficients for the six subscales range from .64 to .89. I obtained written permission from Dr. Mary Blegen in September 2015 to use and modify the survey as needed (Appendix A, item #2).

**3.** The **Demographic questionnaire** (Appendix C) was used to obtain data on work title/position, gender, age range, education, years of work experience and length of time working in the critical care areas, ethnicity, and other relevant information.

***Inclusion criteria for the survey***

The following were the inclusion criteria for the survey: (1) Registered Nurse (RN) currently employed in one of the five critical care units (Table 2); (2) Registered Nurse (RN) directly involved in the supervision or professional development of RN's in one of the critical care units; and 3) willing to participate and complete the survey questionnaires. There were 230 RNs employed in the five adult critical care units, thus providing a potential sample of 230 RNs available for survey (Table 2).

**Sample size calculation:** Power analysis was conducted using G*Power 3.1software (Paul, Erdfelder, Buchner, & Lang, 2009) to estimate sample size to ensure adequate statistical power for data analysis. According to the calculation, with an effect size of 0.30, an alpha of 0.05, and power of 0.90, 88 nurses were needed for the sample.

**Administration of survey**

All three surveys were combined and administered via Qualtrics software tool using the site license provided by the University of North Carolina (UNC), Chapel Hill. After obtaining prior written permission from the respective directors to initiate the project, the potential participants were notified through e-mail one week prior to the survey. In addition fliers with

information about the survey were posted in the bulletin boards in the break rooms and bathrooms of the five adult critical care units. There were 230 RNs from five adult critical care units invited to take part in the survey (survey packet in Appendix J). Survey was open for two weeks from November 2, 2015 to November 17, 2015. A reminder email was sent on the seventh day to obtain maximum participation. During the two weeks, 95 nurses completed the survey (41.3 % response rate). Of the 95 responses, two surveys were blank, without any information and were eliminated during the analysis.

**Assessment of resources**

The survey instruments for the project were available through the UNC-Chapel Hill site license. The student version of all three software packages, i.e. Qualtrics software for administering survey, SPSS software for survey data analysis and Atlas software for qualitative data, were available through the Odum Institute of Research at University of North Carolina at Chapel Hill. FGIs were conducted in conference rooms in the clinical areas at UNCH for convenience Interviews were recorded with permission and used the transcription hub for transcribing the focus group interview data.

## Data Analysis

Analysis of FGI transcripts and the surveys were performed using descriptive statistics and the distribution was calculated in absolute and relative frequencies.

**Analysis of FGI using ATLAS**

The digitized audio recordings were electronically sent to a transcribing agency for transcription into verbatim notes by trained professional transcriptionists. PI subsequently listened to all seven recorded interviews and audited the transcripts for accuracy. Content analysis of the data obtained through FGI was conducted utilizing the technique described by Miles and Huberman (1994). The stages of content analysis include *data reduction* (into codes or

summaries), *data display* (display of data in the form of tables) and *conclusion drawing/verification* of themes (Miles and Huberman, 1994).

To maintain rigor, content analysis of the transcript was done with a co reader who has extensive qualitative research background and experience. Initially, PI and the co-reader read each of the interview transcripts independently to identify emerging themes by using line by line coding and highlighting key words, phrases and quotes. The PI and the co- reader extensively discussed these codes until a consensus was reached that the codes developed were valid, mutually exclusive and exhaustive. A codebook (Table 7) with eight themes and 41 sub themes were created and this codebook was submitted to the faculty chairperson for approval.

After receiving approval the transcripts were imported into data analysis software ATLAS.ti 7 with the help of experts from Odum Institute of Research at UNC. Using ATLAS.ti 7, the PI coded all seven FGI transcripts. Later the coding was checked and verified for discrepancies by the co-reader and faculty chairperson.

Qualitative analysis of the coded data was conducted through ATLAS.ti 7 using the analysis features such as *codes-primary documents table, code-co occurrence table,* and *Query tool*. This method of displaying of the data in tables made it convenient to get an in-depth understanding of the data and draw conclusions about the perception of the concept of MR among various nurse positions in the critical care units.

**Analysis of Surveys using SPSS**

Demographic data was analyzed through Statistical Package for Social Sciences (SPSS) using descriptive statistics with statistical assistance from experts at the Odum Research Institute. Frequency distribution and percentages were calculated and reported for each demographic question listed in Appendix C.

Descriptive and inferential statistics for the data collected through HWE and Recognition surveys were computed using IBM SPSS 23.0 software, accessed through the virtual lab at UNC (https://virtuallab.unc.edu). The survey data imported from Qualtrics software was subjected to pre-analysis screening to ensure accuracy of the data imported. Descriptive analyses of data were conducted to describe the characteristics of the entire sample and the subgroups and were reported as frequencies, means, standard deviations, and percentages. Inferential statistical tests such as t-tests and analysis of variance (ANOVA) with Bonferroni post hoc multiple comparison were used to explore critical care nurses perceived levels of MR and HWE and the preferred methods of recognition. Correlational analysis was conducted using Pearson bivariate correlation coefficient to examine the relationship between critical care nurses perceived levels of MR and HWE and preferred methods of recognition with the demographic characteristics of nurses such as age, years of experience as a nurse, years of experience at UNCH, and years of experience in the unit. A $p$ value of $\leq 0.05$ was considered statistically significant.

# CHAPTER 4. RESULTS

The findings of qualitative data from FGI were cross-referenced with the quantitative data from the surveys. Analyses were similar and there were many parallels between the findings, further elaboration is found in the discussion section.

## Focus Group Interview

Twenty-Six Registered Nurses who work in the five participating ICU units participated in seven different FGI sessions, conducted between October 27, 2015, and November 3, 2015. For the purpose of interpretation and comparison of results, nurse managers, nurse directors, and nurse educators were categorized as leaders due to their position and decision-making capacity over staff nurses and the monthly salary status. Clinical nurses I, II, III and IV, were grouped into the staff category because they were direct caregivers at the bedside and were paid on an hourly basis with lesser decision-making capacity. According to the demographic data, 16 staff nurses and 10 nurse leaders attended the FGI interviews, thus ensuring a representative sample of all levels of nurses from the five adult critical care units of UNCH hospitals (Table1).

Each focus group interview lasted between 30 and 55 minutes. Data saturation was achieved by the seventh FGI with no new themes emerging and this was reported to the research nurse at UNCH. To validate the content analysis, themes, subthemes, and appropriate coding of the content, one transcript each from the leader FGIs and one transcript from the staff nurse FGIs category was reviewed by the faculty chairperson. .

**Demographic Data**

Demographic data included position, gender, race, education, specialty certification, intent to stay, age group, years of experience as a nurse, years of experience in the institution, and years of experience in the unit. The FGI participants were predominantly female (*n*=19, 73.0 %); BSN educated (*n* =19, 73.0%), staff nurses (*n* = 16, 62.0%), hold a specialty certification (*n* =22, 85.0%), and were Non Hispanic white (*n* =22, 85.0%). The majority of the participants were between 31 and 40 years of age (*n* =33, 35.9%) with a mean group age of 40.6 years. Twenty-seven percent of participants (*n* =7) had 6–10 years of nursing experience, 38% (*n* =10) worked at UNCH for 6–10 years, and 58% of the nurses (*n* =15) were employed in the same unit for 0–5 years. All levels of clinical nurses (CN) were represented: 62.0% staff nurses (*n* =16)(CN I, CN II, CN III, and CN IV) and 38% nurse leaders (*n* =39) (Nurse managers, directors, and nurse educators). Seventy-seven percent of the group (*n* =20) intent to remain at UNCH for the next 12 months; 19% (*n* =5) were undecided about their intent to stay. Eighty-five percent of the nurses (*n* =22) had a specialty certification. Table 7 provides the details of demographic data for the focus group participants.

Table 8. Demographic Data for the FGI Participants (N=26)

| | | Frequency | Percentage |
|---|---|---|---|
| Position | Staff Nurse | 16 | 62 |
| | Leader | 10 | 38 |
| | | | |
| Gender | Female | 19 | 73 |
| | Male | 7 | 27 |
| | | | |
| Race | African American/Black | 0 | 0 |
| | American Indian/Alaskan Native | 0 | 0 |
| | Asian/Pacific Islander | 4 | 15 |
| | Non Hispanic/White | 22 | 85 |
| | Other | | |

| | | | |
|---|---|---|---|
| Education | Associate degree | 1 | 4 |
| | BSN | 19 | 73 |
| | Masters and doctorate | 6 | 23 |
| Specialty Certification | Yes | 22 | 85 |
| | No | 4 | 15 |
| Intent to Stay | Yes | 20 | 77 |
| | No | 1 | 4 |
| | Undecided | 5 | 19 |
| | | | |
| Age (Mean 40.6) | 20 - 30 years | 4 | 15 |
| | 31- 40 years | 11 | 43 |
| | 41- 50 years | 6 | 23 |
| | 51-60 years | 5 | 19 |
| | | | |
| Years of experience as a nurse (Mean= 12.78). | Less than 1 year | 2 | 7 |
| | 1 year to 5 years | 3 | 12 |
| | 6 years to 10 years | 7 | 27 |
| | 11 years to 20 years | 6 | 23 |
| | 21 years to 30 years | 5 | 19 |
| | More than 30 years | 3 | 12 |
| | | | |
| Years of experience in UNCH (Mean=10.38 years) | Less than 1 year | 2 | 7 |
| | 1 year to 5 years | 7 | 27 |
| | 6 years to 10 years | 10 | 38 |
| | 11 years to 20 years | 3 | 12 |
| | 21 years to 30 years | 3 | 12 |
| | More than 30 years | 1 | 4 |
| | | | |
| Years of experience in the unit (Mean =5.79 years) | Less than 1 year | 3 | 12 |
| | 1 year to 5 years | 12 | 46 |
| | 6 years to 10 years | 8 | 31 |
| | 11 years to 20 years | 2 | 7 |
| | 21 years to 30 years | 1 | 4 |
| | More than 30 years | | |

The qualitative data analysis revealed the participant's perceptions about MR and helped to identify themes related to effectively, economically, and efficiently provide MR. A total of 1,069 codes were assigned to the seven FGI transcripts that lasted for 302 minutes. Out of this,

staff nurses' comments contributed to 668 codes (16 staff nurses) and leaders' contributed to 401 codes (10 nurse leaders). These codes were categorized into eight primary themes and related subthemes (Table 8). Many times there were overlap of themes as the individual participants' comments referred to multiple aspects of the concept of MR and this resulted in multiple codes assigned to the same statement.

Table 9. Code Book for FGI Qualitative Analysis

| Themes | Subthemes | Examples given by the FGI participants |
|---|---|---|
| 1.What is MR (3 subthemes) | MR is...(Direct) | |
| | MR is...(Indirect) | |
| | MR is...(Received) | |
| 2. When to give MR (5 subthemes) | Achieving Organizational Goals | Example: HCAHPS, Patient Satisfaction, QI, VAP, Hand washing, Ulcer, Public Recognition (any admin goal achieved) |
| | Acknowledgements by patient/family | Letter of acknowledgement from patient read at leadership meeting, Patient returns to unit to say thank you.. |
| | Exceptional Work Quality | Team player, job done above and beyond, teaching the new nurse, acquiring new skills, taking an extra shift |
| | Interpersonal and social skills | Bedside manner, the presence nurses bring, values they share, the culture they create around them (ask questions, etc.) |
| | Staff Accomplishments | Certifications, graduate school, research, paper presentation, magnet |
| 3.Appropriate Timing to give MR (3 subthemes) | Delayed | Because you remember they stood out |
| | End of Shift | From people who observed you. |
| | In the moment | During the event, so it doesn't lose value. |
| 4.Benefits of Giving MR (2 subthemes) | Impacts Satisfaction | Self esteem, Feeling that you are valuable (not expendable), uplifting |
| | Improves Morale | Feeling that you are a part of a team, Building confidence |
| 5. Ways to give MR (6 subthemes) | Financial | Salary, gift cards, body massages. |
| | Formal Recognition | Awards, Public Recognition |

| | | |
|---|---|---|
| | Informal Recognition | Leader's presence |
| | Opportunities for Growth | Conferences, etc., freedom to ask questions, progression for those who wish to stay at bedside |
| | Verbal Recognition | Staff Meeting, Positive feedbacks |
| | Written recognition | Email, Texts, Cards, Personal letters of acknowledgement |
| 6. From: Who Is giving MR (6 subthemes) | From Collective | Unit, shift, educators, staff nurses in general |
| | From Individual | Peer to peer, one on one recognition. |
| | From Institution | The hospital, higher ups, etc. |
| | From Leaders | Ex: letter of acknowledgement from patient read at leadership meeting |
| | From Patients and Families | |
| | From Self | Intrinsic MR from achieving goals, the warm and fuzzy feeling when patient gets better or when families trust the nurse. |
| 7.To: Who is receiving MR (6 subthemes) | To Collective | Unit, shift, educators, staff nurses in general |
| | To Individual | Peer to peer, one on one recognition |
| | To Institution | The Hospital, higher Ups, etc. |
| | To Leaders | Ex: Letter of acknowledgement from patient read at leadership meeting |
| | To Patients and Families | |
| | To Self | Intrinsic MR from achieving goals. |
| 8. Reasons MR doesn't happen now/struggle to give (10 subthemes) | Apathy | Rude, unprofessional, negative, general near burn out. |
| | Belief that MR is Negative | Has negative consequences, cliques, entitlement, offend other people |
| | Common Misconceptions | We do a good job, getting paid (compensation), |
| | Culture Change | Current tendency is to point out mistakes |
| | Current Efforts Devalued | MR needs to constantly change or it gets stagnant, takes time, expectations change |
| | Diverse Individual Needs | |
| | Institutional Barriers | No growth opportunity for nurses who stay at the bedside, Undertones of recognition set by the organization, The criteria set for recognition is vague |
| | Lack of Awareness about | Leaders and staff are unaware of the benefits and ways to |

| | |
|---|---|
| MR | give MR |
| Maintain Status Quo | No MR is ok, we have shared governance, voice is being heard |
| Resources | Time, Money, Staffing, Size of the workforce |

Table 10. Qualitative Analysis of Meaningful Recognition via Atlas (N= 1,069 codes)

| Primary Themes | Sub-themes | Staff (CN IV, Staff) Leader (Director, Educator, and Manager) | | |
|---|---|---|---|---|
| 1.What is MR (3 subthemes) | | Staff | Leader | Total |
| | MR is...(Direct) | 26 | 13 | 39 |
| | MR is...(Indirect) | 10 | 1 | 11 |
| | MR is...(Received) | 19 | 11 | 30 |
| | TOTALS: | 55 | 25 | 80 |
| | Percentage in the overall themes | 8.2% | 6.2% | 7.48% |
| 2. When to give MR (5 subthemes) | | Staff | Leader | Total |
| | Achieving Organizational Goals | 1 | 8 | 9 |
| | Acknowledgements by patient/family | 5 | 2 | 7 |
| | Exceptional Work Quality | 39 | 24 | 63 |
| | Soft Skills | 19 | 6 | 25 |
| | Staff Accomplishments | 1 | 4 | 5 |
| | TOTALS: | 65 | 44 | 109 |
| | Percentage in the overall themes | 9.7% | 11% | 10.2% |
| 3.Appropriate Timing to give MR (3 subthemes) | | Staff | Leader | Total |
| | Delayed | 1 | 4 | 5 |
| | End of Shift | 6 | 0 | 6 |
| | In the moment | 13 | 6 | 19 |
| | TOTALS: | 20 | 10 | 30 |
| | Percentage in the overall themes | 3% | 2.4% | 2.8% |
| 4.Benefits of Giving MR (2 subthemes) | | Staff | Leader | Total |
| | Impacts Satisfaction | 24 | 7 | 31 |
| | Improves Morale | 25 | 7 | 32 |
| | TOTALS: | 49 | 14 | 63 |
| | Percentage in the overall themes | 7.3% | 3.5% | 5.9% |
| 5. Ways to give MR (6 subthemes) | | Staff | Leader | Total |
| | Financial | 32 | 14 | 46 |
| | Formal Recognition | 8 | 12 | 20 |
| | Informal Recognition | 15 | 8 | 23 |
| | Opportunities for Growth | 19 | 16 | 35 |
| | Verbal Recognition | 15 | 10 | 25 |
| | Written recognition | 12 | 9 | 21 |
| | TOTALS: | 101 | 69 | 170 |
| | Percentage in the overall themes | 15% | 17.2% | 15.9% |
| 6. Who is giving MR (6 subthemes) | | Staff | Leader | Total |
| | From Collective | 16 | 7 | 23 |
| | From Individual | 25 | 15 | 40 |
| | From Institution | 21 | 14 | 35 |

| | | | | |
|---|---|---|---|---|
| | From Leaders | 39 | 36 | 75 |
| | From Patients and Families | 11 | 11 | 22 |
| | From Self | 1 | 8 | 9 |
| | TOTALS: | 113 | 91 | 204 |
| | Percentage of overall themes | 17% | 22.7% | 19.08% |
| 7.Who is receiving MR (6 subthemes) | | Staff | Leader | Total |
| | To Collective | 4 | 10 | 14 |
| | To Individual | 26 | 43 | 69 |
| | To Institution | 0 | 0 | 0 |
| | To Leaders | 1 | 8 | 9 |
| | To Patients and Families | 0 | 1 | 2 |
| | To Self | 1 | 13 | 14 |
| | TOTALS: | 44 | 63 | 107 |
| | Percentage of overall themes | 7% | 16% | 10% |
| 8. Struggles related to MR (10 subthemes) | | Staff | Leader | Total |
| | Apathy | 24 | 5 | 29 |
| | Belief that MR is Negative | 10 | 2 | 12 |
| | Common Misconceptions | 1 | 8 | 9 |
| | Culture Change | 33 | 8 | 41 |
| | Current Efforts Devalued | 39 | 9 | 48 |
| | Diverse Individual Needs | 17 | 8 | 25 |
| | Institutional Barriers | 9 | 10 | 19 |
| | Lack of Awareness about MR | 40 | 16 | 56 |
| | Maintaining Status Quo (Staff) | 1 | 4 | 5 |
| | Resources | 47 | 15 | 62 |
| | Percentage of overall themes | 221 (33%) | 85 (21.2%) | 306 (28.69%) |
| | Total number of codes under all themes | 668 | 401 | 1069 |

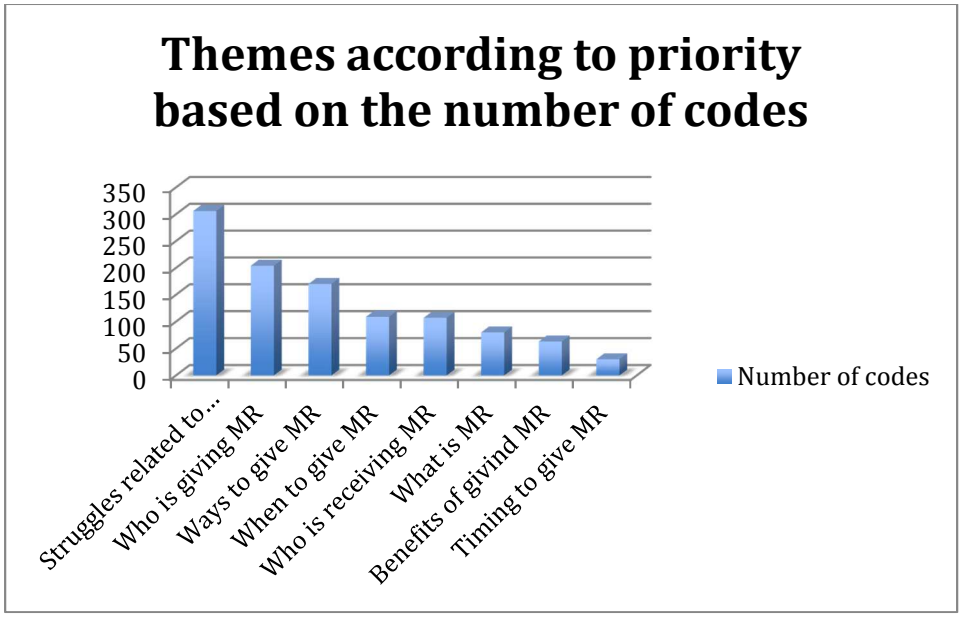


Figure 1. Themes according to priority based on the number of codes.

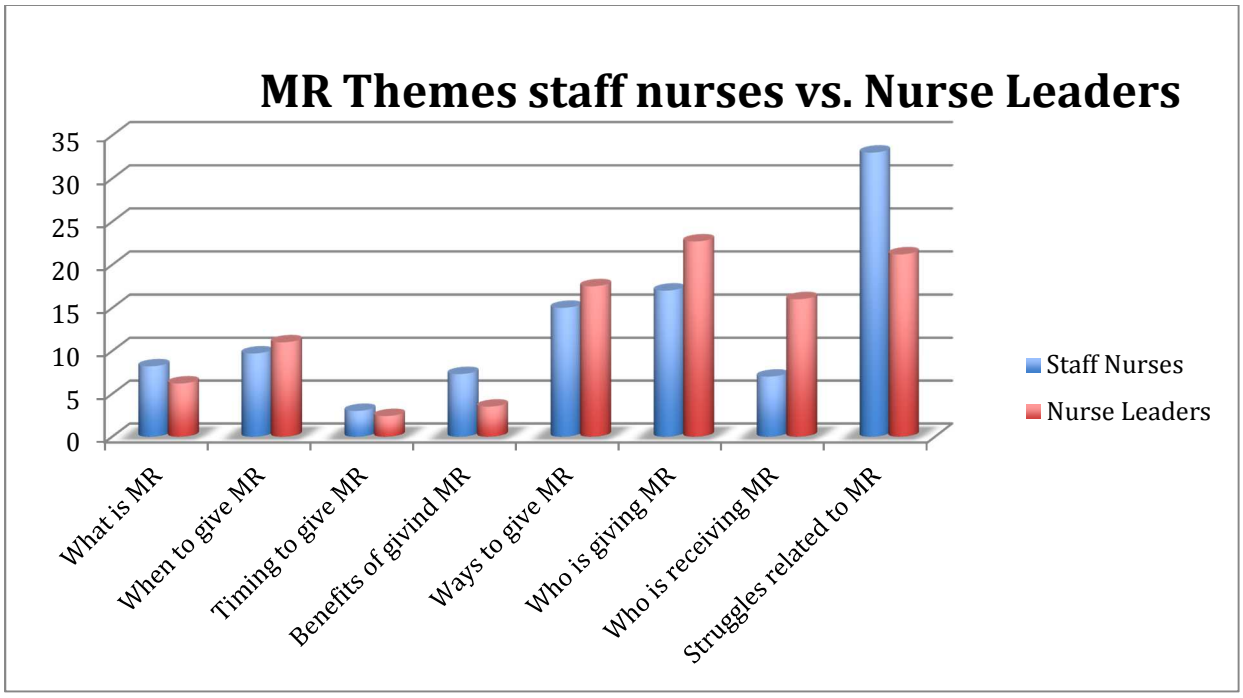



Figure 2. MR themes staff nurses vs. nurse leaders.

**Theme 1: What is MR?**

Subthemes: MR is direct; MR is indirect; MR is received.

The theme **"**what is MR" and its subthemes were coded for 80 comments from the entire FGI transcripts. Overall, the question what is MR was very difficult for staff nurses and leaders to answer directly. One of the nurse leaders verbalized, *"For me meaningful recognition is hard to articulate".* The following statement made by a nurse leader, *"MR is something that a person can really take to heart and feel as the genuine expression of whoever is recognizing and something that is very valued"* was the response that was closest to the AACN's definition of MR (AACN, 2005). More often participants gave examples of when to give MR, who to give MR to, or ways to give MR and associated MR with the Workforce Engagement Survey (WES) scores, *"this was an area it was low in one of our previous surveys and so we talked about what does that mean".* The focus group discussions confirmed that although nurses and nurse leaders had some awareness about the concept of MR, mostly MR remains as an abstract concept.

Table 10 provides examples of participant responses that answer the question directly and contrasts the questions "What is MR?" to "What is the most MR you've received?"

Table 11. Contrasting Quotations from Leaders vs. Staff

| What is Meaningful Recognition? | Leaders | Staff |
|---|---|---|
| When to give it: Above and Beyond | *"Meaningful recognition is something I struggle with, it should be done when people are above beyond".*<br><br>*"For me meaningful recognition is hard to articulate"* | *"I think it has to be given for action that is above and beyond. and not just general.* |

| | | |
|---|---|---|
| Association with results of previous 'workforce engagement survey 'conducted by the organization | *"This was an area it was low in one of our previous surveys and so we talked about what does that mean."* | *"Our WES survey results were actually lowest for that question [MR], than for anything. And. I don't even know whether people had a clear feeling of what is meaningful to them."* |
| Individualized | *"I think it's two different things; There is. what meaningful recognition for me, and what do I want to be recognized for."* | *".... Culture component and gender are factored into meaningful recognition. Males probably don't get as much as females do…. people who have been in profession for longer time don't expect that much as somebody who [is new].* |
| Value of MR for the Individual | *"I find it such an interesting topic…. meaningful recognition. What is it? Is it different [for different] people and how valuable [MR] really is?"* | *"For me being acknowledged as an autonomous person and not just a part of a machine…. not someone who just brings the company profits…."* |
| From Who? | *"I think what is important is giving verbal one to one feedback to the nurse who has done a good job… that gives them a lot of recognition."* | *".... At least people that I know are looking for confirmation [recognition] from upper management, I think people feel like management will tell you when things are bad, but not when it is good."*<br><br>*"…Just somebody in the moment, when something good happens and … acknowledging it."* |
| | | |
| Intrinsic | *"I guess my recognition has really very little to do with what my boss say or… for me If I had a goal and I accomplished it, I feel really good about myself ….a sense of euphoria".*<br><br>*"… Those recognitions – they are personal and the things which you set out and you wanted to accomplish…. That's a really professional way of looking recognition.* | *I just think that as a nurse your self worth has to come from. The result you get…[from your work]"*<br><br>*"… When the families trust me that's a big complement [for me]… it's more than anything because somebody is leaving their family member in my care and trust that I will take care of them".* |

| | | |
|---|---|---|
| | *"On a day to day basis it was the satisfaction that I receive when my patients do well and getting that feedback from families".* | |
| From (staff to leader and leader to staff) | *From Staff:*<br>*…when my staff was recognized that was recognition to me, because it meant that I was leading them [well]…*<br><br>*" To me the most meaningful [recognition] was when the staff said, thank you so much for your hard work… thank you for what you do."* | *From Leaders:*<br>*…. My manager came up to me and said …I would entrust any of my family members to your care and that sticks with me.*<br><br>*"…. One charge nurse who would make it a point when they rounded every morning to say thank you and it was such a big difference"*<br><br>*"For us it is. …When our manager actually had to come in to be charge [during a night shift]"* |
| From Patient | *" A patient coming back and saying you made the difference ... That was meaningful to me".*<br><br>*"I really enjoy when the patients comeback…and appreciate the staff and everybody is taking care".* | *… Patients mother coming back making from Alabama [to thank] the nurse who took care of her son was the most meaningful for me.*<br><br>*For me it's all from patients…. when someone tells me, wow! I thank you so much for listening to me or treating me as a human being.... that's more meaningful to me.* |
| Indifference | *I'm kind of same way as far as personal recognition I don't necessarily need that.* | *I got recognition of most valuable person …but I never feel that happy because ….god knows why your name is there… it doesn't say why are you the most valuable person to this unit.* |

**Theme 2: When to Give MR**

Subthemes: Achieving Organizational goal; Acknowledgements by patient and family; Exceptional work quality; Interpersonal skills; Staff accomplishments. (Table 8: details of subthemes & Table 9: qualitative analysis of MR).

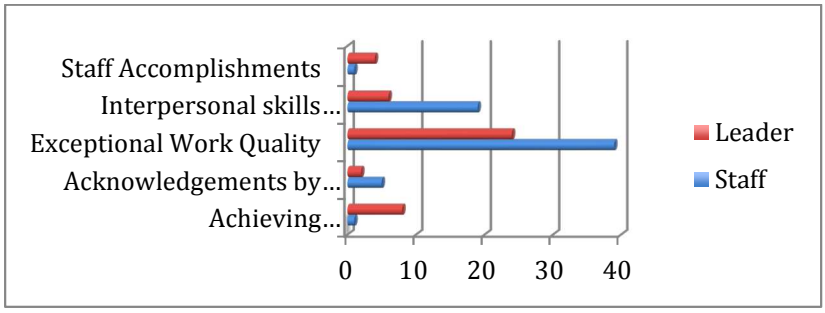



Figure 3. When to give MR.

The theme **'**when to give MR' and its subthemes were supported by 109 comments. Nurses, regardless of their title, agreed that 'exceptional work quality" should be a reason to give MR. Some examples of Exceptional Work Quality given by the cohort included "going above and beyond, being a team player, teaching new nurses, acquiring new skills or picking up extra shifts" (Figure 3).

For staff nurses, the subtheme "interpersonal skills ("soft skills") was the second most important reason to give MR and came up 19 times out of the 65 total comments of the staff nurses' discussions under this theme. One of the staff nurse commented,

> *Sometimes as a manger you don't necessarily see [a nurse] how they're working with other nurses. Specially, if they [nurse] have a quiet personality and doesn't brag on themselves, [the manager] might not see them helping the nurses next door … they quietly do those things…*

Although managers identified this subtheme as a reason to give MR, it was not mentioned with the same frequency as among staff nurses. Thus leaders need to be aware that recognition for interpersonal skill is very valuable for staff nurses.

Another difference noted among leaders and staff was regarding the subtheme 'achieving organizational goal'. This was the second most common theme that emerged from the leaders' transcripts where it was mentioned 8 out of 44 comments. Improved patient satisfaction scores, hand washing scores, Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) scores and reduced HAC rates were the examples of organizational goals mentioned by the leaders. However, this subtheme was rarely mentioned in the staff nurses' transcripts. One leader wondered, *"does the staff consider this [high score in HCAHPS] as a recognition of what they did at the bedside... because they took such phenomenal care of the patient, now [patients] are willing to acknowledge it publically."* This points out the importance of communication to staff nurses about the organizational goals and how staff nurse can influence the organizational goal, which can ultimately be a meaningful recognition for staff nurses.

**Theme 3: Appropriate Time to Give MR**

Subthemes: Delayed; End of the shift; in the moment.
(Table 8: details of subthemes & Table 9: qualitative analysis of MR).

The theme 'appropriate time to give MR', supported by 30 comments, was the least-mentioned theme among the focus groups. In the instances the theme 'appropriate time to give MR' was mentioned, the majority of FGI participants believed that giving MR 'in the moment', would be most effective. However leaders, in addition to real time feedback, found value in giving delayed recognition as a more sustained form of recognition. One of the leaders commented,

*I'm a big fan of delayed feedback, so, I always do that. [When someone is performing exceptionally well] I try to say things in the moment, but then the next day or a week later, I will send an email specifically, separate and apart from the context and it means more.*

Leaders added that delayed feedback was more meaningful and validating.

*The most meaningful recognition to me is when someone takes the time on a Saturday afternoon to email me and say, "Thanks for all you're doing, I really appreciate it," instead of [saying thank you in the mid meeting]. If they're thinking about it afterwards and they take the time to let you know, that really means a lot.*

Add a therefore sentence here…does this mean all managers should recognize in the moment, and then follow up? Is it OK for this manager to use HER perceptions of what is meaningful as the way She gives MR or should she recognize that people are different and as a leader she needs to act outside of her own frame of reference?

**Theme 4: Benefits of Giving MR**

Subthemes: Impacts Satisfaction, Impacts Morale.
(Table 8: details of subthemes & Table 9: qualitative analysis of MR).

A total of 63 comments contributed to the theme of "benefits of giving MR." Both staff and leaders agreed that MR impacted staff satisfaction and morale. One staff nurse articulated so well as to what happens when there is no MR;

*I think it [lack of MR] affects not only the nursing turnover rate, but I think it affects the patient of care in that unit, because you can have the best and smartest nurses, but if they do not feel appreciated the [quality] of their care [will] go down.*

However it was concerning to note that staff nurses contributed to the majority of comments under the theme "benefits"(49 out of 63), whereas in leaders' transcripts the theme of 'benefits' was mentioned far and few in between. This gap in awareness needs to be explored and addressed.

**Theme 5: Ways to give MR**

> Subthemes: financial ways, formal recognition, Informal recognition, opportunities for growth, verbal Recognition and written recognition. (Table 8: details of subthemes & Table 9: qualitative analysis of MR).

The theme "ways to give MR" and its subthemes were supported by 170 comments. For staff nurses the sub-themes were listed in the following order: finance, opportunities for growth, verbal recognition, informal recognition, written recognition, and formal recognition. In contrast, for nurse leaders the order of sub-themes were opportunities for growth, finance, formal recognition, verbal recognition, written recognition, and informal recognition (Figure 5). Overall, the discussions on subthemes "finance" and "opportunities for growth" made up a great portion of nurses' and leaders' discussions on ways to give MR (Figure 4). The subthemes are explored in detail next.

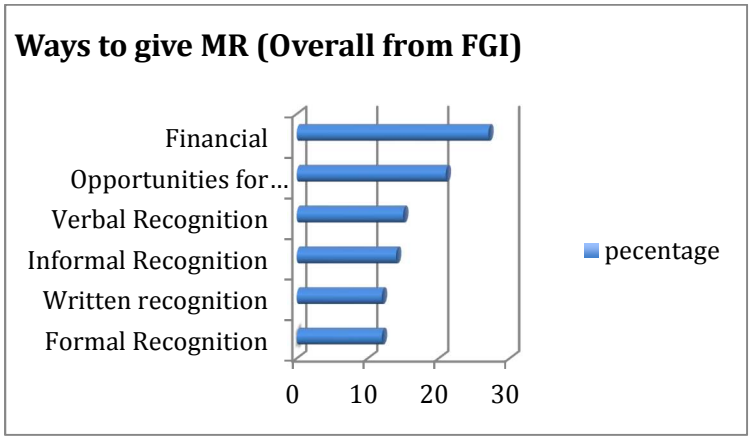



Figure 4. Overall ranking of ways to give MR.

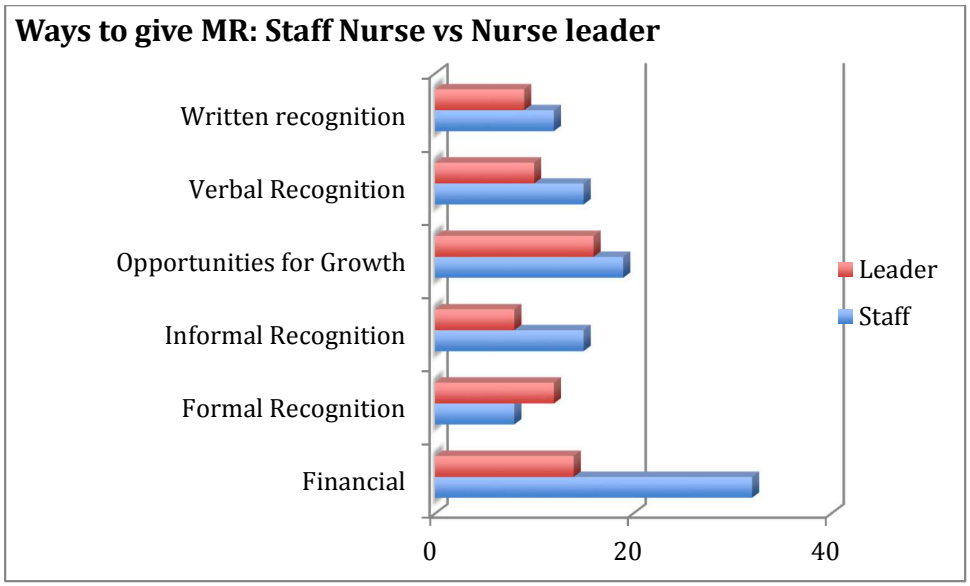



Figure 5. Ways to give MR: Staff nurses versus Nurse leaders.

***1. Finance:*** For staff nurses, financial ways of MR included any form of recognition that had monetary value such as an incremental rise in salary based on performance, experience, education and specialty certification, financial incentives for longevity and loyalty to the institution, promotions and clinical ladder opportunities with built-in financial incentives for nurses remaining at the bedside, financial supports for conferences, support for education, scholarships, bonuses, gift cards, massages, and food.

During discussions, many times the subtheme "opportunity for growth" and written recognition overlapped with the subtheme of financial form of recognition. In contrast, when leaders mentioned finance as a way to provide MR, they referred to remuneration for work at bedside or for services that contributed to the unit or organizational goals such as serving in a unit-based committee. One leader commented,*" when the manager ask [the nurse] to serve as the [unit's] representative on a committee or to serve on a counsel that is recognition [of the nurses ability and in addition they are paid for the hours they do committee related work]".*

***2. Opportunities for growth***. Some of the ideas that came under this subtheme are the opportunity to attend conferences, freedom to ask questions, and career progression for those who wish to stay at the bedside.

In nurse leaders discussion about "opportunities for growth" included comments like this:

> *The most meaningful recognition I received in the four months of my job was my direct supervisor sending me across the country to do presentation on the topic because she knew that when I was capable to do that and she recognized and wanted me to be progressing in that direction. So, it's really recognizing of several aspects of who I was as a nurse.*

Another comment related to opportunities for growth was this,

> *When she got chosen [to represent the unit in a committee] it was very meaningful for her. I do the same thing with teaching by encouraging some of the new people to do in-services or help teach some of the classes…it builds their confidence. It is like when I can teach newer people then I am not the new person any more.*

This points out the need for the leader to be mindful about the opportunities and how even a relatively small action such as requesting the nurse to serve in a committee is meaningful for the nurse.

It was interesting and surprising to note that the freedom to ask questions was considered as an opportunity for growth for staff nurses.

> *You can have a group of nurses who may not have the expertise, but because they feel like they're in a safe supportive environment they can grow as nurses who can give better patient care and learn from past mistakes because of the safe supportive environment.*

This shows the need for leaders refine the interpersonal skills and give nurses the space and freedom to grow and mature, which is considered as valuable recognition for nurses.

Staff nurses also discussed career progression opportunities for those nurses who stayed at bedside.

> *Well, there are some of us who got in to nursing as a second career, and chose to be a bedside nurse. And sometimes I think that is looked almost down upon if you are not getting masters [degree] and progressing yourself. I got into this profession because I want to be a bedside nurse, so that until the day I die, I want to take care of patients at bedside or in some form of taking care of patient. I think there is no recognition for that, at all. I think almost everybody is put in front of you, because they're going to go on and do this or they're going to go on and do that. But yeah when people come here and they clearly say I'm going to go to anesthesia school or be a CRNA we're happy to give them a job knowing that they are only going to be here for so long… because we're progressing their career…. which is great. What about me?*

One of the nurse leaders also verbalized their concerns about losing clinical nurses with higher education from bedside. Organizational leaders need to explore into this situation and create opportunities for clinical nurses to grow.

***3. Formal Recognition,*** including awards and public recognition.

For nurse leaders this was the third-most discussed form of recognition, while for staff nurses the discussed formal recognition only a few times. One leader stated,

> *Recognition as great 100 was a big deal to me, but that was a joint effort because I worked with somebody to fill out that application and the institution supported*

*me. So, that was another meaningful recognition and that was sort of self-sort out board and then supported by the institution.*

A lack of awareness or perceived lack of institutional support for staff nurses to obtain formal recognition may be the reason for relatively low discussions on formal recognition.

***4. Written Recognition,*** including a wide variety such as personal notes, electronic high-fives, e-mails of acknowledgement, letters from managers, and thank you letters from patients and families. Written both groups equally valued recognition and the advantage was that this could be used during annual evaluations and promotions, which in turn has a monetary value in the long run.

***5. Verbal Recognition to individual,*** including words of praise, acknowledgement, and positive feedback given publically or privately. *"One-on-one feedback from managers or experienced coworkers, I'm a new nurse. So that's important to me."*

***6. Informal Recognition***. Staff nurses and leaders viewed the responses to this subtheme from a slightly different angle. For staff, informal recognition included leaders' presence in the unit and caring behaviors demonstrated by nurses and leaders.

*You want to feel valued for your work and you want to be known for your strengths and your qualities. I think that is part of the challenge for upper level management in this organization and how do they know what the contributions are from their employees if they do not even come to the unit. And if you have a manager that's not kind of out on the floor on day to day basis seeing what's going on and knowing what the employees are doing they have trouble really knowing what the contributions are from their team; but knowing is a big part of recognition.*

For managers, requesting a staff to represent the unit in a hospital committee or to be a part of a project was considered as informal ways of providing recognition to the special strength they bring. A leader responded, "*...the reason that you are asking [a staff nurse to join a committee or counsel) is because you have identified some quality about them and [believe that they] will be able to excel in that work and we need to help [the staff nurses] understand that, it is a part of recognition".*

**Theme 6: Who Should Give MR?**

Subthemes: Leaders; Individual; Patients/families; Self; Collective. (Table 8: details of subthemes & Table 9: qualitative analysis of MR).

With 204 supporting comments, this was the second-most widely discussed theme. Regardless of their title in the organization, nurse's valued MR provided by their leaders as the most valuable form of recognition, followed by peers, institution, and patient and family.

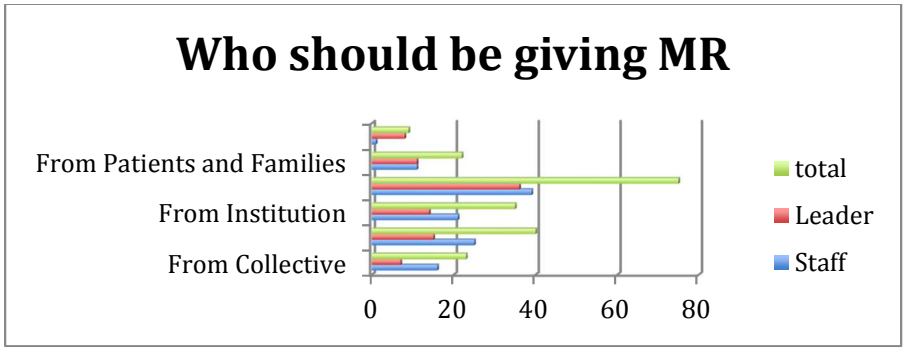



Figure 6. Who should be giving MR?

A comment by a leader says it all:

*I think the most meaningful way to recognize somebody is for a leader of whatever level to walk up and look that person in the face and say to them I think what you did was really great work... I think this is the best [way to recognize]*

*than all the other stuff that you do… that's one of the most important things to do to recognize them.*

Leaders stated that nurse leaders personally recognizing the staff nurses added weight and value to the recognition because of the time and effort invested in that kind of recognition and ultimately resulted in nurses' satisfaction. Collective recognitions occurred when the unit or the organization "*met a milestone".*

Nurses identified the subtheme of MR from self; of the nine responses related to MR from self were from the leaders' group and only once by the staff nurses' group. This intrinsic form of recognition stated by staff nurses and leaders could be summarized in the following comment made by a leader: *"Those recognitions – they are personal and the things which you set out and you wanted to accomplish. I am not sure I always see that. I mean that's a really professional way of looking at recognition."* Another leader added, *"I guess my recognition has really very little to do with what my boss say or… for me I had a goal and I accomplish it, I feel really good about myself."* This comment sums it up all for a nurse: *"On a day to day basis it was the satisfaction that I receive when my patients do well and look their best, being empathetic with families, getting that feedback from families what kind of job you have done… that's mainly the most important recognition I necessarily care about."* Related to the theme, a staff nurse made this statement, "*I just think that as a nurse if your self worth is based on what other people say about you, you would not be a nurse for long. I think your self worth has to come from what your patients say about you is a result you get."*

**Theme 7: Who Should Receive MR?**

Subthemes: Leaders; Individual; Patients/families; Self; and Collective. (Table 8: details of subthemes & Table 9: qualitative analysis of MR).

The theme "who should receive MR" was supported by 107 comments. Irrespective of their job titles, nurses agreed that individual recognition was more meaningful than collective recognition. The comments below are examples of how some leaders provide recognition in a systematic way so that every nurse will feel valued.

> *Leaders have to deliberately seek ways to provide individual recognition [such as] having a roster so that I'm thinking about people who are maybe less visible. Some people you're going to recognize more easily, some people do contribute more, but [it is important to] figure out a way recognize everybody.*

> *Another thing we started to do is when opportunities come up [such as the recent request for help to plan a conference] we deliberately picked certain people. One of them is recognized kind of fair amount but she is working on her portfolio and this was an opportunity to add that to her portfolio. We also picked someone who is not routinely recognized. She is more introverted and overlooked because she works night shifts, but definitely ready to take that kind of responsibility. I think that meant a lot to her to get that email.*

Leaders also mentioned that when their staff received recognition they felt recognized and staff imitating their leadership style was a form of recognition for them.

**Theme 8: Struggles Related to MR**

Subthemes: Current efforts devalued; Common misconceptions; Maintaining status quo; Belief that MR is negative; Diverse individual needs; Apathy; Culture change; Lack of awareness about MR; Institutional barrier. (Table 8: details of subthemes & Table 9: qualitative analysis of MR).

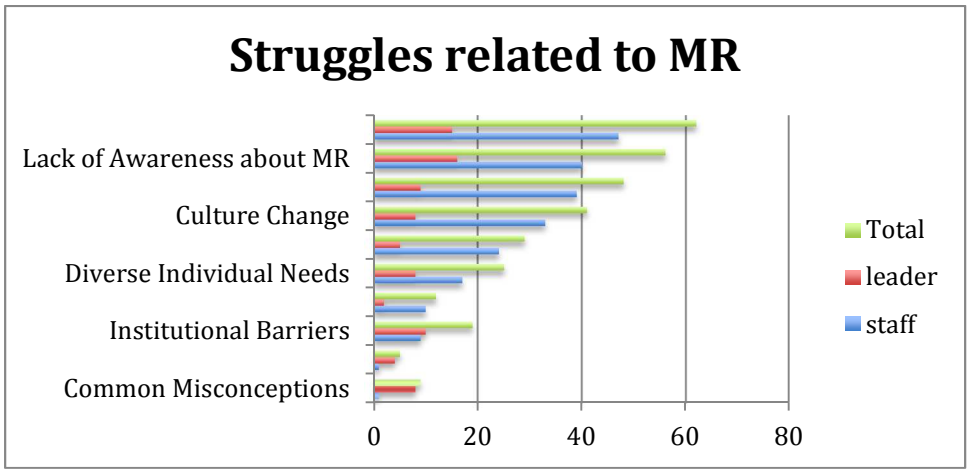



Figure 7. Struggles related to MR.

With a total of 306 comments, "struggles related to MR" was the largest theme that emerged from the focus group discussions and had 10 subthemes associated with it. The top four struggles identified by staff nurses were resources, lack of awareness about MR, devaluation of the current efforts, and cultural changes. For nurse leaders, the top four struggles were lack of awareness about MR, resources, devaluation of the current efforts, and diverse individual needs.

Lack of awareness about MR was evident from both staff and leaders' discussion. On asking how important MR was to create an HWE, one leader responded that "it's part of, I do not think it is all of it." Leaders also supported the idea that the institution is doing a good job of recognition, citing the multiple ways of formal recognitions available at UNCH. A few leaders were of the opinion that compensation for work (salary) is a form of recognition:

*I don't understand it, this is our job, this is what we are supposed to be doing…. like why are we supposed to be patting people on the back… and that's where we struggle as leadership team like what does that mean.*

The common misconception was that we do a good job of giving MR and this was evident from comments such as,

*Yeah, ….I think as an organization we probably do a fairly good job of recognition and we have [many formal recognitions for] nursing here, we have inspiring nurse leader award, aspiring nurse leader award, individual unit based [recognitions]. We also do recognition of units.*

The leader continued to state that the struggle was to give recognitions of value to nurses in a professional and consistent manner.

Both groups considered institutional barriers as a struggle in giving MR. The major barriers cited by staff were the minimal opportunity for growth available for nurses who stay at the bedside. One focus group participant commented,

*There is limited opportunity to progress. I think there should be two arms of nursing; one that gears into education and management; and there needs to be another one for those people who excel in their skills their abilities at the bedside one way or the other. But there is only one path here at UNC; it is CN 1,11,111 or whatever. But every single thing is geared towards going into management and I think nursing is a lot more than that.*

The undertones of recognition set by the organization was another perceived problem for MR. Two of the examples given for the undertones were the T-shirt given for employee recognition last year, which the nurses were not allowed to wear because it did not comply with

the nurses' uniform. A seemingly trivial matter like this came up in two of the four staff nurses' group.

Then there was this contradicting statement from a leader:

*It's not about how many resources, you don't actually need [many resources], and meaningful recognition is one of the cheapest things you can do. You don't need money for it. You just need time to go and thank people and that's what's I struggle with as a leader. I don't have any, I'm getting less and less time to do walk along on the units and chat with people and thank them for what they do … that's really all you need, But it is specifically an expensive resource.*

It appears that, like the leader who stated this meant that MR actually does not need any new resources but that it is important to recognize the importance of MR and deliberately allocate the time for providing recognition.

It was interesting to note that nurses perceived that MR had a negative implication at times.

*I also do think though sometimes the danger of that [giving MR] is that you can alienate people if they're not getting a lot of high fives. … But I think sometimes managers don't really know what the day-to-day as on a unit your peers do, but I also think the danger about peers that sometimes, this is a clique and it can be kind of a popularity contest, so I think that's kind of a double edged sword.*

The size and diversity of nursing workforce was another common theme that came up during the discussion among nurse leaders.

*To me the hard part is when you got 70, 80, 90, 100 employees, how do we know what meaningful is to each one of those and how do you have the time to figure that when they don't even seemed to able to tell you what that means?*

Another leader echoed this: *"For me personally meaningful recognition is hard to articulate because it is very individualized… and that is one of the challenges that you would face because it is so diverse."*

The culture of the particular unit and apathy among the nursing staff, both nurse and the leader, was also cited as a reason for not giving or receiving MR. One leader commented,

*In healthcare settings and especially in nursing setting, we tend to be very focused on finding problems and being negative and sometimes tend to tear each other down, and so, trying to encourage recognition to help build each other up would be very important in creating a work environment where there's good solid teamwork and you want them to feel good about it.*

This FGI discussion gave an in depth understanding of what the staff nurses considered as MR. Leadership presence and acknowledgement by the leaders were important for all the nurses. For leaders to be present, they need to be aware of the short term and long term benefits of MR. Staff nurses, instead of waiting for external means of recognition, should learn to find intrinsic ways of recognition.

**2. Results of surveys**

Surveys were administered to 230 RNs employed in five adult critical care units at UNCH. The surveys were open for two weeks from November 2, 2015, to November 17, 2015. Reminder e-mail was sent on the seventh day to encourage participation from RNs. Ninety-five

nurses completed the survey (41.3 % response rate) and I closed the survey after two weeks. Two surveys had missing data and were eliminated during the analysis, leaving 93 usable surveys.

***Healthy Work Environment (HWE) Survey***

*Demographic Data.* The survey participants (*n*=93) were predominantly female (*n*=85, 92.0 %), BSN educated (*n* =67, 72.0%), staff nurses (*n* = 89, 94.0%), holding a specialty certification (*n* =58, 62.0%), and belonged to the non-Hispanic white (*n* =69, 75.0%) race. The majority of the participants were between 31 and 40 years of age (*n* =33, 35.9%), with a mean group age of 35.33 years. Thirty-nine participants (42.4%) had 0–5 years of nursing experience, 54.3% (*n* =50) have worked at UNCH for 0–5 years, and 69.2% of the nurses (*n* =63) were employed in the same unit for 0–5 years. All levels of the clinical nurses (CN) were represented, with 2.2% (*n* =2), CN Is, 69.2% (*n* =39) CN IIs, 18.7 % (*n* =17) CN IIIs, 7.7% (*n* =7), CN IVs and nurse 2.2% (*n* =39). Managers. Seventy-seven percent of the group (*n* =71) stated that they intended to stay for the next 12 months but 17% of the group (*n* =39) was undecided about their intent to stay. Table 11 provides the demographics for the study group.

Table 12. Demographic Data for the Survey Participants (N=93)

| Item | | Frequency | Percentage |
|---|---|---|---|
| Position | Clinical Nurse I | 2 | 2.2 |
| | Clinical Nurse II | 63 | 69.2 |
| | Clinical Nurse III | 17 | 18.7 |
| | Clinical Nurse IV | 7 | 7.7 |
| | Nurse Manager | 2 | 2.2 |
| | Missing | 4 | |
| | | | |
| Gender | Female | 85 | 92.4 |
| | Male | 7 | 7.6 |
| | Missing | 3 | |
| | | | |
| Race | African American/Black | 8 | 8.7 |
| | American Indian/Alaskan Native | 1 | 1.1 |

| | | | |
|---|---|---|---|
| | Asian/Pacific Islander | 13 | 14.1 |
| | Non Hispanic/White | 69 | 75 |
| | Other | 1 | 1.1 |
| | Missing | 3 | |
| | | | |
| Education (>two categories) | Associate degree | 15 | 16.1 |
| | BSN | 67 | 72 |
| | MSN/Doctorate | 11 | 11.8 |
| | Missing | 2 | |
| | | | |
| Specialty Certification | Yes | 58 | 62.4 |
| | No | 35 | 37.6 |
| | Missing | 2 | |
| | | | |
| Intent to Stay | Yes | 71 | 77.2 |
| | No | 4 | 4.3 |
| | Undecided | 17 | 18.5 |
| | Missing | 3 | |
| | | | |
| Age (Mean 35.33 years) | 20–30 years | 32 | 34.8 |
| | 31–40 years | 33 | 35.9 |
| | 41–50 years | 19 | 20.7 |
| | 51–60 years | 8 | 8.7 |
| | Missing | 3 | |
| | | | |
| Years of experience as a nurse (Mean= 10.91) | Less than 1 year | 2 | 2.2 |
| | 1 year to 5 years | 37 | 40.2 |
| | 6 years to 10 years | 17 | 18.5 |
| | 11 years to 20 years | 19 | 20.7 |
| | 21 years to 30 years | 14 | 15.2 |
| | More than 30 years | 3 | 3.3 |
| | Missing | 3 | |
| | | | |
| Years of experience in UNCH (Mean=7.25 years) | Less than 1 year | 6 | 6.5 |
| | 1 year to 5 years | 44 | 47.8 |
| | 6 years to 10 years | 23 | 25 |
| | 11 years to 20 years | 13 | 14.1 |
| | 21 years to 30 years | 6 | 6.5 |
| | More than 30 years | 0 | |
| | Missing | 3 | |
| | | | |
| Years of experience in the unit (Mean =5.71 years) | Less than 1 year | 12 | 13.2 |
| | 1 year to 5 years | 51 | 56 |
| | 6 years to 10 years | 15 | 16.5 |
| | 11 years to 20 years | 9 | 9.9 |
| | 21 years to 30 years | 4 | 4.4 |
| | More than 30 years | 0 | 0 |
| | Missing | 4 | |

Table 13. Healthy Work Environment Individual Item Score (N=93)

| | Mean score | SD | Subscale Category |
|---|---|---|---|
| 1. Administrators, nurse managers, physicians, nurses and other staff maintain frequent communication to prevent each other from being surprised or caught off guard by decisions | 3.56 | 0.99 | Skilled Communication |
| 2. Administrators, nurse managers, and physicians involve nurses and other staff to an appropriate... | 3.51 | 0.97 | True Collaboration |
| 3. Administrators and nurse managers work with nurses and other staff to make sure there are enough... | 3.49 | 1.14 | Appropriate Staffing |
| 4. The formal reward and recognition systems work to make nurses and other staff feels valued. | 3.04 | 0.99 | Meaningful Recognition |
| 5. Most nurses and other staff here have a positive relationship with their nurse leaders (manage... | 3.57 | 1.02 | Authentic Leadership |
| 6. Administrators, nurse managers, physicians, nurses, and other staff make sure their actions ma... | 3.31 | 0.96 | Skilled Communication |
| 7. Administrators, nurse managers, physicians, nurses, and other staff are consistent in their us... | 3.54 | 0.84 | Effective Decision Making |
| 8. Administrators and nurse managers make sure there is the right mix of nurses and other staff t... | 3.4 | 1 | Appropriate Staffing |
| 9. Administrators, nurse managers, physicians, nurses, and other staff members speak up and let p... | 3.45 | 0.97 | Meaningful Recognition |
| 10. Nurses and other staff feel able to influence the policies, procedures, and bureaucracy around... | 2.92 | 1.2 | True Collaboration |
| 11. The right departments, professions, and groups are involved in important decisions. | 3.38 | 0.89 | Effective Decision Making |
| 12. Support services are provided at a level that allows nurses and other staff to spend their time effectively... | 3.05 | 1.07 | Appropriate Staffing |
| 13. Nurse leaders (managers, directors, advanced practice nurses, etc.) demonstrate an understand... | 3.31 | 1.07 | Authentic Leadership |
| 14. Administrators, nurse managers, physicians, nurses, and other staff have zero-tolerance for d... | 3.12 | 1.16 | Skilled Communication |
| 15. When administrators, nurse managers, and physicians speak with nurses and other staff, it's n.. | 3.34 | 1.01 | True Collaboration |
| 16. Administrators, nurse managers, nurses, and other staff are careful to consider the patient's... | 3.82 | 0.85 | Effective Decision Making |
| 17. There are motivating opportunities for personal growth, development, and advancement. | 3.62 | 0.91 | Meaningful Recognition |
| 18. Nurse leaders (managers, directors, advanced practice nurses, etc.) are given the access and. | 3.6 | 0.84 | Authentic Leadership |

Score 1-5; Overall HWE mean= 3.4 (SD=0.69)

Scoring Guidelines: 1.00 - 2.99 - Needs Improvement
3.00 - 3.99 - Good
4.00 - 5.00 – Excellent (AACN, 2005)

Table 14. Healthy Work Environment and Six Subscales

| HWE Standard domains | Mean score scale (1–5) N=93 | Subscale Question Number |
|---|---|---|
| Skilled Communication | 3.33(SD 0.84) | 1, 6,14 |
| True Collaboration | 3.26(SD 0.86) | 2,10,15 |
| Effective Decision making | 3.58(SD 0.69) | 7,11,16 |
| Appropriate staffing | 3.32(SD 0.91) | 3, 8, 12 |
| Meaningful recognition | 3.37(SD 0.77) | 4, 9, 17 |
| Authentic Leadership | 3.49(SD 0.81) | 5,13,18 |
| Healthy Work Environment Aggregate score is 3.4(.69) | | |

1.00 - 2.99 - Needs Improvement
3.00 - 3.99 - Good
4.00 - 5.00 – Excellent (AACN, 2005)

Table 15. Meaningful Recognition individual items scores

| **Survey Items specific to Meaningful Recognition** | **Mean (SD)** |
|---|---|
| 4. The formal reward and recognition systems work to make nurses and other staff feels valued. | 3.04(0.99) |
| 9. Administrators, nurse managers, physicians, nurses, and other staff members speak up. | 3.45(0.97) |
| 17. There are motivating opportunities for personal growth, development, and advancement. | 3.62(0.91) |
| Overall Meaningful Recognition Mean = 3.37 (0.77) | |

**Healthy Work Environment Survey Scores**

The mean differences among the various demographic groups were compared. There was no significant difference in the mean HWE score when computed for position (F 0.004, df (1,90), *p* 0.949), gender, race, education (F 0.389, df (1,91), *p* 0.679), age (F 1.47, df (1,90), *p* 0.23), years of experience as a nurse (F 1.32, df (1,90), *p* 0.27), and years of experience in the unit (F 2.11, df (1,89), *p* 0.08), (Appendix K). However there was a significant difference in the means of HWE when compared to the subgroups of specialty certification (*p* 0.029) (Table 13) and

intent to stay (F 6.76, df (1,90), *p* 0.002) (Table 14) and the years of experience at UNCH (F 3.33, df (1,90), *p* 0.01) (Table 15).

Table 15. Specialty Certification Levene's Test for Equality of Variances for HWE and MR

| | Specialty certification | N | Mean | SD | Significance | T | df | Sig. (2-tailed) |
|---|---|---|---|---|---|---|---|---|
| HWE | Yes | 58 | 3.39 | 0.61 | 0.029 | -0.091 | 91 | 0.927 |
| | No | 35 | 3.4 | 0.83 | | -0.085 | 56.22 | 0.933 |
| MR | Yes | 58 | 3.43 | 0.68 | 0.039 | 0.936 | 91 | 0.352 |
| | No | 35 | 3.28 | 0.91 | | 0.87 | 56.50 | 0.388 |

Table 16. Intend to Stay ANOVA Table

| | **Intend to stay** | **N** | **Mean** | **S D** | **df** | **F** | **Sig.** |
|---|---|---|---|---|---|---|---|
| HWE | Yes | 71 | 3.53 | 0.65 | 91 | 6.76 | 0.002 |
| | No | 4 | 2.71 | 0.91 | | | |
| | Undecided | 17 | 2.99 | 0.62 | | | |
| MR | Yes | 71 | 3.51 | 0.71 | 91 | 5.93 | 0.004 |
| | No | 4 | 2.5 | 0.69 | | | |
| | Undecided | 17 | 3.02 | 0.85 | | | |

Table 17. Years of Experience at UNCH ANOVA Table

| | **Years of experience at UNCH** | **N** | **Mean** | **SD** | df | **F** | **Sig.** |
|---|---|---|---|---|---|---|---|
| HWE | Less than 1 year | 6 | 4.1389 | 0.48528 | 91 | 3.33 | 0.01 |
| | 1 year to 5 years | 44 | 3.2727 | 0.69686 | | | |
| | 6 years to 10 years | 23 | 3.5386 | 0.61965 | | | |
| | 11 years to 20 years | 13 | 3.094 | 0.54546 | | | |

**Meaningful Recognition**

The overall mean score for MR was 3.32, which was rated the third highest item among the six HWE standards with a standard deviation score of .91) (Table 16). The mean differences among the various demographic groups were compared. There was no significant difference in the mean MR score when computed for position (F 0.88, df (1,89), *p* 0.351), race, education (F

0.601, df (1,91), sig. 0.55), age (F 1.13, df (1,90), *p* 0.34), years of experience as a nurse (F 1.32, df (1,90), sig. 0.26), years of experience at UNCH ((F 3.23, df (1,90), *p* 0.15), and years of experience in the unit (F 2.07, df (1,90), *p* 0.09) (Appendix K). There was a statistically significant difference in the perception of MR based on gender (Table 17), specialty certification (*p* 0.039) (Table 13) and the intent to stay (F 5.93, df (1,90), *p* 0.004) (Table 14). Nurses who identified as females reported a higher level of perceived MR (Mean=3.43, SD=0.75) compared to nurses who identified as Male (Mean = 2.71, S.D 0.80). The difference was statistically significant. F=5.741(1,90), *p* 0.019.

Table 18. ANOVA Table for Gender, HWE, and MR

| | **Gender** | **N** | **Mean** | **SD** | **df** | **F** | **Sig.** |
|---|---|---|---|---|---|---|---|
| HWE | Female | 85 | 3.43 | 0.67 | 1 | 3.8 | 0.054 |
| | Males | 7 | 2.9 | 0.94 | 90 | | |
| MR | Female | 85 | 3.43 | 0.75 | 1 | 5.74 | 0.019 |
| | Males | 7 | 2.71 | 0.8 | 90 | | |

Bonferoni test for difference in means of "intend to stay" is significant for perception of HWE and MR F=5.93(1,90), *p* 0.004. Those who planned to stay had a mean score of HWE (Mean = 3.53, S.D 0.65), approximately 0.8 point higher compared to nurses who were not planning to stay (Mean = 2.71, S.D 0.91), and half point higher than nurses who were undecided (Mean = 2.99, S.D 0.62). Those who had plans to stay (Mean = 3.51, S.D 0.71), had a mean score of perception of MR about one point higher compared to nurses who were not planning to stay (Mean = 2.50, S.D 0.69) and half point higher than nurses who were undecided (Mean = 3.02, S.D 0.82).

Comparison of HWE and MR means across the various titles (Figure 8) did not yield any statistically significant differences (F=0.004 (1,89), *p*=0.949), yet, it is interesting to note that

among the titles there is a wide range between the lowest and highest HWE means (over 0.5 points) and MR mean (over 1 point). It is also interesting to note that Clinical Nurse I with less than 1 year of experience had the highest mean score in both HWE (Mean = 4.11, SD =0.39) and MR (Mean = 4.33, SD =0.94) categories, followed by Nurse Managers' HWE (Mean = 3.78, SD =0.00) and MR (Mean = 3.87, SD 0.047). Clinical Nurse IVs had the lowest perception of HWE (Mean = 3. 285, SD= 0.54), but Clinical Nurse IIs had the lowest score in MR (Mean = 3.29, SD= 0.79). The differences in both HWE and MR mean scores from Clinical Nurse I to Clinical nurse II is an area that needs exploration.

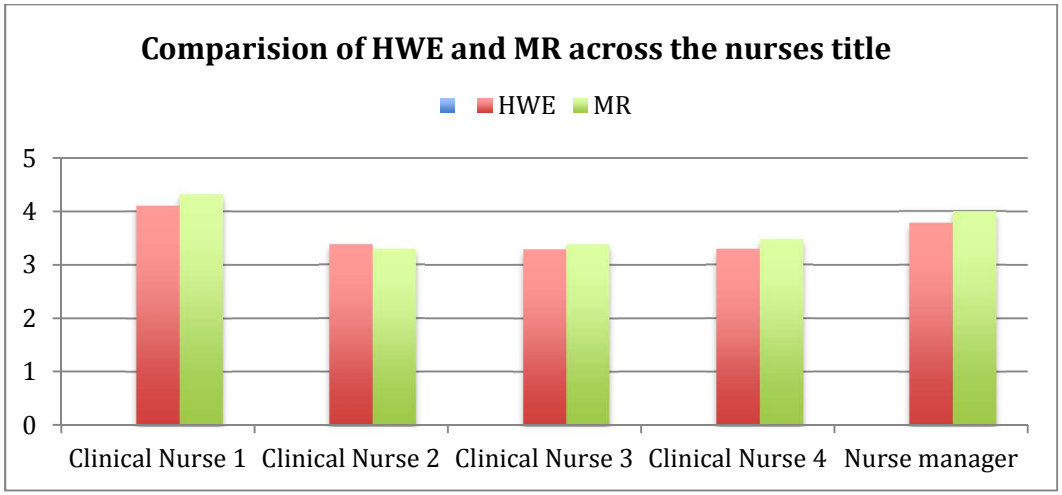



Figure 8. Comparison of HWE and MR across titles

**Recognition Scale**

The recognition scale had 31 items under 6 factors—growth and development, written recognition, private recognition, public recognition, schedule, and salary. See the average score for each item (Table 18), scores based on individual item categorized under each factor (Table 19), and average score for each factor (Table 20).

Table 19. Recognition Scale Individual Score for Each Item

| Recognition Items | N | Mean Score (Scale 1-5) | SD | Recognition Factors |
|---|---|---|---|---|
| 1. Private verbal feedback | 86 | 3.99 | 0.95 | F3 |
| 2. Encouraging participation in professional activities/conferences at the state and national level | 86 | 3.51 | 1.22 | F1 |
| 3. Giving a letter of appreciation to the staff nurse and placing a copy in the personnel file. | 86 | 3.6 | 1.17 | F2 |
| 4. Holding regular meetings to discuss and develop consensus on values related to patient care | 86 | 3.49 | 1.05 | F1 |
| 5. Giving release time to work on special projects. | 85 | 3.64 | 1.08 | F1 |
| 6. Asking staff nurses to represent the unit at hospital meetings. | 86 | 3.33 | 1.12 | F1 |
| 7. Selecting staff nurses as preceptor for new employees. | 86 | 3.78 | 0.95 | F3 |
| 8. Selecting staff nurse to be unit charge nurse on a rotation basis | 86 | 3.8 | 0.98 | F3 |
| 9. Sending a letter regarding the staff nurse's performance to senior nursing management (e.g., V... | 86 | 3.62 | 1.33 | F2 |
| 10. Providing on-the-job feedback for the patient care provided. | 86 | 3.86 | 1.11 | F3 |
| 11. Holding a celebration for nurses' years of service (for every 5 years, 10 years etc.) | 86 | 3.44 | 1.19 | F4 |
| 12. Encouraging the staff nurse to develop expertise in one aspect of care. | 86 | 3.43 | 1.04 | F1 |
| 13. Sending a copy of patient evaluations that compliment the staff nurse to senior nursing manager... | 86 | 3.65 | 1.25 | F4 |
| 14. Asking the staff nurse to participate in planning for the unit. | 86 | 3.62 | 1.03 | F1 |
| 15. Giving the nurse priority (first choice) to be off work when the unit census allows. | 86 | 3.79 | 1.16 | F5 |
| 16. Asking the staff nurse to establish unit criteria to assure fairness of rewards. | 86 | 3.55 | 1.07 | F1 |
| 17. Recommending the staff nurse as an expert speaker. | 86 | 3.44 | 1.17 | F1 |
| 18. Giving release time to spend a day with the supervisor to experience management functions. | 85 | 2.81 | 1.27 | F1 |
| 19. Giving time and support to develop a booklet describing the services that nurses provide on t... | 86 | 2.94 | 1.28 | F1 |
| 20. Bragging about the performance of the staff nurse. | 86 | 3.26 | 1.21 | F4 |
| 21. Giving preference for selection of work hours. | 85 | 4.05 | 0.97 | F5 |
| 22. Posting patient evaluations that compliment the staff nurse on unit bulletin boards. | 86 | 3.62 | 1.16 | F4 |
| 23. Consulting with the staff nurse on important unit decisions. | 86 | 3.92 | 0.97 | F1 |
| 24. Congratulating the staff nurse in front of peers. | 86 | 3.48 | 1.11 | F4 |
| 25. Meeting with the staff nurse to provide support and assistance towards professional and career... | 86 | 3.87 | 0.98 | F1 |
| 26. Providing an opportunity for the staff nurse to share projects/materials developed with peers... | 85 | 3.36 | 1.02 | F1 |
| 27. Increasing salary commensurate with level of performance. | 86 | 4.2 | 1.09 | F6 |

| | | | | |
|---|---|---|---|---|
| 28. Giving a letter of appreciation to the staff nurse for consistently working extra hours and p... | 86 | 3.49 | 1.28 | F2 |
| 29. Giving a day off with pay to attend a workshop. | 86 | 4.05 | 1.02 | F5 |
| 30. Announcing achievements in the unit newsletter. | 86 | 3.69 | 1.03 | F4 |
| 31. Announcing achievements in the hospital newsletter. | 86 | 3.53 | 1.16 | F4 |

Scores between 1 and 5
Highly preferred 4-5
Preferred 3-3.99
Least preferred 1-2.99

Table 20. Factors of Recognition Behaviors

| | | **Score** | Question No. |
|---|---|---|---|
| Factor 1. Opportunities for growth and development (13) | Spend a day with the supervisor | 2.81 | 18 |
| | Participate in unit planning | 3.62 | 14 |
| | Develop booklet describing services | 2.94 | 19 |
| | Support for career goals | 3.87 | 25 |
| | Recommended as expert speaker | 3.44 | 17 |
| | Time to work on special project | 3.64 | 5 |
| | Opportunity for peer review | 3.36 | 26 |
| | Set criteria for reward fairness | 3.55 | 16 |
| | Represent unit at hospital meetings | 3.33 | 6 |
| | Consulted on important decisions | 3.92 | 23 |
| | Discuss patient care and management | 3.49 | 4 |
| | Encouraged to develop expertise | 3.43 | 12 |
| | Encouraged to participate in state and national activities | 3.51 | 2 |
| Factor 2: Written acknowledgment (3) | Letter about performance to file | 3.6 | 3 |
| | Letter about extra hours to file | 3.49 | 28 |
| | Letter about performance to Director | 3.62 | 9 |
| Factor 3: Private verbal feedback (4) | Private verbal feedback | 3.99 | 1 |
| | On the job feedback | 3.86 | 10 |
| | Selected as charge nurse | 3.8 | 8 |
| | Selected as preceptor | 3.78 | 7 |
| Factor 4: Public acknowledgment (7) | Congratulates in front of peers | 3.48 | 24 |
| | Patient evaluations posted | 3.62 | 22 |
| | Patient evaluation copy to the director | 3.65 | 13 |
| | Announcing achievements in the unit newsletter | 3.69 | 30 |
| | Announcing achievements in the hospital newsletter | 3.53 | 31 |
| | Head nurse brags about staff nurses | 3.26 | 20 |

| | | | |
|---|---|---|---|
| | Celebration for years of service | 3.44 | 11 |
| Factor 5: Schedule (3) | Preference for selection of hours | 4.05 | 21 |
| | Priority to stay home with low census | 3.79 | 15 |
| | Day off with pay for workshop | 4.05 | 29 |
| Factor 6: Salary (1) | Salary increases are commensurate with level of performance | 4.2 | 27 |

Scores between 1 and 5; highly preferred 4-5; preferred 3-3.99; least preferred 1-2.99

Table 21. Preferred Methods of Recognition Based on Six Factors

| Recognition factors | N | Mean (Scale 1-5) | Std. Deviation |
|---|---|---|---|
| Factor 6: Salary | 86 | 4.20 | 1.09 |
| Factor 5: Schedule | 86 | 3.96 | 0.82 |
| Factor 3: Private Verbal Feedback | 86 | 3.86 | 0.80 |
| Factor 2. Written acknowledgement | 86 | 3.57 | 1.14 |
| Factor 4: Public Recognition | 86 | 3.52 | 0.90 |
| Factor 1: Opportunities for growth and development | 86 | 3.45 | 0.83 |

Based on the aggregate score, salary increases commensurate with level of performance (Factor 6, Mean 4.2, SD 1.09) is the most preferred method of recognition, followed by a schedule (Factor 5, Mean 3.96, SD 0.82) that provided flexibility and preference of working hours, private verbal feedback (Factor 3, Mean 3.86, SD 0.80), written acknowledgement (Factor 2, Mean 3.57, SD 1.14), public recognition (Factor 4, Mean 3.52, SD 0.90), and opportunities for growth and development (Factor 1, Mean 3.45, SD 0.83) (Figure 9 and Table 20).

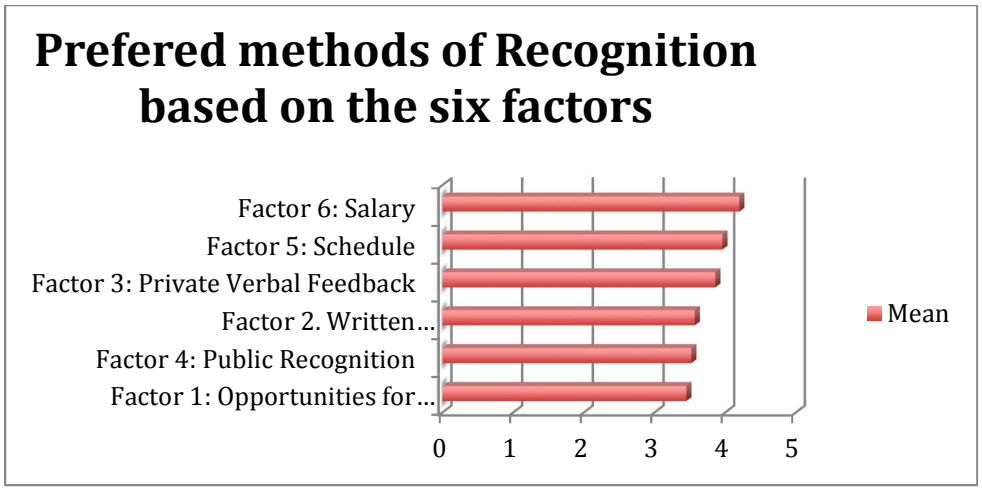



Figure 9. Preferred methods of recognition based on the six factors.

# CHAPTER 5. DISCUSSION

Five questions guided development of the project. Each will be discussed using the results from qualitative and quantitative data.

1. **How do staff nurses working in the critical care units rate their work environment and what is the reported level of MR as measured by the HWE survey?**

The AACN recommends the following scoring guidelines for interpreting the results for overall HWE score and MR subscale; a score between 1.00 and 2.99 means there is need for improvement; a score between 3.00 and 3.99 means the HWE and MR is Good; and a score between 4.00 and 5.00 is considered excellent HWE and MR (AACN 2005).

The overall HWE survey score was 3.39, and MR score was 3.37, both of which are considered good according to the AACN guidelines for interpreting the HWE and MR scores (AACN, 2005). Attempts to compare the results of HWE and MR in this study with other Magnet-designated organizations with similar characteristics to the study site and participants did not yield many results in the literature. Willingham (2014) conducted a study using the AACN HWE scale among 74 nurses in a 550-bed acute care teaching hospital and reported a HWE mean score of 3.41 and MR mean score of 3.4. Another study conducted by Thomas (2012) among 300 nurses in a 276-bed community hospital resulted in a MR mean score of 3.31. Not only were the sites of the two studies smaller, their Magnet designation status was not specified. There were research studies that compared the work environment in Magnet-designated and non–Magnet-designated hospitals using other scales to measure the health of the

work environments. Kelly, McHugh, and Aiken (2011) used Practice Environment Scale of the Nursing Workforce Index, endorsed by the National Quality Forum to explore the work environments in 567 acute care hospitals to evaluate differences in work environments and nurse outcomes in Magnet and non-Magnet hospitals and reported that Magnet hospitals have significantly better work environments than non-Magnet hospitals. Kramer, Maguire, and Brewer (2011) studied 12,233 experienced nurses from 717 clinical units in 34 Magnet hospitals using the 'Essentials of Magnetism II' scale that grouped the scores into three different categories; Very Healthy Work Environments (VHWE), HWE, or Work Environments Needing Improvement (WENI). So although a fair comparison is not possible, it is recommended that the nurses and nurse leaders should aim for a HWE and MR score higher than 3.39 and 3.32, respectively. Based on the evidence in literature, improving the HWE and MR score may positively impact the quality of patient care, nurse and patient outcomes, and eventually the organizational outcomes.

Breakdown analysis of the HWE into the six essential standards showed that MR (the standard of interest for this study) received the third score among the six standards 3.37(SD=. 77) (Table 13). Further analysis of the MR components (Table 14) shows that among the three items specifically measuring MR, item #4 of the HWE survey, *"the formal reward and recognition systems work to make nurses and other staff feel valued",* had the lowest score of 3.04 and the highest standard deviation (SD 0.99). The similarity of this finding to that of the FGI results is to be noted. From the FGI analysis formal recognition was the least mentioned subtheme among staff nurses preferred method of recognition, whereas formal recognition was the third-most preferred subtheme in the nurse leaders' transcripts.

According to the FGI participants, in the recent years, formal recognitions for nurses have proliferated in UNCH. Aspiring nurse leader award, inspiring nurse leader award, Linda Boote award for excellence in ICU nursing, and employee of the quarter were some of the formal recognitions mentioned by the focus group interview participants. Despite the availability of multiple formal recognitions, which cost a substantial amount of resources, these formal recognitions do not always reach the intended nurses, which are resulting in a lower perception of value for these formal rewards. Ventrice (2013) stated that ineffective recognition is a waste of both money and time and that many employee recognition programs fail because recipients don't find them meaningful. The real cause of this lower preference and utilization of formal recognitions needs to be explored in-depth and the nurse leadership should be formulate strategies to provide recognition that has value for the staff.

Further discussion was done among the nurses and nurse leaders regarding this low preference for formal recognition. The following issues were identified as the cause for decreased perception of value of the formal recognitions.

1. Minimally available resources: Formal recognitions need a substantial amount of time on the part of nurse leader to put together the application packet. When the leaders are trying hard to fix the issues of day to day unit or service operations such as staffing and patient care, formal recognitions moves to the back of their lists.

2. Lack of planning: Formal recognitions are given the least priority and usually thrown in together at the last minute, with minimal effort.

3. Rationing of formal recognition within the service lines: Each service line has a limited quota and they also have to take turns to nominate nurses for certain formal awards.

4. Criteria for nominating is not clear and exhaustive, although a lot of resources are spent on revising the award criteria every year.

5. Lack of writing skills: Most formal awards depend on how well the recommendation is written. Some organizations hire professional writers to

appoint someone skilled to prepare the applications for the employees of the organization.

6. Lack of awareness among nurses about all the formal recognitions available at UNCH.

7. Negative attitude toward formal recognitions were expressed during the FGI such as *'it is about popularity'* or *'I am never going to be nominated for one, as I do not meet the criteria.'*

Nursing practice council could take action to address the above issues to some extent and thus help the organization develop and maintain a robust, evidence-based recognition program for nurses.

**2. How do nurses and nurse leaders from adult critical care units perceive Meaningful Recognition (MR)?**

Analysis of the qualitative data from the focus group discussions explored the perceptions of staff nurse and nurse leaders on the concept of HWE and MR. Eight themes and 41 subthemes emerged from the seven focus group discussions among seven groups of nurses working in the critical care areas at UNCH.

MR appeared to be a fairly abstract concept among nurses and nurse leaders. Based on the analysis of FGI discussions, there is a need to create awareness regarding the evidence-based standard of MR, its role in creating an HWE, and the far-reaching influence of MR on nurse satisfaction and nurse retention, patient outcome, patient satisfaction, and organizational outcomes.

For the theme "When to give MR," all nurses regardless of their title agreed that "Exceptional Work Quality" should be a reason to give MR. Some examples of exceptional work quality given by the FGI cohort included going above and beyond, being a team player, teaching new nurses, acquiring new skills, or picking up extra shifts.

For leaders, achieving organizational goals was the second-most discussed reason for providing MR, whereas staff nurses discussed the subtheme once. Examples of organizational goals cited by nurse leaders are improved patient satisfaction scores, hand-washing scores, patient satisfaction scores, and reduction in the occurrence of hospital-acquired conditions (HAC). One of the possible reasons for this difference in preference may be the inability of staff to connect what they do at the bedside to the organizational goal and therefore place value on and take pride in those achievements. Another reason for not relating achieving organizational goals to MR may be due the lack of awareness among the staff nurses about the monetary benefits (dollar value of nurses' actions at bedside, referring to such as higher income and less penalty for not having HAC) of achieving an organizational goal. One of the leaders gave an example of how they tried to close this gap by doing case studies on HAC by including the nurses who took care of the particular patient. Such case studies helped the nurses remember the patient who was affected by the HAC and personalize the data related to HACs. This exercise made the nurses aware of the long-term implications of their care on patient outcomes and organizational outcomes and reminded them to be mindful about consistently adhering to the standards of patient care. Another leader did similar case studies on patient cases that did not develop any HACs. The purpose of this action was to reinforce those positive nursing care behaviors of learning, improving, and developing. These case studies gave the nurses an opportunity to reflect and learn from their actions in a safe environment, which is a form of meaningful recognition and confirmation of the value they bring to the organization. Thus it is important to note that creating awareness among nurses and creating the consensus as to what is meaningful is the first step in providing MR for nurses.

About one-third of the discussions under the theme "When to give MR" was suggested that interpersonal skills, mostly referred to by the staff as "soft skills," should be recognized, thus making it the second-highest reason for giving MR. In contrast, during the nurse leaders' discussion of the same theme, "soft skills" was mentioned fewer times. "Soft skill" is the colloquial term used for inter-professional and inter-personal skills of the nurse while the term "hard skill" refers to the psychomotor skills needed to perform patient care duties. Hard skills are relatively easy to observe, measure, and evaluate and hence a nurse who is proficient in psychomotor skills is readily recognized. The Society for Human Resource Management (SHRM) emphasizes that employees should be proficient in soft skills such as critical thinking, problem solving, leadership, professionalism, empathy, work ethic, teamwork, collaboration, and adaptability (Kroning, 2015). The label 'soft skills', is a much debated term due to the implied devaluing of such important interpersonal skills and essential components of emotional intelligence (EI) that are crucial for fostering a dynamic workforce (Kroning, 2015) in professional nursing. It is encouraging to know that five of the American Association of Critical-Care Nurses (AACN's) HWE standards align with the previously mentioned soft skills—Skilled Communication (effective communication), True Collaboration (teamwork, networking), Effective Decision Making (problem solving, critical thinking), Authentic Leadership (professionalism, integrity), and Meaningful Recognition (enthusiasm and positive attitude) (AACN, 2005). Furthermore, a study conducted by the Indiana Business Research Center (IBRC) found that although certifications and degrees are important, what really counted is a person's possession of the soft skills that are essential for fostering a dynamic workforce (Kroning, 2015). Organizations should focus on developing and recognizing soft skills competencies through leadership development courses and staff orientation. When the nurses and

nurse leaders are proficient at using and recognizing these soft skills, the more success they will have in leading and managing others. This comment by staff nurse points out the need for demonstrating empathy, one of the soft skills:

> *I vividly remember being a new graduate [nurse] about two and half years ago. I think it's very important [while interacting with other new nurses] to keep that in the back of your mind that not too long ago you were in their shoes. It is important for experienced nurses to be a good mentor and be willing to instill self-esteem into the new nurses, [which] will give them the assurance and freedom to ask questions without the fear of reprimand or repercussion.*

The theme of "Timing of giving MR" was the least discussed theme among the focus groups. But when it was mentioned, the majority of focus group participants believed that giving MR in the moment, in real time, would be most effective. Leaders brought up the topic of delayed recognition as meaningful and a more sustained form of recognition. According to the leaders, from their experience, delayed feedbacks outside the circumscribed settings were genuine and meaningful for the giver and the recipient. These are valuable lessons that can be added to the leaders' recognition tool kit, for any leaders who intend to reap the benefits of MR.

Under the theme "Benefits of MR," staff nurses and nurse leaders equally agreed that MR impacted staff satisfaction and morale, which in turn affected the quality of patient care and staff turnover. However it is concerning that benefits of MR comprised only about of the total discussions in the focus groups. This raises the question whether there is a gap in the awareness about the far-reaching benefits of MR on the part of staff nurses and nurse leaders. This gap in awareness needs to be explored and rectified so that MR will not be given as an afterthought. Leaders should be mindful and deliberate in providing MR so as to reap the benefits of MR. In

addition, it should be kept in mind that that the factors involved in producing job satisfaction and motivation are separate and distinct from the factors that lead to job dissatisfaction. Herzberg (1967) studied 1,685 employees in 12 different investigations among a wide variety of employees and reported that achievement; recognition for achievement, the work itself, responsibility, and advancement at work are the intrinsic factors that motivate people. Herzberg added that extrinsic factors of the job such as company policy and administration, supervision, interpersonal relationships, work environment, salary, (schedule) status, and security are dissatisfaction-avoidance (hygiene) factors (Herzberg, 1967).

The discussions on the theme "Who should give MR" confirmed that across the positions the most valued MR was provided by their leaders (37%), followed by peers (20%), the institution (17%), and the patient and their family (10%). FGI participants voiced that when nurse leaders personally recognized the staff nurses, it added weight and value to the recognition because of the time and effort invested in that recognition and this sort of recognition ultimately impacted nurses' satisfaction. The leaders included both formal and informal leaders as long as it was a leader whom the staff respected. In addition, leaders should be aware that by providing MR, they are also role-modeling a behavior and setting up a standard so that the staff will learn to the provide recognition to each other. Thus it is a teaching point for the nurse leaders that a leader's recognition has an added value for the staff.

The subtheme of MR derived from self-recognition fits into the theoretical framework of Maslow's Theory of Human Motivation. This intrinsic form of MR could originate from interaction with patients and families and meeting goals set for self. A staff nurse made this profound statement: "*I just think that as a nurse if your self-worth is based on what other people say about you, you would not be a nurse for long. I think your self-worth has to come from the*

*result you get [from patient care]."* The art and skill of providing intrinsic-MR should be included in the staff development competencies and in the nursing school curriculum. Herzberg, in his classic article on motivation, stated, "I can charge a person's battery and then recharge it, and recharge it again. But it is only when one has a generator of one's own that we can talk about motivation. One then needs no outside stimulation. One wants to do it" (Herzberg, 1987). This points out the importance of training staff in ways to find intrinsic recognition instead of always seeking recognition and validity from outside.

Some of the examples that were discussed during the focus group discussion were taking pride in a job well done, reflections on the activities of the day, patient getting well, and certifications. Critical Reflective Practice (CRP) refers to being mindful of self within or after professional practice situations so as to continually grow, learn, and develop personally, professionally, and politically (Lawrence, 2011). Due to CRP's effectiveness, the United Kingdom government now requires post-registration nurses practicing in work environments to include "reflective practice" as part of their ongoing education (Lawrence, 2011). The principles of reflective practices and related exercises such as reflection papers based on prompts, explained by Sherwood and Horton-Deutsch (2012), are valuable methods that can be used to train nurses and nurse leaders. These reflective practices provide an evidence-based framework for nurses to examine their professional practice that will ultimately promote self-awareness, enhance self-esteem (self MR), improve performance, and help the nurse move toward professional maturity (Sherwood & Horton-Deutsch, 2012).

For the discussion on "Who should receive MR," nurses and nurse leaders agreed that individual recognition was more meaningful than collective recognition. Leaders also mentioned that when their staff received recognition, they felt validated. Creating the awareness among

nurse leaders about the importance of deliberately seeking ways to provide individual recognition that are genuine, intentional, and personalized according to the need of the individual is crucial. One leader in the focus group follows a "no nurse is left behind" policy and maintains a list of the nurses in the unit to ensure that every nurse gets some form of recognition that is tailored to the individual nurse's need. The discussions relating to this theme confirmed the need for leaders to take an active role in meaningfully recognizing their staff. This can be summarized in this quote by a leader:

> *In order to create a healthy work environment, meaningful recognition is something that leadership can create with intention, but it's a hallmark when it, sort of, like popcorn is just popping up all the time, spontaneously, aside from the formal channels, but when it's baked in goodness.*

As mentioned previously, this is an important learning point for the nurse leaders that a leader's recognition and institutional recognition has added value for the staff, no matter how big or small those recognitions are.

"Struggle related to giving MR" was the most widely discussed theme in the focus groups in staff nurses' group and nurse leaders' group. One reason provided was that some of the barriers are too hard to tackle in a short time. Resources, mainly time and financial resources, were perceived as a barrier in providing MR. The available resources were stretched due to the unique characteristics of the nursing workforce such as size, diversity, six different education entry levels among registered nurses, shift work and weekend work that result in leaders having less opportunity to meet the staff, and the essential nature of work, personality differences, generational difference, and the presence of micro cultures within the institution.

Lack of awareness about MR was a theme that derived mostly from the discussion with nurse leaders and some of the staff nurses' discussion. Nurses and leaders stated that they did not realize the importance of MR in creating an HWE. This gap in perception of MR and HWE needs to be addressed and rectified as the first step in creating an environment where staff nurses are recognized for the value they bring to the organization. Education sessions addressing this gap may help the nurse leaders be mindful to notice what your team members are doing right and take deliberate efforts to tell them. As one of the seasoned nurse who participated in the FGI stated, "this [MR] will validate what we are doing right" and another FGI participant stated, "MR will provide a positive reinforcement for the behaviors that the organization expects to grow." It is equally important for the nurse leaders to know that the need for MR is different for different individuals. The leaders' success in providing MR depends on their ability to modulate the frequency and intensity of MR to the need of the individual. For example, newer and younger team members may need MR often for even the small things they do. But with more experienced members, save the praises for more significant accomplishments so that the recognitions will be valued.

Institutional barriers included the limited growth opportunities available for nurses who stay at the bedside, the undertones of recognition set by the organization, and vague criteria set for recognition. The reasons for limited opportunities available for progression for nurses who stay at the bedside need to be explored. There is no differentiation in the title for a nurse who has one year of experience and one who has 30 years of clinical experience. Even the clinical ladder opportunities that are available are geared toward a managerial role. The suggestion was to have two arms of clinical ladder in nursing—one that leads into education and management and another one for those people who excel in their skills at the bedside one way or the other. The

suggestion was that the entry to the clinical ladder should be self-propelled by excelling in the clinical competency, fulfilling the preset expectations, and completing the paperwork.

Other struggles related to providing MR are "Devaluation of current MR efforts" due to change in expectations of staff and stagnant MR efforts. There were common misconceptions related to MR, especially among nurse leaders, such as "we are doing a good job of providing MR, is MR needed beyond the compensation for work," and so forth. The "Belief that MR is negative" was another subtheme that came up during the discussions. Some of the staff nurses and nurse leaders verbalized that they hesitate to give MR due to the unintended negative consequences related to MR such as MR eventually may be considered an entitlement or the problem that giving recognition to one nurse may offend other nurses who also perform at the same level but unfortunately were not noticed by the nurse leader. Diverse individual needs are another barrier for providing MR, which can be overcome by extra effort from the nurse leader to know their staff nurses on a personal level. This requires awareness, energy, time, and effort on the part of leader.

Cultural characteristics of the organization, especially the current tendency to criticize mistakes instead of praising what was done correctly, was another barrier that will take time to tackle. Based on the organizational culture framework used to guide this project, there is hope that the "culture in systems can be ultimately created, embedded, evolved, and ultimately manipulated by leaders" (Schein, 1992, p. 22). One of the nurse leaders stated a quote, "great leaders make things happen when they're not there and they do that by system change, by creating a culture." It is important that the leaders create a culture that encourages recognition to help build each other up by being deliberate and explicit about modeling recognition behaviors to nurses.

Many of the barriers mentioned are not easy to overcome. However, considering the short-term and long-term benefits of MR, it is imperative to explore each of these barriers in depth and find ways to provide MR. One leader in the group stated that the key is for "every leader to take ownership and build a structure [to provide MR] in some shape or form and make sure that they [nurses] are touched." This would contribute to creating a work environment that is healthy.

3. **Are there differences in perception of HWE and MR based on the adult critical care staff nurses' level of education, position in the institution, generation, gender, intent to leave, years of service in the unit, years of experience in the institution, and years of experience in nursing?**

*Relationship between nurses' level of education and specialty certification and Perception of HWE and MR.*

The mean scores of HWE (F 0.389, df (1,91), *p* 0.679) and MR (F 0.601, df (1,91), sig. 0.55) among three education subgroups were compared and did not yield any statistically significant difference. However raw (absolute) mean scores among the three education subgroups was slightly different. Nurses with an associate degree in nursing had the highest mean score for perception of HWE (Mean 3.52, SD 0.8) and MR (Mean 3.53, SD 0.78), followed by nurses with a master's/doctorate-level (HWE Mean 3.45, SD 0.6) (MR Mean 3.48, SD 0.58) education. Nurses with a bachelor's degree (N=67) had the lowest perception of HWE (Mean 3.35, SD 0.69) and MR (Mean 3.32, SD 0.8). These results are contrary to the results reported by Kramer, Brewer, and Maguire (2011), where a larger percent of BSN-educated nurses confirmed HWE compared to nurses with other educational backgrounds. The authors attributed this higher rate of perception of HWE by BSN-educated nurses to the BSN curricula that included more didactic information regarding clinical autonomy, control over nursing

practice, patient-centered cultural values, and the greater emphasis on leadership, collaboration, and teamwork in BSN curricula (Kramer, Maguire, & Brewer, 2011). This raises the question whether the attributes of the BSN curriculum are setting an unrealistically high expectation for nurses regarding their professional work environment and is that the reason for the low perception of HWE among this educational subgroup? In addition, taking into account some of the FGI comments, the limited growth opportunity and lack of salary difference based on education could have resulted in the lower score. This trend may need intervention because an unsatisfied BSN workforce has a higher chance of leaving the institution or even the profession itself. One logical explanation for a higher score among nurses with a higher education could be the masters/doctoral-level education curriculum prepared these nurses to have a broader and more positive view of their work environments compared to their BSN counterparts and their higher education might have opened up new opportunities within the institution. In addition, the nurses with higher education may have received academic assistance from their institution to further their education, which could be perceived as MR. Thus it is important to create awareness among nurses and guide them to use the many opportunities for advancement and avenues for recognition UNCH has so that they will find meaningful recognition at work.

Those who obtained a specialty certification had a higher mean score for HWE (Mean 3.43, SD 0.68) when compared to those who did not have a specialty certification (Mean 2.71, SD 0.91), and the difference was statistically significant ($p = 0.029$) (Table 13). It is interesting to note that this trend reversed when for MR scores where specialty-certified nurses perceived lesser recognition (Mean 3.39, SD 0.83) compared to non-specialty-certified nurses (Mean 3.40, SD 0.83) Although the mean scores were not (arithmetically) different, they were statistically different for specialty certification ($p = 0.039$).

On analyzing the reason for this difference in perception, it may be safely assumed that the additional knowledge and confidence gained through certification may have contributed to improved communication, collaboration, and decision-making abilities of the staff nurses, which in turn may have impacted their perception of the work environment as healthier than their non-certified counterparts. At the same time, certified nurses are not compensated differently by the organization nor do they have additional growth opportunities based on these certifications except for limited availability for clinical ladder advancements. Whether this is a reason for the lesser perception of MR among certified nurses need to be explored. This lack of continued support for certifications is a cause of concern because continued competence requires continuing professional development. Recently there appears to be an increased tendency for nurses to move to other organizations that compensate nurses differently based on their certification status. Therefore the lower perception of MR among certified nurses may lead to a brain drain (intellectual capital drain) from the organization. Ulrich et.al (2014) confirms that certification is associated with verification of professional competence, enhancing the quality of care, increased confidence, more frequent and effective nurse-physician collaboration, and a higher level of competence. Lack of support for continuing education is shortsighted and potentially dangerous to safety (for both nurses and patients) and quality of care (Ulrich et.al, 2014) and nurse retention.

*Relationship between nurses' gender and perception of HWE and MR*

There was no statistically significant difference in the means of HWE scores when computed for subgroup gender (F 0.3.085, df (1,90), $p = 0.054$). However, there were gender differences in perception of MR: male nurses felt less recognized than their female peers. Female nurses reported a higher level of perceived MR (Mean 3.43, SD=0.75) compared to their male

counterparts (Mean 2.71, SD 0.80). The difference was statistically significant (F=5.741(1,90), $p$ = 0.019). It could be that because there are larger percentages of female nurses, males feel they are recognized less often.

*Relationship between nurses' intent to stay and perception of HWE and MR* (Table 14).

Bonferoni test for difference in means of those who "intend to stay" is significant for perception of HWE (F 6.76 (1,90), $p$ = 0.002) and MR (F 5.93(1,90), $p$ = 0.004). For those who have plans to stay, the mean score for HWE (Mean 3.53, SD 0.65) was about 0.8 points higher compared to nurses who are not planning to stay (Mean 2.71, SD 0.91) and one-half point higher than nurses who are undecided (Mean 2.99, SD 0.62). For those who have plans to stay, the MR (Mean 3.51, SD 0.71) mean score was 1 point higher compared to nurses who are not planning to stay (Mean 2.50, SD 0.69) and one-half point higher than nurses who are undecided (Mean 3.02, SD 0.82).

Nurses leave the organization for reasons such as returning to school, retirement, relocation due to family reasons, moving up the nursing ladder within the institution, taking up a clinical job in another institution, moving to a non-clinical nursing position, and moving to a non-nursing position. Ulrich et.al (2014) conducted a survey among 8,444 critical care nurses and reported a list of possible factors that would influence those nurses who expressed intent to leave to reconsider their plans to leave their current position. The options respondents said would very likely influence them to reconsider were better leadership (selected by 51.8%), followed by better staffing (48.1%), more respect from administration (47.6%), and more respect from frontline management (47.4%). It is interesting to note that all the four options directly related to respect, staffing, and leadership, which are the essential components of HWE. Again, this

indicates a need for education for leaders to have better awareness about what is valued by staff nurses that could incentivize retention.

Li and Jones (2012) calculated that the cost of RN turnover was 1.2–1.3 times their average salaries. With nurses' turnover, healthcare organizations incurred loss of the intellectual capital of nurses and potential productivity losses. Thus, hypothetically, if the organization is able to retain even some of the 17 nurses who were undecided about leaving the organization and induce them to reconsider their plans by providing MR, it will be gain in terms of intellectual capital, productivity, and financial capital.

*Relationship between nurses' title in the institution (position) and perception of HWE and MR (Figure 8)*

Comparison of HWE and MR means across the various titles (Figure 8) did not yield any statistically significant differences [HWE- F 0. 004 (1,89), $p = 0.949$], [MR F 0. 88 (1,89), $p = 0.351$], yet it is interesting to note that among the titles there is a wide range between the lowest and highest HWE means (over 0.5 points) and MR mean (over 1 point). Clinical Nurse I, with less than 1 year of experience, had the highest mean score in both HWE (Mean = 4.11, SD =0.39) and MR (Mean = 4.33, S.D =0.94) category. The reason for this high score may be attributed to the excitement of completing the nursing course, passing licensure exam, passion for nursing and the novelty associated with the new career. Kramer, Maguire, and Brewer (2011) state that it would require at least 1 year of exposure to the unit work environment before a nurse could accurately confirm the health of that work environment.

Clinical Nurse IIs had the lowest score in MR (Mean = 3.29, S.D= 0.0.79). This group is comprised of nurses who have been in the nursing profession between 2 years to 30-plus years and may have experienced limited opportunities for growth and promotion. Reinsvold (2008) reported that newly graduated RN turnover is currently between 35% and 60% within the first 12

months of employment and 57% at 2 years of hire. Newly graduated nurses have a steep learning curve with problems unique to this time in their careers, causing high organizational investments in these nurses. The direct cost of filling a vacancy is estimated to be at least a 100% of the new graduates' annual salary (Reinsvold, 2008). Recent calculations show that the actual cost of replacing a nurse runs between $92,442 and $145,000 (Huddleston, 2014), which result in new graduate turn over to be a substantial cost to the hospital. It is estimated that the costs of newly licensed RN turnover is about $856 million for organizations and ranges between $1.4 and $2.1 billion for society in general (Li & Jones, 2012). Due to these repercussions, the drastic drop in the perception of both HWE and MR mean scores from Clinical Nurse I to Clinical nurse II may be worth exploring.

Nurse managers had the second highest HWE (Mean = 3.78, SD =0.00) & MR (Mean = 3.87, SD 0.047) scores, followed by Clinical Nurse IVs HWE (Mean = 3. 29, SD= 0.54) & MR scores (Mean = 3.47, SD 0.47). And Clinical Nurse IIIs HWE ((Mean = 3. 29, SD= 0.67) & MR. (Mean = 3.39, SD 0.79) scores. Opportunity for growth and development and the leadership responsibilities, along with the salary increment, may be the reasons for this increased score among nurse managers and Clinical Nurse IVs.

*Relationship between nurses' age (generation) and perception of HWE and MR*

There was no statistically significant difference in means of HWE and MR when compared to various age groups. However one interesting finding is the spike in the mean score of HWE and MR from age 41 to 50 (HWE Mean 3.14 and MR mean 3.10) and 51 to 60 (HWE Mean 3.70 and MR mean 3.62). Reinvigoration of their professional lives and less distractions in their personal lives could be the reason of high perception of HWE score among older nurses (Kramer, Maguire, & Brewer, 2011).

*Relationship between nurses' years of experience in nursing, institution, and unit and perception of HWE and MR*

Years of experience at UNCH were the one category where there was a statistically significant difference in the mean perception of HWE (F 3.33, df (1,90), *p* 0.01). Nurses with experience between 11 and 20 years at UNCH had the lowest perception of HWE and this was about 0.5 points lesser than the group with 21 to 30 years of experience and 1 point lesser than the nurses with less than 1 year experience at UNCH.

During the focus group discussions there were multiple comments from staff nurses about the feeling of routine after the "five year mark, six year mark" where they felt, "okay, well, I can help everybody out, I can do all these things, what else should I be doing…" Another comment was "once you hit a burnout (after few years in the unit) you are coming in and you are clocking your 12 hours and you are going home, that's why I think the [MR from] peers is something that doesn't work." This points out the need for designing specific growth opportunities targeted toward nurses who are reaching the 10-year mark so as to get them more engaged and "have actual use of my brain," as another nurse stated during a conversation apart from the FGI. Cindy Ventrice, an "employee loyalty specialist," conducted a survey on MR and reported that employees did not perceive rewards and recognition as the same thing. Employees are motivated by recognition more than rewards and it is important to attach meaning to rewards (Ventrice, 2013). To sum it up there are many ways to provide meaningful recognition to nurses. A key factor is the leader's awareness about the importance of MR and deliberate actions in providing individualized recognition to the nurses.

**4. What are adult critical care staff nurses' preferred ways of being recognized as measured by the Recognition Questionnaire?**

Both qualitative and quantitative data showed similar trends in the nurses' preferred ways of recognition and involved tangible and non-tangible methods. Overall, the preferred methods of MR were in the following order: finance, opportunities for growth and development, verbal recognition, informal recognition, written recognition, and formal recognition. Because MR is an essential aspect of a HWE, this data is particularly significant for this project goal of improving the quality and relevance of MR among the ICU units.

Based on the focus group discussion results, there were slight differences in the preference among staff nurses and nurse leaders, as shown in Figure 5. For staff nurses the top three methods of recognition were in the order of finance, opportunities for growth, verbal recognition, and written recognition whereas for nurse leaders the preferences are in the following order: opportunities for growth, finance, and formal recognition.

Quantitative and qualitative data supported that the top MR preference for nurses was an increase in salary commensurate with level of performance professions other than nursing have reported that the most valuable recognitions are the ones that have monetary value. Until recently financial ways of recognition was not widely supported by the nursing literature whereas recognition from patients and families were reported as the most meaningful recognition for nurses. Somensa and Duran (2014) reported that remuneration is associated with the feeling of recognition and not merely as an allowance and may be a motivation factor for nurses. Some of the financial recognition methods other than salary were gift cards, massages, and food delivered to staff on busy days.

Opportunities for growth is the second-most preferred method of recognition. Many staff nurses considered educational opportunities supported by the institution such as offsite conferences as MR. A staff nurse added that the leaders need to ensure *"rotation for nurses to attend conferences, so it is not the same people every time,"* emphasizing that fairness in growth opportunity is equally important for staff nurses. Opportunities for progression for those nurses who choose to stay at the bedside were considered important for staff nurses. Currently the clinical ladder opportunities are limited and are geared toward more managerial roles. The suggestion was to have two arms of clinical ladder in nursing; one that leads into education and management and another one for those people who excel in their skills their abilities at the bedside one way or the other. The suggestion was that the entry to the clinical ladder should be self-propelled by excelling in the clinical competency, fulfilling the preset expectations and completing the paperwork. Surprisingly staff nurses considered the *freedom to ask questions* and *the opportunity to learn* as meaningful recognition. This emphasizes the importance of having emotionally intelligent nurses at the bedside who are willing to coach fellow nurses so nurses feel recognized instead of being intimidated.

The other major forms of recognition valued by the staff nurses were informal recognition and verbal forms of recognition. Examples of informal recognition included leader's presence in the unit and caring behaviors demonstrated by nurses and leaders such as providing food for staff on a busy day, the manager putting on a pair of scrubs to help with an emergency situation on the unit, or the staff letting another staff member walk out of the unit for a few minutes to de-stress. A leader stated, *"on the one hand it can be very informal, just pulling somebody aside after the shift to just say, thanks for helping me with that bed change, or it can also be very strategic and deliberate in terms of trying to pull someone along forward in their*

*professional trajectory."* Verbal recognition included acknowledging individual nurses during staff meetings, saying "thank you," and providing positive feedbacks. "*For some nurses a genuine message, just a thank you, could be something that they carry with them that means more than a framed award in front of an auditorium,"* said one leader in the group, pointing out the importance of taking personality difference into account while providing MR.

Formal recognitions such as awards and public recognition and written recognition to individuals through e-mails and electronic high-five boards were equally valued by staff nurses and nurse leaders. These forms of recognition had the advantage that they could be used during annual evaluations and promotions, which in turn had a monetary value in the long run.

Staff nurses and leaders reported that the most meaningful recognitions came from a manager, a team leader, or an informal leader (preceptor, charge nurse, educator, mentor). One nurse leader stated, *"The most meaningful way to recognize somebody is for a leader, at whatever level, to walk up and look that person in the face and say to them I think what you did was really great work."* It is essential to include MR skills in the leadership development classes. Specifically, the leaders need to be taught to deliberately seek out what the team members are doing right and to take the time and make the effort to acknowledge that. With newer and younger team members, do this often and acknowledge even the small things they do. In the words of FGI participants, timely and frequent MR will *"validate what the nurses are doing right"* and *"will provide a positive reinforcement for the behaviors that the organization expects to grow."* More experienced team members may prefer praises be limited to more significant accomplishments so that the recognitions will be valued.

5. **Are there differences in preferred ways of recognition based on the nurses' gender, nurses' level of education, position in the institution, generation, years of service in the unit, years of experience in the institution, and years of experience in nursing?**

The means of various preferred forms of recognition were compared to gender. While the sample was small, men had a lower preference for the following category of recognitions and the difference was statistically significant different from women: Factor 1—Opportunities for growth and development, F 9.48 (1,82) p 0.003; Factor 2—Written acknowledgement, F 4.313 (1,82) p 0.041; and Factor 4—Public acknowledgement, F 12.42 (1,82) p 0.001. However both genders had an equal preference to recognition in the form of private feedback, schedule, and salary.

The means of preferred forms of recognition when compared to the other demographic subgroups such as education, title in the organization, age of the nurse, years of experience as a nurse, years of experience at UNCH, and years in the unit did not show statistically significant differences.

## Limitations

One limitation to this project was the convenience sampling method used that might pose limits to its external validity. The sample only included nurses from the adult critical care units and thus the small sample size and limited diversity may not be generalizable to the population. Focus group interviews were conducted during work (for leaders) or after work (for staff nurses) when the nurses were in a hurry to either get back to work or get out of work and therefore the timing may not have been conducive for an in-depth and whole-hearted participation in the focus group discussions. The presence of the PI who is a colleague of the participants could have prevented the staff from discussing their opinions openly. Cultural norms and hierarchical and

power gradients may have inhibited open responses, especially as the PI functions as clinical nurse 3 in one of the critical care units. The presence of the hospital's nurse researcher during the FGI of leaders may have caused concerns for the leaders to contribute openly during the discussions. In addition there is a possibility that one dominating participant in the group could have driven the direction of responses of the group. The lack of diversity among the 26 participants in the focus groups with no representation from African Americans or Native Americans could also be considered as a limitation of this project.

The surveys could have posed some limitations too. The surveys required an average of 20 minutes to complete. The questions in the HWE survey were are elaborate and wordy and had to be read at least twice to really understand the item to be answered. Two of the returned surveys did not have any data filled and there were several partially filled surveys indicating that the participants may not have had the time. The Likert scale system also could have caused confusion for participants who may have indicated the wrong score unintentionally. In addition, eighteen nurses to whom the survey was administered had participated in the FGI a week prior, and were thus exposed to the idea of MR and HWE, which could have influenced their answers.

## Significance and Implications

Patient outcomes, nurse outcomes and organizational outcomes are empirically related to healthy work environments and it is no longer a question of should or if but when and how HWEs can be developed and sustained on all clinical units (Kramer, 2011). MR, one of the evidence-based standards of HWE is essential in creating and maintaining healthy work environments. The ultimate goal of this project is to increase understanding and implementation of MR across all ICU units, which can have long term implications as noted in evidence about retention and nurse satisfaction. With the multiple regulatory agencies, stakeholders and

reimbursements tied to quality, health care organizations have to strategically implement methods to provide MR to create HWE that are conducive for delivering quality nursing care.

The findings of this project are important to the following groups in the organization:

1. Nurses who will be benefit from the increased global awareness about MR. Recognizing each member for the value they bring will lead to a positive cultural shift and thereby result in better engagement from the workforce
2. Nurses leaders who are aware of the impact of MR will refine their MR skills and utilize the opportunities to deliberately provide MR. The findings of this project will also assist nurse leaders to build a business case to address nurse turnover in their units. In addition, successful ways to provide MR is a topic of interest to many leaders since MR is *consistently* scored low in the yearly Workforce Engagement Surveys, which determine department tier rankings.
3. Nurse researchers who may be interested in further research on MR such as the difference in the perception of HWE and MR among demographic subgroups, which will help to tailor MR programs that will fit the needs of the sub groups. More research is also needed to identify ways to overcome the barriers related to MR.
4. Nurse educators may use the finding of this project to develop staff development courses, leadership development courses, continuing education and new employee orientation, which will help to sustain the MR initiatives. Eventually these strategies could be used for education and development of other members of the health care team such as nursing assistants, housekeeping staff, physicians, respiratory therapists, physical therapists, etc. because fundamentally all humans have the same need for MR.

5. Policy-makers as they develop policies targeting patient care quality and nurse retention. As the paradigm of MR becomes universally accepted in the nursing profession, today's efforts will become tomorrow's success (Clevenger, 2009).

## Dissemination

The objective is to disseminate the findings from this project to (a) create awareness among nurses and nurse leaders about the problems associated with lack of recognition and (b) to educate the nurses and leaders on evidence based ways to provide MR. I have compiled a set of recommendations based on the analysis of responses from interviews and surveys, which would be presented to the nursing practice council to develop strategies to deliver MR in a systematic and consistent manner to the nurses.

The PI will communicate the results of this project in the staff nurses' meetings and leadership meetings of the respective critical care units that were involved in the project. A face-to-face dissemination method will allow opportunity to discuss the project in detail and allow the staff and leaders to ask questions about the results of the project. In addition results will be shared in the hospital wide nurse manger and directors meeting at UNCH. It is hoped that by working with hospital educators, the findings of this project may be developed as a Learning Management System (LMS) module through which nurses can obtain Continuing Education (CE) credits. Beyond the institution, the project will be submitted for presentation at professional meetings and research conferences and for multiple professional publications to be able to reach a broad audience.

Potential obstacles that may arise in disseminating findings from the project include buy-in from the multiple stakeholders, time constraints, cost associated with staff participation in the dissemination, championing the project, and resources needed for effective dissemination such as space. In addition, securing time on the meeting agenda for the monthly director's meeting at

UNCH may be difficult. Advance planning can help to overcome potential obstacles. Presentations can be concise and more interesting with appropriate examples. Permission to present the project results in staff meeting will be obtained through written permission from the service line directors and the unit managers. Tailoring the presentation to the needs of the audience is essential for successful dissemination of the product. For example, with nursing administrators, the presentation will emphasize the importance of training leaders to provide MR and the effects of MR on retention, patient outcomes, patient satisfaction scores and financial outcomes and emphasize that this is an evidence-based practice that can help stay ahead of competitors. Presentation to the staff nurses will be directed towards the potential effect of MR in enhancing teamwork, job satisfaction and improving workplace morale. For educators and quality improvement departments, this topic opens doors in terms of future research. Recruiting I project champions who will act as the contact persons and continue to disseminate and diffuse the concept of MR can help raise awareness of this important domain, and could lead to organizing a MR committee for the ICU areas.

There are a number of ways to implement follow up beyond dissemination. Follow up surveys could further investigate how staff and leaders respond to the findings and identify priority areas for implementation. On-going measurement can be part of annual nurse surveys distributed by the institution and used to assess improvement in staff and leader satisfaction about MR.

## Conclusion

Providing Meaningful Recognition for nurses, the largest workforce in health care, is not a choice but essential to improve the quality of care delivered, the productivity and retention of nurses, and the viability of the organization. One of the striking findings of this project was the low in awareness among nurses and nurse leaders about the concept of MR and its role in

creating an HWE and the contrast in what nurses and leaders considered meaningful recognition. Individually, every one acknowledged that recognition was needed for personal and professional growth, but collectively, priority for recognition was low and ability to provide MR was not considered an essential leadership skill. Other findings include the struggles associated with providing MR in an efficient manner, obstacles such as lack of resources to provide MR, devaluation of the current MR efforts, diverse individual needs, the concept that MR is negative, the specific culture in the units, and institutional factors that influence MR for nurses. The combined results of quantitative and qualitative analysis show that monetary incentives (salary) commensurate with the level of performance, flexibility in schedule, opportunities for growth and development, private verbal feedback, and written recognition were among the top five methods of recognition that nurses valued. The first step towards tapping into the power of MR is to create awareness about MR and its benefits among nurses in the organization. Healthcare organizations have to strategically implement evidence-based methods to provide MR that is of value to nurses. Equally important is the fact that MR should be delivered to the intended group of nurses in a systematic and uniform manner so that nurses, patients, and the organization will reap the benefits of MR and HWE. When nurse leaders are trained in the art of providing MR they will be able to enhance the engagement, motivation, commitment, satisfaction, and involvement required from followers to constantly improve their work performance and outcomes. MR practices guided by these nurse leaders and imitated and implemented by the staff may produce superior outcomes for staff nurses, patients, and organization.

## Recommendations for Nursing Practice Council

Based on these findings it is recommended that the Nursing Practice Council undertake a review of HWE and MR among nurses and leaders in the ICU units. These are high stress roles that contribute to burnout. MR is one strategy that could help to keep nurses in the work force at

higher levels of engagement. Recommendations are two-fold: first the barriers identified in the project can help leaders and nurses better understand the challenges in finding MR that matches the various needs, values, and work contributions of a large and diverse staff, and secondly, an action plan can help develop a roadmap to address this important but challenging area of the nursing workforce.

Current challenges in providing MR:

1. *Minimally available resources for recognition.* Formal recognitions need a substantial amount of time on the part of nurse leader to put together the application packet. When the leaders are focused hard to fix issues related to day-to-day operations such as staffing, and patient care, non-urgent tasks such as recognitions is moved to the bottom of their tasks list.

2. *Lack of planning*. Formal recognitions are given the least priority and usually compiled together at the last minute, with minimal effort.

3. *Rationing of formal recognition within the service lines*. Each service line has a limited quota and they also have to take turns to nominate nurses for certain formal awards.

4. *Criteria for nominating* is not clear and exhaustive, although a lot of resources are spent on revising the award criteria every year.

5. *Lack of writing skills*. Most formal awards require a well-written recommendation letter. Some organizations hire professional writers or appoint someone skilled to prepare the applications for the employees of the organization and those employees may win, by virtue of what is documented.

6. *Lack of awareness among nurses about all the formal recognitions available at UNCH*. The retention and recognition committee could create a master list of all the recognitions

available in the organization and make it available in the Web site, new employee orientation, and leadership development classes.

7. *Negative attitude toward formal recognitions* were expressed during the FGI, such as *"it is about popularity", "If I nominate someone, it may offend the other person", "I will never g be nominated"* etc. Nursing practice council could take action to address these issues to some extent and thus help the organization develop and maintain a robust, fair, evidence-based recognition program for nurses. It is anticipated that the information from the survey in combination with the themes that arise from the FGI interviews will shed light into the gaps in the current recognition methods for nurses and will assist the professional development council to create innovative and evidence-based methods to provide MR and improve the nurses' work environment.

**Recommended action plan**

Based on the survey results that also served as a needs assessment survey, and the findings from the focus group discussions, MR among nurses in the organization could be improved if the organization can address the following issues: 1) Lack of awareness about MR and HWE among nurses and nurse leaders, 2) Lack of training in the art and science of providing MR, 3) Lack of best practice guidelines on how to give MR, and 4) Challenges associated with MR.

1. **Build awareness about HWE and MR among staff nurses and nurse leaders.**

Short staff development sessions during the unit-wide and department-wide meetings provide an ideal opportunity to better understand the nuances about MR and HWE revealed in this project. Some of the intended groups are the nurses from the intensive care units that participated in the project, Nurse manager forums, Nursing research council and Nurse retention committee. Through these short sessions, nurses and nurse leaders can be encouraged to be more mindful about what nurses are doing well and take deliberate actions to acknowledge their actions. When more nurses are aware of the impact of MR and mindfully provide MR, it will enhance the engagement, motivation, productivity, and commitment of nurses and improve nurse, patient, and organizational outcomes.

2. **Develop leadership knowledge on MR.**

One of the preferred ways of recognition nurses felt most meaningful came from a manager, a team leader, or informal leader (preceptor, charge nurse, educator, mentor). Nurses in both formal leadership (directors, managers, and educators) and informal leadership (Clinical Nurse III, Clinical Nurse IV, charge nurse, and preceptors) roles need to undergo this training so as to work through the vague and abstract nature of MR. The leaders' success in providing MR lies in their ability to modulate the frequency and intensity of MR to the need of the individual (such as more frequent recognitions for newer nurses versus MR for special accomplishments for more experienced nurses). The education sessions could be delivered in various forms such as formal didactic sessions and role plays based on the themes emerged from FGI, 'What is MR' (concept of MR), 'Why provide MR' (The ultimate goals are nurse retention, patient satisfaction, and organizational finance), 'When to provide MR' (Appropriate timing and events that call for MR), 'Ways to effectively provide MR' (Tangible and intangible methods, recognition for

psychomotor skills and interpersonal skills) and 'Who should provide MR' (Nurses prefer acknowledgement from leaders) self paced- Learning Management Service (LMS) modules,. In addition, selection criteria for leadership positions should include interpersonal and inter-professional relationships skills.

3. **Promote reflective practices for self-assessment and continuous learning that may contribute to intrinsic form of MR.**

Based on Maslow's Theory of Motivation, motivation is essential for growth. A significant finding of this project is reflecting on ones work and finding meaning in ones own work. Evidence-based methods of reflective practices will assist nurses to develop the capacity to analyze their own nursing practices work, learn from it, and be motivated to excel in the art and science of patient care. Therefore promoting reflective practices among staff nurses and leaders, through private journaling or shared spaces such as nurse rounds, should be considered, as an essential part of professional training to provide MR to self.

4. **Explore the current opportunities for growth and recognition available in the institution for clinical nurses.**

Set up a committee to study and evaluate the current pathway for advancement in the clinical ladder and other opportunities available in the organization. Opportunities for growth are associated with financial incentives, which was the top form of recognition identified from both quantitative and qualitative data. In addition there should be clear and standard guidelines for scheduling and flexibility across the organization. (For example how many part times positions can be allowed in a particular unit or how many nurses will be allowed to have a fixed schedule such as weekend only options, etc.) Such a move might help in the long-term retention of nurses, which will be a gain for the organization in terms of intellectual and financial capital. This

committee could explore the possibilities of developing a dual path for career advancement with two distinct tracks; one geared to prepare nurses in administrative roles and the other one to prepare nurses to be leaders at the clinical front.

5. **Appoint a representative group to review current recognition systems and match them to align with nurses' values.**

This group should have representation from the various subgroups of nurses to ensure that the nurses' voices are heard. One of first task for the committee will be to prepare a catalogue of the entire individual, unit and organization based formal recognitions available for staff nurses. Each critical care unit should form a committee that will nominate staff nurses for the various formal recognitions in such a way that every nurse will have a fair opportunity for nomination.

## APPENDIX A: PERMISSIONS

### 1. DNP project Permissions for the HWE survey from AACN

Hi Usha,

Thank you for your inquiry.

AACN grants you permission to include the AACN Standards for Establishing and Sustaining Healthy Work Environments survey in your grant proposal. All content is owned by AACN so the only thing we ask, is that you include a statement such as "survey questions used with the permission of AACN". You may also take the 18 questions and adapt them for use in your own survey, in which case we simply ask that you include the statements "questions adapted with the permission of AACN."

Good Luck!
Chelley D'Amato
AACN Info [aacn.info@aacn.org]

*Sent Items*

Thursday, August 13, 2015 6:58 PM

I am Usha Koshy Cherian, a graduate student doing DNP in Health Care Systems at University of North Carolina, Chapel hill, NC. My DNP project is on role of Meaningful Recognition in creating Healthy Work Environment for nurses in the Critical Care Units. My advisor for the DNP project is Dr. Gwen Sherwood, Professor and Associate Dean for Academic Affairs, School of Nursing, at University of North Carolina at Chapel Hill.

I am writing this letter to obtain permission to use the Healthy Work Environment survey for my DNP project, which will serve as the need assessment survey. The Recognition questionnaire will be administered to the nurses and nurse leaders of six critical care units at the University of North Carolina Hospitals, Chapel Hill, along with the Recognition Questionnaire developed by Blegen, et.al in 1992.

If you would kindly grant the permission to use the survey, then I would pass out the appropriately cited paper copy's of the surveys and collect the surveys myself.

Please let me know if I have permission to use the Healthy Work Environment Survey in my DNP project.

Thank you for your time and consideration.

Usha Koshy Cherian

**2. DNP project Permissions for the Recognition Survey from Dr. Mary Blegan.**

Yes - you have my permission to use the Recognition Questionnaire and can modify it as needed. Best wishes on your project.

Mary Blegen

*Sent Items*

Thursday, August 13, 2015 6:51 PM

Hello Dr. Blegen,

I am Usha Koshy Cherian, a graduate student doing DNP in Health Care Systems at University of North Carolina, Chapel hill, NC.

My DNP project is on role of Meaningful Recognition in creating Healthy Work Environment for nurses in the Critical Care Units. My advisor for the DNP project is Dr. Gwen Sherwood, Professor and Associate Dean for Academic Affairs, School of Nursing, at University of North Carolina at Chapel Hill.

I am writing this letter to obtain permission to use the Recognition Questionnaire for my DNP project, which will serve as the need assessment survey. The Recognition questionnaire will be administered to the nurses and nurse leaders of six critical care units at the University of North Carolina Hospitals, Chapel Hill, along with the Healthy Work Environment Survey developed by AACN in 2005.

If you would kindly grant the permission to use the survey, then I would pass out the appropriately cited paper copy's of the surveys and collect the surveys myself.

Please let me know if I have permission to use the Recognition Questionnaire in my DNP project.

Thank you for your time and consideration.
Sincerely,

Usha Koshy Cherian

**3. Letter to the directors seeking permission to conduct the project.**

**Letter to the directors of Surgery, Medicine and Heart &Vascular services, seeking permission to conduct the project in the adult critical care units.**

Usha Koshy Cherian
Doctor of Nursing Practice Student, University of North Carolina, Chapel Hill.
August 24, 2015

Angela Overman, Jacci Harden, Eric Wolak, Billy Bevill,

Greetings! This is Usha Cherian, staff nurse in Surgical Intensive Care Unit. I am currently enrolled in the DNP program in the Health Care System track at UNC, Chapel Hill.

For the DNP project, I am interested in exploring the work environment of nurses in the ICUs. Through this project I would like to (i) assess the nurses' perception of the Health of their Work Environments, (ii) measure the level of perceived satisfaction regarding the work environments and (iii) gain ideas to improve the work environments in the critical care areas.

The project has two parts; (1) a **Focus Group Interview** of nurse leaders (directors, nurse managers, educators) and staff nurses who are directly involved with the six adult critical units at UNCH (12 nurse leaders and 12-16 staff nurses) and (2) **Survey** of all the staff nurses and nurse leaders of the six adult critical care areas at UNCH.

Through this email I would like to request your permission and support for conducting this project i**n (NSICU, BICU, SICU**, **CTICU, CICU and MICU)** so that I can submit the application to the Nurse Research Council (NRC) and Institutional Review Board (IRB). I will keep you informed about the progress of NRC and IRB and the dates of the project.

Thank you for considering the above request. Your support is essential in completing this project that is aimed to enhance the health of the work environments of nurses in the adult critical care units which in-turn will improve the nurse outcomes, patient outcomes and organizational outcomes. If you have any questions or concerns about any aspect of this study, please contact Usha Cherian (Principal Investigator) by email at ucherian@email.unc.edu or Dr. Gwen Sherwood (Project chair person) at Gwen.Sherwood@unc.edu.

Sincerely,
Usha Koshy Cherian

**4.Permissions from critical care department directors to conduct the DNP project.**

Usha,
You have my permission and support to include the Clinical Nurse Education Specialist in Critical Care in your DNP project.
Billy

Billy Bevill MSN, RN, NE-BC
Director: Nursing Practice & Professional Development
UNC Hospitals
4th Floor Old Infirmary
101 Manning Drive
Chapel Hill, NC 27514
CB#7600

*james.bevill@unchealth.unc.edu*
Office Phone: 984-974-7694

Cell Phone: 919-951-9656
Fax: 919-843-0274
Pager: 919-123-6221

*Sent Items*

Monday, August 24, 2015 4:44 PM

Hello Sir,

Greetings! This is Usha Cherian, staff nurse in Surgical Intensive Care Unit. I am currently enrolled in the DNP program in the Health Care System track at UNC, Chapel Hill.

For the DNP project, I am interested in exploring the work environment of nurses in the ICUs. Through this project I would like to (i) assess the nurses' perception of the Health of their Work Environments, (ii) measure the level of perceived satisfaction regarding the work environments and (iii) gain ideas to improve the work environments in the critical care areas.

The project has two parts; (1) a **Focus Group Interview** of nurse leaders (directors, nurse managers, educators) and staff nurses who are directly involved with the six adult critical units at UNCH (12 nurse leaders and 12-16 staff nurses) and (2) **Survey** of all the staff nurses and nurse leaders of the six adult critical care areas at UNCH.

Through this email I would like to request your permission and support for including the nurse educators who oversee the staff development of critical care nurses under surgery service, heart and vascular service and Medicine service, so that I can submit the application to the Nurse Research Council (NRC) and Institutional Review Board (IRB). I will keep you informed about the progress of NRC and IRB and the dates of the project.

Thank you for considering the above request. Your support is essential in completing this project that is aimed to enhance the health of the work environments of nurses in the adult critical care units which in-turn will improve the nurse outcomes, patient outcomes and organizational outcomes.

Please contact me with any questions or concerns at ucherian@email.unc.edu.

Thank you once again,

Sincerely,

Usha Koshy Cherian RN, MSN, CCRN, NEA-BC

Hello Usha,

Yes, as far as I am concerned, you have my support in this work. Please make sure to reach out to MICU leadership to see if this is something they are willing and able to be a part of.

Thanks,
Eric Wolak
Clinical Director, Medicine Inpatient Management
University of North Carolina Hospitals
101 Manning Drive
Chapel Hill, NC 27514

*Sent Items*

Monday, August 24, 2015 12:26 PM

Hello Eric,

Greetings! This is Usha Cherian, staff nurse in Surgical Intensive Care Unit. I am currently enrolled in the DNP program in the Health Care System track at UNC, Chapel Hill.

For the DNP project, I am interested in exploring the work environment of nurses in the ICUs. Through this project I would like to (i) assess the nurses' perception of the Health of their Work Environments, (ii) measure the level of perceived satisfaction regarding the work environments and (iii) gain ideas to improve the work environments in the critical care areas.

The project has two parts; (1) a **Focus Group Interview** of nurse leaders (directors, nurse managers, educators) and staff nurses who are directly involved with the six adult critical units at UNCH (12 nurse leaders and 12-16 staff nurses) and (2) **Survey** of all the staff nurses and nurse leaders of the six adult critical care areas at UNCH.

Through this email I would like to request your permission and support for conducting this project in **MICU** so that I can submit the application to the Nurse Research Council (NRC) and Institutional Review Board (IRB). I will keep you informed about the progress of NRC and IRB and the dates of the project.

Thank you for considering the above request. Your support is essential in completing this project that is aimed to enhance the health of the work environments of nurses in the adult critical care units which in-turn will improve the nurse outcomes, patient outcomes and organizational outcomes.

Please contact me with any questions or concerns at ucherian@email.unc.edu.

Thank you once again,

Sincerely,

Usha Koshy Cherian RN, MSN, CCRN, NEA-BC

Usha,

You are welcome to work with the CICU however the CTICU is in a period of transition right now and it is probably not the best time to add more to their plates. Cristie Dangerfield is the manager of the CICU and would be your point of contact.

Thank you,
Jacci Harden

Director, Heart and Vascular IP management
University of North Carolina Hospitals
101 Manning Drive
Chapel Hill, NC 27514

*Sent Items*

Monday, August 24, 2015 12:28 PM

Hello Jacci,

Greetings! This is Usha Cherian, staff nurse in Surgical Intensive Care Unit. I am currently enrolled in the DNP program in the Health Care System track at UNC, Chapel Hill.

For the DNP project, I am interested in exploring the work environment of nurses in the ICUs. Through this project I would like to (i) assess the nurses' perception of the Health of their Work Environments, (ii) measure the level of perceived satisfaction regarding the work environments and (iii) gain ideas to improve the work environments in the critical care areas.

The project has two parts; (1) a **Focus Group Interview** of nurse leaders (directors, nurse managers, educators) and staff nurses who are directly involved with the six adult critical units at UNCH (12 nurse leaders and 12-16 staff nurses) and (2) **Survey** of all the staff nurses and nurse leaders of the six adult critical care areas at UNCH.

Through this email I would like to request your permission and support for conducting this project in **CTICU, and CICU**, so that I can submit the application to the Nurse Research Council (NRC) and Institutional Review Board (IRB). I will keep you informed about the progress of NRC and IRB and the dates of the project.

Thank you for considering the above request. Your support is essential in completing this project that is aimed to enhance the health of the work environments of nurses in the adult critical care units which in-turn will improve the nurse outcomes, patient outcomes and organizational outcomes.

Please contact me with any questions or concerns at ucherian@email.unc.edu.

Thank you once again,

Sincerely,

Usha Koshy Cherian RN, MSN, CCRN, NEA-BC

Hi Usha,
Yes, you have my permission and support to proceed. Please let me know if you need anything. Thanks, Angela

Angela S. Overman, MSN, RN, NE-BC
Director, Surgery Services
University of North Carolina Hospitals
101 Manning Drive
Chapel Hill, NC 27514
Office (984) 974-0055
Pager (919) 123-9541

Monday, August 24, 2015 12:24 PM

Hello Angela,

Greetings! This is Usha Cherian, staff nurse in Surgical Intensive Care Unit. I am currently enrolled in the DNP program in the Health Care System track at UNC, Chapel Hill.

For the DNP project, I am interested in exploring the work environment of nurses in the ICUs. Through this project I would like to (i) assess the nurses' perception of the Health of their Work Environments, (ii) measure the level of perceived satisfaction regarding the work environments and (iii) gain ideas to improve the work environments in the critical care areas.

The project has two parts; (1) a **Focus Group Interview** of nurse leaders (directors, nurse managers, educators) and staff nurses who are directly involved with the six adult critical units at UNCH (12 nurse leaders and 12-16 staff nurses) and (2) **Survey** of all the staff nurses and nurse leaders of the six adult critical care areas at UNCH.

Through this email I would like to request your permission and support for conducting this project in **NSICU, BICU, and SICU**, so that I can submit the application to the Nurse Research Council (NRC) and Institutional Review Board (IRB). I will keep you informed about the progress of NRC and IRB and the dates of the project.

Thank you for considering the above request. Your support is essential in completing this project that is aimed to enhance the health of the work environments of nurses in the adult critical care units which in-turn will improve the nurse outcomes, patient outcomes and organizational outcomes.

Please contact me with any questions or concerns at ucherian@email.unc.edu.

Thank you once again,
Sincerely,

Usha Koshy Cherian RN, MSN, CCRN, NEA-BC

## APPENDIX B: HEALTHY WORK ENVIRONMENT PROJECT FLIER

**Do you receive meaningful recognition at work place? Your input is valuable!**

Calling all nurses from adult critical care units at UNCH to participate in a Quality Improvement Project to establish a Healthy Work Environment.

Nurses' work environments significantly impact patient outcomes, nurse outcomes and organizational outcomes. Meaningful Recognition (MR) is an essential component in creating and maintaining a Healthy Work Environment (HWE). Yet, the concept of MR remains unclear and under utilized. You are invited to participate in a research study aimed to explore ways to provide Meaningful Recognition (MR) to nurses in the critical care areas at UNCH.

This project will be conducted in two stages:

1. Focus Group Interview among groups of nurses that will include clinical directors, nurse managers, clinical educators and staff nurses from adult critical care areas (done in different sessions).
2. Survey of nurses from adult critical care units (either online or paper)

The Principal Investigator (PI)) may approach you to participate in Focus Group Interview and Survey. Your feedback is very valuable towards improving the nurses work environment. The findings of this research project will be presented to Nursing Professional Development Council to develop strategies to effectively provide Meaningful Recognition to nurses.

If you have any questions or concerns about any aspect of this study, please contact Usha Cherian (Principal Investigator) by email at ucherian@email.unc.edu or Dr. Gwen Sherwood (Project chair person) at Gwen.Sherwood@unc.edu.

Sincerely,

Usha Cherian RN, MSN, CCRN, NEA-BC
Doctorate of Nursing Practice Student
University of North Carolina, Chapel Hill.

## APPENDIX C: DEMOGRAPHIC QUESTIONNAIRE

**Demographic Questionnaire for the project on Meaningful Recognition**

Please answer each question by placing a check mark in the appropriate box.

**1. What is your highest nursing degree? Check all that apply**

☐ Licensed Practical Nurse (LPN) ☐ Associate Degree

☐ Accelerated BSN ☐ Bachelor Degree

☐ Master's Degree ☐ Doctorate Degree

☐ Second career

**2. Do you hold a specialty certification from a professional nursing organization (CCRN, CNRN, etc.)?**

☐ No ☐ Yes

**3. What is your job title and clinical level? Check all that apply**

☐ Staff Nurse ☐ Clinical Nurse I

☐ Assistant Manager ☐ Clinical Nurse II

☐ Nurse Manager ☐ Clinical Nurse III

☐ Nurse Educator ☐ Clinical Nurse IV

☐ Nurse Director ☐ Other

**4. What is your work status?**

☐ Part time ☐ Full Time ☐ Per-diem ☐ Traveler contract ☐ Other

**5. What shift do you work? Check all that apply**

☐ Day shift ☐ Night Shift ☐ Weekends ☐ Rotation ☐ Other

**6. How many years of nursing experience do you have in total?**

☐ less than 1 year ☐ 1 years to 5 years

☐ 6 years to 10 years ☐ 11years to 20 years

☐ 21 years to 30 years ☐ More than 30 years

**7. How long have you been employed at UNCH?**

☐ less than 1 year ☐ 1 years to 5 years

☐ 6 years to 10 years ☐ 11years to 20 years

☐ 21 years to 30 years ☐ More than 30 years

**8. How long have you been employed at the current unit?**

☐ less than 1 year ☐ 1 years to 5 years

☐ 6 years to 10 years ☐ 11years to 20 years

☐ 21 years to 30 years ☐ More than 30 years

**9. Do you plan to stay in your current job setting for the next 12 months?**

☐ No ☐ Yes ☐ Undecided

**10.What age range do you belong to?**

☐ 20- 30 years ☐ 31-40 years ☐ 41-50 years

☐ 51-60 years ☐ 61 years and over

**11. What race/ethnicity group do you most identify with?**

☐ African American/Blacks ☐ Caucasian

☐ American Indian/Alaskan Native ☐ Hispanic / Latino

☐ Asian/Pacific Islander ☐ Other

**12. What is your gender?**

☐ Male ☐ Female

## APPENDIX D: HEALTHY WORK ENVIRONMENT ASSESSMENT TOOL (AACN, 2005)

| Healthy Work Environment Assessment Tool | | | | | |
|---|---|---|---|---|---|
| Please circle the number that best represents your opinion to the statement. | | | | | |
| | Strongly Disagree (1) | Disagree (2) | Neutral (3) | Agree (4) | Strongly Agree (5) |
| 1. Administrators, nurse managers, physicians, nurses and other staff maintain frequent communication to prevent each other from being surprised or caught off guard by decisions. | 1 | 2 | 3 | 4 | |
| 2. Administrators, nurse managers, and physicians involve nurses and other staff to an appropriate degree when making important decisions. | 1 | 2 | 3 | 4 | |
| 3. Administrators and nurse managers work with nurses and other staff to make sure there are enough staff to maintain patient safety. | 1 | 2 | 3 | 4 | |
| 4. The formal reward and recognition systems work to make nurses and other staff feels valued. | 1 | 2 | 3 | 4 | |
| 5. Most nurses and other staff here has a positive relationship with their nurse leaders (managers, directors, advanced practice nurses, etc.). | 1 | 2 | 3 | 4 | |
| 6. Administrators, nurse managers, physicians, nurses, and other staff make sure their actions match their words—they "walk their talk." | 1 | 2 | 3 | 4 | |
| 7. Administrators, nurse managers, physicians, nurses, and other staff are consistent in their use of data-driven, logical decision-making processes to make sure their decisions are the highest quality. | 1 | 2 | 3 | 4 | |
| 8. Administrators and nurse managers make sure there is the right mix of nurses and other staff to ensure optimal outcomes. | 1 | 2 | 3 | 4 | |
| 9. Administrators, nurse managers, physicians, nurses, and other staff members speak up and let people know when they've done a good job. | 1 | 2 | 3 | 4 | |
| 10. Nurses and other staff feel able to influence the policies, procedures, and bureaucracy | 1 | 2 | 3 | 4 | |

| | | | | | |
|---|---|---|---|---|---|
| around them. | | | | | |
| 11. The right departments, professions, and groups are involved in important decisions. | 1 | 2 | 3 | 4 | |
| 12. Support services are provided at a level that allows nurses and other staff to spend their time on priorities and requirements of patient and family care. | 1 | 2 | 3 | 4 | |
| 13. Nurse leaders (managers, directors, advanced practice nurses, etc.) demonstrates an understanding of the requirements and dynamics at the point of care, and use this knowledge to work for a healthy work environment. | 1 | 2 | 3 | 4 | |
| 14. Administrators, nurse managers, physicians, nurses, and other staff have zero-tolerance for disrespect and abuse. If they see or hear someone being disrespectful, they hold them accountable regardless of the person's role or position. | 1 | 2 | 3 | 4 | |
| 15. When administrators, nurse managers, and physicians speak with nurses and other staff, it's not one way communication or order giving. Instead, they seek input and use it to shape decisions. | 1 | 2 | 3 | 4 | |
| 16. Administrators, nurse managers, nurses, and other staff are careful to consider the patient's and family's perspectives whenever they are making important decisions. | 1 | 2 | 3 | 4 | |
| 17. There are motivating opportunities for personal growth, development, and advancement. | 1 | 2 | 3 | 4 | |
| 18. Nurse leaders (managers, directors, advanced practice nurses, etc.) are given the access and authority required to play a role in making key decisions. | 1 | 2 | 3 | 4 | |

## APPENDIX E: RECOGNITION QUESTIONNAIRE (BLEAGAN, 1992)

| Recognition Questionnaire | | | | | |
|---|---|---|---|---|---|
| Definition: Recognition is defined as behaviors that acknowledge, with a show of appreciation, staff nurse achievements and performance. Recognition can be given for:<br>1. Competent/satisfactory performance (i.e., meets standards)<br>2. Outstanding/excellent performance (i.e. exceeds standards)<br>3. Achievements (i.e., professional accomplishments) | | | | | |
| Instructions: Please indicate the extent to which each of the following behaviors would provide meaningful recognition to you as a staff nurse by circling the appropriate number. If you believe the listed behavior is not a form of recognition, circle the number in the "Not At All" box. I am not asking whether your supervisors do these things; but, if they did, to what extent would the behavior provide meaningful recognition to you? There are no right or wrong answers. I want to know your perceptions only | | | | | |
| **Recognition Behavior** | **Not At All (1)** | **Very Little (2)** | **Moderate (3)** | **Considerable (4)** | **Great (5)** |
| 1. Private verbal feedback | 1 | 2 | 3 | 4 | |
| 2. Encouraging participation in professional activities/conferences at the state and national level... | 1 | 2 | 3 | 4 | |
| 3. Giving a letter of appreciation to the staff nurse and placing a copy in the personnel file. ... | 1 | 2 | 3 | 4 | |
| 4. Holding regular meetings to discuss and develop consensus on values related to patient care an... | 1 | 2 | 3 | 4 | |
| 5. Giving release time to work on special projects. | 1 | 2 | 3 | 4 | |
| 6. Asking staff nurse to represent the unit at hospital meetings. | 1 | 2 | 3 | 4 | |
| 7. Selecting staff nurse as preceptor for new employees. | 1 | 2 | 3 | 4 | |
| 8. Selecting staff nurse to be unit charge nurse on a rotation basis | 1 | 2 | 3 | 4 | |
| 9. Sending a letter regarding the staff nurse's performance to senior nursing management. | 1 | 2 | 3 | 4 | |
| 10. Providing on-the-job feedback for the patient care provided. | 1 | 2 | 3 | 4 | |
| 11. Holding a celebration for nurses' years of service (for every 5 years, 10 years etc.) | 1 | 2 | 3 | 4 | |
| 12. Encouraging the staff nurse to develop expertise in one aspect of care. | 1 | 2 | 3 | 4 | |
| 13. Sending a copy of patient evaluations that compliment the staff nurse to senior nursing manager... | 1 | 2 | 3 | 4 | |
| 14. Asking the staff nurse to participate in planning for the unit. | 1 | 2 | 3 | 4 | |

| | | | | | |
|---|---|---|---|---|---|
| 15. Giving the nurse priority (first choice) to be off work when the unit census allows. | 1 | 2 | 3 | 4 | |
| 16. Asking the staff nurse to establish unit criteria to assure fairness of rewards. | 1 | 2 | 3 | 4 | |
| 17. Recommending the staff nurse as an expert speaker. | 1 | 2 | 3 | 4 | |
| 18. Giving release time to spend a day with the supervisor to experience management functions. | 1 | 2 | 3 | 4 | |
| 19. Giving time and support to develop a booklet describing the services that nurses provide on t... | 1 | 2 | 3 | 4 | |
| 20. Bragging about the performance of the staff nurse. | 1 | 2 | 3 | 4 | |
| 21. Giving preference for selection of work hours. | 1 | 2 | 3 | 4 | |
| 22. Posting patient evaluations that compliment the staff nurse on unit bulletin boards. | 1 | 2 | 3 | 4 | |
| 23. Consulting with the staff nurse on important unit decisions. | 1 | 2 | 3 | 4 | |
| 24. Congratulating the staff nurse in front of peers. | 1 | 2 | 3 | 4 | |
| 25. Meeting with the staff nurse to provide support and assistance towards professional and career... | 1 | 2 | 3 | 4 | |
| 26. Providing an opportunity for the staff nurse to share projects/materials developed with peers... | 1 | 2 | 3 | 4 | |
| 27. Increasing salary commensurate with level of performance. | 1 | 2 | 3 | 4 | |
| 28. Giving a letter of appreciation to the staff nurse for consistently working extra hours and p... | 1 | 2 | 3 | 4 | |
| 29. Giving a day off with pay to attend a workshop. | 1 | 2 | 3 | 4 | |
| 30. Announcing achievements in the unit newsletter. | 1 | 2 | 3 | 4 | |
| 31. Announcing achievements in the hospital newsletter. | 1 | 2 | 3 | 4 | |

## APPENDIX F: NURSING RESEARCH COUNCIL APPROVAL


Date: 9.23.15

To: Usha Koshy Cherian, RN, MSN, CCRN, NEA-BC DNP student at UNC-School of Nursing

The UNCH Nursing Research Council (NRC) has approved your study "Impact of Meaningful Recognition on Nurses' Work Environment; A Comparative Exploration of Nurse Leaders' and Staff Nurses' Perception" to be performed at UNC Hospital. Dr. Cheryl A. Smith-Miller, PhD, RN-BC will be your site contact to assist you. If you have any questions, please do not hesitate to contact either of us. Thank you for the opportunity to review and be a site for your research. We look forward to hearing about your findings once you are completed. We wish you the best of luck Ms. Cherian.

With best regards,

Ana Gil Del Villar, BSN, BA, RN-BC, CNIV
Chair, Nursing Research Council
agildelv@unch.unc.edu

## APPENDIX G: UNC IRB APPROVAL

| IRB Study Management | | | |
|---|---|---|---|
| **IRB Number:** | **15-2052** | **Study Status:** | Exempt |
| **PI:** | Cherian, Usha | **IRB:** | Non-Biomedical |
| **Study Title:** | Impact of Meaningful Recognition on Nurses' Work Environment: A comparative exploration of nurse leaders' and staff nurses' perception | | |

## APPENDIX H: DNP Project Focus Group Interview Packet

| Item | Healthy Work Environment Project |
|---|---|
| 1 | **Focus Group Interview Information Sheet**<br><br>Thank you for agreeing to participate in a Focus Group Interview to discuss the challenges in implementing and maintaining a Healthy Work Environment in the adult critical care areas of UNCH academic medical center. This project was reviewed and approved by UNCH Nursing Research Council and approved as exempt under non biomedical category by the University of North Carolina IRB, (IRB number-15-2052).<br><br>**Background**<br><br>The health of nurses' work environments significantly impacts nursing practice, which in turn impact patient outcomes, nurse outcomes and may impact the financial viability of the organization. According to the previous researches, Meaningful Recognition (MR) is an essential component in creating and maintaining a Healthy Work Environment. Yet, the concept of Meaningful Recognition (MR) remains unclear and under utilized. This project intends to explore ways to meaningfully recognize nurses working in adult critical care units.<br><br>**Focus Group Interview (FGI)**<br><br>Each focus group will have 5-6 members. The FGI is based on the Appreciative Inquiry 4D Framework. The facilitator of FGI will prompt you to discover, dream, design and deliver the ways to effectively provide Meaningful Recognition to nurses in adult critical care areas.<br><br>The findings of this FGI will be used to provide recommendations to the Nursing Professional development Council on strategies to effectively provide Meaningful Recognition to nurses that will increase staff satisfaction, retention, and improved patient outcomes.<br><br>**Risk/Discomfort.** Risks for participating in the FGI are minimal. However, you may feel emotionally uneasy when asked about the challenges you or your colleagues experience in the work environment<br><br>**Benefits.** There are no direct benefits for participating.<br><br>**Consent.** Your participation in the FGI is considered as your consent for this project.<br><br>**Confidentiality.** We are not asking you for your name or any other |

| | |
|---|---|
| | identifiers. Your responses in the FGI /Survey will be anonymous. All information you provide will be combined with the group's responses; any unit data will only be reported as a group data. Only the primary investigator (PI) will have access to the recordings.<br><br>No names will appear anywhere in the data and will be kept confidential until it has been deleted by the primary investigator.<br><br>**Compensation.** There will be no direct compensation for your participation in the focus group interview.<br><br>**Participation.** Participation in this research study is completely voluntary. You have the right to withdraw at any time or refuse to participate entirely without jeopardy. Participation will not affect your current or future employment.<br><br>**Questions about the project.** If you have any questions or concerns about any aspect of this study, please contact Usha Cherian (Principal Investigator) by email at ucherian@email.unc.edu or Dr. Gwen Sherwood (Project chair person) at Gwen.Sherwood@unc.edu. |
| **Item 2** | **Demographic Data in Appendix C** |
| **Item 3** | **Laminated copy of Simple definition of HWE and MR**<br><br>**Meaningful recognition** (MR) is the process of acknowledging one's behaviors and the impact these actions has on others, ensuring the feedback is relevant to the recognized situation, and is equal to the person's contributions (AACN, 2005). MR has the following characteristics: it is ongoing and builds on itself; relevant to the person being recognized; congruent with the person being recognized; occurs in response to the value they add; is a fundamental human need; and an essential requisite to personal and professional development (AACN, 2005).<br><br>**Healthy work environment (HWE):** World Health Organization (WHO) defines HWE as "a workplace in which workers and managers collaborate to use a continual improvement process to protect and promote the health, safety and well-being of workers and the sustainability of the workplace" (Burton, 2010). The American Association of Critical-Care Nurses (AACN) established six evidence-based standards: skilled communication, true collaboration, effective decision-making, appropriate staffing, meaningful recognition, and authentic leadership (AACN 2005). |

## APPENDIX I: FOCUS GROUP INTERVIEW SESSION SCRIPT

**Focus Group Interview session script**

**Introduction:**

This session will use appreciative approach using Appreciative Inquiry (AI) framework and focus on the positives and values on what would be meaningful recognition.

**FGI Prompts**

1.What is your understanding of Meaningful Recognition and Healthy Work Environment

2.Think of the times in your nursing career when you felt rewarded. What is the most meaningful recognition you have received as a nurse? (Personal anecdotes). Who provided the most meaningful recognition for you?

3. If you could dream most valuable way of providing MR what would it be? (What are examples of MR that you value). Who should be involved in determining in the process of MR? What kind of evaluation process should be in place to determine the effectiveness of the MR and how often should the evaluation take place

4.What are considerations in designing and delivering a MR process among nurses in our organization?

5.How would you design an efficient and effective process to implement MR among nurses? What are the resources you will need in terms of finance and manpower to implement this process?

## APPENDIX J: DNP PROJECT SURVEY PACKET (VIA QUALTRICS )

| Item 1 | **Healthy Work Environment Project**<br><br>**Survey Information Sheet**<br><br>You are invited to participate in a quality improvement project survey that aims to explore the challenges in providing Meaningful Recognition (MR) to nurses and maintaining a Healthy Work Environment in the adult critical care areas of University of North Carolina Hospitals. This project was reviewed and approved by UNCH Nursing Research Council and approved as exempt by the University of North Carolina IRB, (IRB number-15-2052).<br><br>**Background.** The health of nurses' work environments significantly impacts nursing practice and patient outcomes. According to the previous researches, Meaningful Recognition (MR) is an essential component in creating and maintaining a Healthy Work Environment. Yet, the concept of Meaningful Recognition (MR) remains unclear and under utilized. This project intends to explore ways to meaningfully recognize nurses working in adult critical care units.<br><br>**Survey.** This includes a Healthy Work Environment (HWE) survey, Recognition Survey and a Demographic survey. The survey may take approximately 25-30 minutes to complete. Please take some time to fill out the three questionnaires. Please answer the survey questions honestly as your feedback will help in understanding the ways to create and maintain a healthy work environment.<br><br>You have the choice of completing the survey online or by paper. If you are taking the survey online, then please click the link found in the email invitation you received and follow the prompts. If you are taking the paper version of the survey, please complete the questionnaire and place it in the envelope provided and seal. Place the sealed envelope in the secured box in your break room. Please feel free to contact the primary investigator for any questions or concerns.<br><br>After completing the survey, contact the primary investigator to receive a small token of appreciation for participating in the survey.<br><br>The findings of this survey will be used to provide recommendations to the Nursing Professional development Council on strategies to effectively provide Meaningful Recognition to nurses that will increase staff satisfaction, retention, and improved patient outcomes.<br><br>**Risk/Discomfort.** Risks are minimal for participating. However, you may feel emotionally uneasy when asked about the challenges you or your colleague |
|---|---|

| | |
|---|---|
| | experience in the work environment<br><br>**Benefits.** There are no direct benefits for participating.<br><br>**Confidentiality.** We are not asking you for your name or any other identifiers. Your responses in the FGI /Survey will be anonymous. All information you provide will be combined with the group's responses; any unit data will only be reported as a group data. Only the primary investigator (PI) will have access to the recordings.<br><br>No names will appear anywhere in the data and will be kept confidential until it has been deleted by the primary investigator.<br><br>**Compensation.** There will be no direct compensation for your participation in the focus group interview.<br><br>**Participation.** Participation in this research study is completely voluntary. You have the right to withdraw at any time or refuse to participate entirely without jeopardy. Participation will not affect your current or future employment.<br><br>**Consent.** Your participation in the survey is considered as your consent for this project.<br><br>**Questions about the project.** If you have any questions or concerns about any aspect of this study, please contact Usha Cherian (Principal Investigator) by email at ucherian@email.unc.edu or Dr. Gwen Sherwood (Project chair person) at Gwen.Sherwood@unc.edu.<br><br>Thank you very much for your time and effort,<br><br>Sincerely,<br><br>Usha Cherian RN, MSN, CCRN, NEA-BC<br>Doctorate of Nursing Practice Student<br>University of North Carolina,<br>Chapel Hill. |
| **Item 2** | **Demographic Data in Appendix C** |
| **Item 3** | **Healthy Work Environment Survey (AACN, 2005); See Appendix D** |
| **Item 4** | **Recognition Survey Instrument (Blegen, 1992); See Appendix E** |
| | |

## APPENDIX K: COMPARISON OF MEANS OF HWE, MR, AND THE SIX RECOGNITION FACTORS WITH THE DEMOGRAPHIC CHARACTERISTIC OF THE SAMPLE

**1. Gender**

| ANOVA TABLE FOR GENDER HWE, MR, AND RECOGNITION FACTORS | | | | | | | |
|---|---|---|---|---|---|---|---|
| | **Gender** | **N** | **Mean** | **SD** | **df** | **F** | **Sig.** |
| HWE | Female | 85 | 3.43 | 0.67 | 1 | 3.80 | 0.054 |
| | Males | 7 | 2.90 | 0.94 | 90 | | |
| MR | Female | 85 | 3.43 | 0.75 | 1 | 5.74 | 0.019 |
| | Males | 7 | 2.71 | 0.80 | 90 | | |
| Overall recognition | Female | 77 | 3.67 | 0.72 | 1 | 9.62 | 0.003 |
| | Males | 7 | 2.80 | 0.80 | 82 | | |
| Opportunities for growth and development | Female | 77 | 3.53 | 0.80 | 1 | 9.48 | 0.003 |
| | Males | 7 | 2.56 | 0.74 | 82 | | |
| Written acknowledgement | Female | 77 | 3.64 | 1.13 | 1 | 4.31 | 0.041 |
| | Males | 7 | 2.71 | 1.10 | 82 | | |
| Private verbal feedback | Female | 77 | 3.90 | 0.77 | 1 | 2.59 | 0.112 |
| | Males | 7 | 3.39 | 1.00 | 82 | | |
| Public acknowledgement | Female | 77 | 3.62 | 0.86 | 1 | 12.43 | 0.001 |
| | Males | 7 | 2.43 | 0.76 | 82 | | |
| Schedule | Female | 77 | 3.99 | 0.79 | 1 | 2.05 | 0.156 |
| | Males | 7 | 3.52 | 1.10 | 82 | | |
| Salary | Female | 77 | 4.25 | 1.05 | 1 | 3.67 | 0.059 |
| | Males | 7 | 3.43 | 1.40 | 82 | | |

**2.Education**

| ANOVA TABLE FOR EDUCATION, HWE, AND RECOGNITION FACTORS | | | | | | | |
|---|---|---|---|---|---|---|---|
| **Category** | **Education** | **N** | **Mean** | **S D** | **f** | **F** | **Sig.** |
| HWE | Associate degree | 15 | 3.52 | 0.8 | 92 | 0.389 | 0.679 |
| | BSN | 67 | 3.35 | 0.69 | | | |
| | MSN/Doctorate | 11 | 3.45 | 0.6 | | | |
| MR | Associate degree | 15 | 3.53 | 0.78 | 92 | 0.601 | 0.55 |
| | BSN | 67 | 3.32 | 0.8 | | | |
| | MSN/Doctorate | 11 | 3.48 | 0.58 | | | |
| Overall recognition | Associate degree | 13 | 3.48 | 0.88 | 84 | 0.301 | 0.741 |
| | BSN | 61 | 3.61 | 0.73 | | | |
| | MSN/Doctorate | 11 | 3.72 | 0.77 | | | |
| Opportunities for growth and development | Associate degree | 13 | 3.24 | 1 | 84 | 1.177 | 0.313 |
| | BSN | 61 | 3.43 | 0.78 | | | |
| | MSN/Doctorate | 11 | 3.76 | 0.93 | | | |
| Written acknowledgement | Associate degree | 13 | 3.26 | 1.17 | 84 | 0.543 | 0.583 |

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| | BSN | 61 | 3.62 | 1.17 | | | |
| | MSN/Doctorate | 11 | 3.58 | 1.02 | | | |
| Private verbal feedback | Associate degree | 13 | 3.85 | 0.86 | 84 | 0 | 1 |
| | BSN | 61 | 3.85 | 0.79 | | | |
| | MSN/Doctorate | 11 | 3.84 | 0.87 | | | |
| Public acknowledgement | Associate degree | 13 | 3.52 | 1.04 | 84 | 0.015 | 0.985 |
| | BSN | 61 | 3.53 | 0.91 | | | |
| | MSN/Doctorate | 11 | 3.48 | 0.79 | | | |
| Schedule | Associate degree | 13 | 4.1 | 0.74 | 84 | 0.281 | 0.756 |
| | BSN | 61 | 3.92 | 0.81 | | | |
| | MSN/Doctorate | 11 | 3.88 | 0.99 | | | |
| Salary | Associate degree | 13 | 4 | 1.15 | 84 | 0.231 | 0.795 |
| | BSN | 61 | 4.23 | 1.07 | | | |
| | MSN/Doctorate | 11 | 4.18 | 1.25 | | | |

**3. Specialty certification** Levene's Test for Equality of Variances (Equal variances assumed)

| | Specialty certification | N | Mean | SD | Significance | t | df | Sig. (2-tailed) |
|---|---|---|---|---|---|---|---|---|
| MR | Yes | 58 | 3.43 | 0.68 | 0.039 | 0.936 | 91 | 0.352 |
| | No | 35 | 3.28 | 0.91 | | 0.87 | 56.50 | 0.388 |
| HWE | Yes | 58 | 3.39 | 0.61 | 0.029 | -0.091 | 91 | 0.927 |
| | No | 35 | 3.4 | 0.83 | | -0.085 | 56.22 | 0.933 |

**4. Intend to stay**

| INTEND TO STAY ANOVA TABLE | | | | | | | |
|---|---|---|---|---|---|---|---|
| | **Intend to stay** | **N** | **Mean** | **S D** | **df** | **F** | **Sig.** |
| HWE | Yes | 71 | 3.53 | 0.65 | 91 | 6.76 | 0.002 |
| | No | 4 | 2.71 | 0.91 | | | |
| | Undecided | 17 | 2.99 | 0.62 | | | |
| MR | Yes | 71 | 3.51 | 0.71 | 91 | 5.93 | 0.004 |
| | No | 4 | 2.5 | 0.69 | | | |
| | Undecided | 17 | 3.02 | 0.85 | | | |
| Overall recognition | Yes | 66 | 3.68 | 0.73 | 83 | 1.81 | 0.17 |
| | No | 3 | 3.54 | 1.09 | | | |
| | Undecided | 15 | 3.28 | 0.78 | | | |
| Opportunities for growth and development | Yes | 66 | 3.51 | 0.84 | 83 | 0.82 | 0.444 |
| | No | 3 | 3.36 | 0.92 | | | |
| | Undecided | 15 | 3.21 | 0.82 | | | |
| Written acknowledgement | Yes | 66 | 3.62 | 1.10 | 83 | 0.54 | 0.584 |
| | No | 3 | 3.78 | 1.35 | | | |

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| | Undecided | 15 | 3.29 | 1.39 | | | |
| Private verbal feedback | Yes | 66 | 3.94 | 0.77 | 83 | 2.00 | 0.141 |
| | No | 3 | 3.92 | 1.13 | | | |
| | Undecided | 15 | 3.48 | 0.81 | | | |
| Public acknowledgement | Yes | 66 | 3.61 | 0.91 | 83 | 1.76 | 0.179 |
| | No | 3 | 3.57 | 1.41 | | | |
| | Undecided | 15 | 3.12 | 0.79 | | | |
| Schedule | Yes | 66 | 4.11 | 0.74 | 83 | 6.82 | 0.002 |
| | No | 3 | 3.33 | 1.15 | | | |
| | Undecided | 15 | 3.36 | 0.86 | | | |
| Salary | Yes | 66 | 4.36 | 0.92 | 83 | 4.81 | 0.011 |
| | No | 3 | 3.67 | 1.53 | | | |
| | Undecided | 15 | 3.47 | 1.46 | | | |

**5. Positions**

| ANNOVA LIST FOR Positions | | | | | | | |
|---|---|---|---|---|---|---|---|
| | Position | N | Mean | SD | df | F | Sig. |
| HWE | Clinical Nurse I | 2 | 4.11 | 0.40 | 90 | 0.004 | 0.95 |
| | Clinical Nurse II | 63 | 3.38 | 0.73 | | | |
| | Clinical Nurse III | 17 | 3.29 | 0.67 | | | |
| | Clinical Nurse IV | 7 | 3.29 | 0.54 | | | |
| | Nurse Manager | 2 | 3.78 | 0 | | | |
| MR | Clinical Nurse I | 2 | 4.33 | 0.94 | 90 | 0.88 | 0.35 |
| | Clinical Nurse II | 63 | 3.29 | 0.79 | | | |
| | Clinical Nurse III | 17 | 3.39 | 0.79 | | | |
| | Clinical Nurse IV | 7 | 3.47 | 0.47 | | | |
| | Nurse Manager | 2 | 3.87 | 0.04 | | | |
| Overall recognition | Clinical Nurse I | 2 | 3.87 | 0.47 | 82 | 0.742 | 0.392 |
| | Clinical Nurse II | 57 | 3.47 | 0.78 | | | |
| | Clinical Nurse III | 16 | 3.95 | 0.77 | | | |
| | Clinical Nurse IV | 6 | 3.82 | 0.33 | | | |
| | Nurse Manager | 2 | 4 | 0 | | | |
| Opportunities for growth and development | Clinical Nurse I | 2 | 3.73 | 0.05 | 82 | 0.925 | 0.339 |
| | Clinical Nurse II | 57 | 3.34 | 0.83 | | | |
| | Clinical Nurse III | 16 | 3.73 | 0.99 | | | |
| | Clinical Nurse IV | 6 | 3.70 | 0.53 | | | |
| | Nurse Manager | 2 | 3.88 | 0.16 | | | |
| Written acknowledgement | Clinical Nurse I | 2 | 3.5 | 1.18 | 82 | 0.625 | 0.431 |
| | Clinical Nurse II | 57 | 3.345 | 1.18 | | | |
| | Clinical Nurse III | 16 | 4.21 | 0.93 | | | |

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| | Clinical Nurse IV | 6 | 3.94 | 1.22 | | | |
| | Nurse Manager | 2 | 3.67 | 0 | | | |
| Private verbal feedback | Clinical Nurse I | 2 | 4.38 | 0.18 | 82 | 0.583 | 0.447 |
| | Clinical Nurse II | 57 | 3.76 | 0.82 | | | |
| | Clinical Nurse III | 16 | 4.02 | 0.91 | | | |
| | Clinical Nurse IV | 6 | 4.08 | 0.34 | | | |
| | Nurse Manager | 2 | 4 | 0.71 | | | |
| Public acknowledg ement | Clinical Nurse I | 2 | 3.71 | 1.21 | 82 | 0.516 | 0.475 |
| | Clinical Nurse II | 57 | 3.39 | 0.95 | | | |
| | Clinical Nurse III | 16 | 3.89 | 0.89 | | | |
| | Clinical Nurse IV | 6 | 3.7619 | 0.37976 | | | |
| | Nurse Manager | 2 | 3.7143 | 0.20203 | | | |
| Schedule | Clinical Nurse I | 2 | 4.5 | 0.70711 | 82 | 0.029 | 0.865 |
| | Clinical Nurse II | 57 | 3.8246 | 0.86855 | | | |
| | Clinical Nurse III | 16 | 4.4167 | 0.55109 | | | |
| | Clinical Nurse IV | 6 | 3.9444 | 0.64693 | | | |
| | Nurse Manager | 2 | 3.8333 | 0.70711 | | | |
| Salary | Clinical Nurse I | 2 | 4.5 | 0.70711 | 82 | 0.034 | 0.853 |
| | Clinical Nurse II | 57 | 3.9649 | 1.1947 | | | |
| | Clinical Nurse III | 16 | 4.875 | 0.34157 | | | |
| | Clinical Nurse IV | 6 | 4.1667 | 1.16905 | | | |
| | Nurse Manager | 2 | 4.5 | 0.70711 | | | |

**6. Age of the nurse**

| Age of the nurse ANOVA TABLE | | | | | | | |
|---|---|---|---|---|---|---|---|
| **Age of the nurse** | **Age of the nurse in years** | **N** | **Mean** | **SD** | df | **F** | **Sig.** |
| HWE | 20 - 30 years | 32 | 3.4653 | 0.83109 | 91 | 1.47 | 0.23 |
| | 31- 40 years | 33 | 3.3889 | 0.57702 | | | |
| | 41- 50 years | 19 | 3.1433 | 0.56997 | | | |
| | 51-60 years | 8 | 3.7014 | 0.78339 | | | |
| MR | 20 - 30 years | 32 | 3.4375 | 0.94067 | 91 | 1.13 | 0.34 |
| | 31- 40 years | 33 | 3.404 | 0.65488 | | | |
| | 41- 50 years | 19 | 3.1053 | 0.60911 | | | |
| | 51-60 years | 8 | 3.625 | 0.84398 | | | |
| Overall recognition | 20 - 30 years | 28 | 3.5917 | 0.76512 | 83 | 0.53 | 0.66 |
| | 31- 40 years | 29 | 3.731 | 0.70384 | | | |
| | 41- 50 years | 19 | 3.5215 | 0.87053 | | | |
| | 51-60 years | 8 | 3.4 | 0.70756 | | | |
| Opportunities for | 20 - 30 years | 28 | 3.3626 | 0.78666 | 83 | 0.66 | 0.58 |

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| growth and development | 31- 40 years | 29 | 3.5889 | 0.80842 | | | |
| | 41- 50 years | 19 | 3.4825 | 0.94708 | | | |
| | 51-60 years | 8 | 3.1731 | 0.90434 | | | |
| Written acknowledgement | 20 - 30 years | 28 | 3.631 | 1.28409 | 83 | 0.43 | 0.74 |
| | 31- 40 years | 29 | 3.6552 | 1.14947 | | | |
| | 41- 50 years | 19 | 3.4912 | 1.12419 | | | |
| | 51-60 years | 8 | 3.1667 | 0.77664 | | | |
| Private verbal feedback | 20 - 30 years | 28 | 3.8571 | 0.70194 | 83 | 0.53 | 0.66 |
| | 31- 40 years | 29 | 3.9828 | 0.70689 | | | |
| | 41- 50 years | 19 | 3.6974 | 0.98453 | | | |
| | 51-60 years | 8 | 3.75 | 1.02644 | | | |
| Public acknowledgement | 20 - 30 years | 28 | 3.5612 | 0.99957 | 83 | 0.29 | 0.83 |
| | 31- 40 years | 29 | 3.601 | 0.85064 | | | |
| | 41- 50 years | 19 | 3.3609 | 0.96111 | | | |
| | 51-60 years | 8 | 3.4643 | 0.80722 | | | |
| Schedule | 20 - 30 years | 28 | 3.9762 | 0.86032 | 83 | 1.59 | 0.2 |
| | 31- 40 years | 29 | 4.1379 | 0.77928 | | | |
| | 41- 50 years | 19 | 3.614 | 0.88376 | | | |
| | 51-60 years | 8 | 3.9583 | 0.57563 | | | |
| Salary | 20 - 30 years | 28 | 4.3571 | 1.02611 | 83 | 0.87 | 0.46 |
| | 31- 40 years | 29 | 4.2414 | 1.05746 | | | |
| | 41- 50 years | 19 | 3.8421 | 1.30227 | | | |
| | 51-60 years | 8 | 4.125 | 0.99103 | | | |

**7. Years of Experience as a nurse**

| Years of experience as a nurse ANOVA TABLE | | | | | | | |
|---|---|---|---|---|---|---|---|
| | **Years of experience as a nurse** | **N** | **Mean** | **S D** | df | **F** | **Sig.** |
| HWE | Less than 1 year | 2 | 4.11 | 0.39 | 91 | 1.32 | 0.27 |
| | 1 year to 5 years | 37 | 3.31 | 0.79 | | | |
| | 6 years to 10 years | 17 | 3.47 | 0.53 | | | |
| | 11 years to 20 years | 19 | 3.40 | 0.60 | | | |
| | 21 years to 30 years | 14 | 3.23 | 0.68 | | | |
| | More than 30 years | 3 | 4.07 | 0.89 | | | |
| MR | Less than 1 year | 2 | 4.33 | 0.94 | 91 | 1.32 | 0.26 |
| | 1 year to 5 years | 37 | 3.27 | 0.87 | | | |
| | 6 years to 10 years | 17 | 3.49 | 0.68 | | | |
| | 11 years to 20 years | 19 | 3.37 | 0.68 | | | |
| | 21 years to 30 years | 14 | 3.24 | 0.63 | | | |

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| | More than 30 years | 3 | 4 | 0.88 | | | |
| Overall recognition | Less than 1 year | 2 | 3.87 | 0.47 | 83 | 0.45 | 0.82 |
| | 1 year to 5 years | 32 | 3.62 | 0.78 | | | |
| | 6 years to 10 years | 17 | 3.75 | 0.57 | | | |
| | 11 years to 20 years | 18 | 3.62 | 0.81 | | | |
| | 21 years to 30 years | 14 | 3.36 | 0.89 | | | |
| | More than 30 years | 3 | 3.51 | 0.79 | | | |
| Opportunities for growth and development | Less than 1 year | 2 | 3.73 | 0.05 | 83 | 0.31 | 0.91 |
| | 1 year to 5 years | 32 | 3.50 | 0.81 | | | |
| | 6 years to 10 years | 15 | 3.55 | 0.71 | | | |
| | 11 years to 20 years | 18 | 3.52 | 0.87 | | | |
| | 21 years to 30 years | 14 | 3.23 | 1.06 | | | |
| | More than 30 years | 3 | 3.33 | 1.00 | | | |
| Written acknowledgement | Less than 1 year | 2 | 3.5 | 1.18 | 83 | 0.95 | 0.46 |
| | 1 year to 5 years | 32 | 3.56 | 1.29 | | | |
| | 6 years to 10 years | 15 | 3.93 | 1.05 | | | |
| | 11 years to 20 years | 18 | 3.65 | 1.03 | | | |
| | 21 years to 30 years | 14 | 3.29 | 1.14 | | | |
| | More than 30 years | 3 | 2.56 | 0.192 | | | |
| Private verbal feedback | Less than 1 year | 2 | 4.38 | 0.18 | 83 | 1.07 | 0.39 |
| | 1 year to 5 years | 32 | 3.88 | 0.73 | | | |
| | 6 years to 10 years | 15 | 3.95 | 0.59 | | | |
| | 11 years to 20 years | 18 | 3.86 | 0.89 | | | |
| | 21 years to 30 years | 14 | 3.5 | 1.04 | | | |
| | More than 30 years | 3 | 4.42 | 0.63 | | | |
| Public acknowledgement | Less than 1 year | 2 | 3.71 | 1.21 | 83 | 0.15 | 0.98 |
| | 1 year to 5 years | 32 | 3.57 | 1.00 | | | |
| | 6 years to 10 years | 15 | 3.61 | 0.74 | | | |
| | 11 years to 20 years | 18 | 3.43 | 1.02 | | | |
| | 21 years to 30 years | 14 | 3.45 | 0.75 | | | |
| | More than 30 years | 3 | 3.29 | 1.24 | | | |
| Schedule | Less than 1 year | 2 | 4.5 | 0.71 | 83 | 1.04 | 0.4 |
| | 1 year to 5 years | 32 | 3.98 | 0.83 | | | |
| | 6 years to 10 years | 15 | 4.04 | 0.88 | | | |
| | 11 years to 20 years | 18 | 4 | 0.86 | | | |
| | 21 years to 30 years | 14 | 3.55 | 0.72 | | | |
| | More than 30 years | 3 | 4.33 | 0.67 | | | |
| Salary | Less than 1 year | 2 | 4.6 | 0.71 | 83 | 1.7 | 0.15 |
| | 1 year to 5 years | 32 | 4.16 | 1.11 | | | |
| | 6 years to 10 years | 15 | 4.73 | 0.59 | | | |

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| | 11 years to 20 years | 18 | 4.06 | 1.11 | | | |
| | 21 years to 30 years | 14 | 3.64 | 1.39 | | | |
| | More than 30 years | 3 | 4.67 | 0.58 | | | |

**8. Years of Experience at UNCH**

| Years of experience at UNCH ANOVA TABLE | | | | | | | |
|---|---|---|---|---|---|---|---|
| | **Years of experience at UNCH** | **N** | **Mean** | **SD** | df | **F** | **Sig.** |
| HWE | Less than 1 year | 6 | 4.1389 | 0.48528 | 91 | 3.33 | 0.01 |
| | 1 year to 5 years | 44 | 3.2727 | 0.69686 | | | |
| | 6 years to 10 years | 23 | 3.5386 | 0.61965 | | | |
| | 11 years to 20 years | 13 | 3.094 | 0.54546 | | | |
| | 21 years to 30 years | 6 | 3.6019 | 0.93387 | | | |
| MR | Less than 1 year | 6 | 4.2222 | 0.77936 | 91 | 3.23 | 0.15 |
| | 1 year to 5 years | 44 | 3.1894 | 0.74152 | | | |
| | 6 years to 10 years | 23 | 3.5217 | 0.74418 | | | |
| | 11 years to 20 years | 13 | 3.2051 | 0.60152 | | | |
| | 21 years to 30 years | 6 | 3.6667 | 0.94281 | | | |
| Overall recognition | Less than 1 year | 5 | 3.94 | 0.67429 | 83 | 0.34 | 0.85 |
| | 1 year to 5 years | 39 | 3.5436 | 0.83787 | | | |
| | 6 years to 10 years | 22 | 3.6609 | 0.67145 | | | |
| | 11 years to 20 years | 12 | 3.6 | 0.74887 | | | |
| | 21 years to 30 years | 6 | 3.5389 | 0.75112 | | | |
| Opportunities for growth and development | Less than 1 year | 5 | 3.8462 | 0.6706 | 83 | 0.4 | 0.81 |
| | 1 year to 5 years | 39 | 3.3787 | 0.85483 | | | |
| | 6 years to 10 years | 22 | 3.5076 | 0.87578 | | | |
| | 11 years to 20 years | 12 | 3.3718 | 0.73478 | | | |
| | 21 years to 30 years | 6 | 3.5256 | 1.04956 | | | |
| Written acknowledgement | Less than 1 year | 5 | 3.6 | 1.38243 | 83 | 0.73 | 0.58 |
| | 1 year to 5 years | 39 | 3.453 | 1.27387 | | | |
| | 6 years to 10 years | 22 | 3.697 | 1.07845 | | | |
| | 11 years to 20 years | 12 | 3.9167 | 1.00629 | | | |
| | 21 years to 30 years | 6 | 3.0556 | 0.53403 | | | |
| Private verbal feedback | Less than 1 year | 5 | 4.2 | 0.59687 | 83 | 0.38 | 0.82 |
| | 1 year to 5 years | 39 | 3.8782 | 0.81489 | | | |
| | 6 years to 10 YEARS | 22 | 3.7614 | 0.72571 | | | |
| | 11 years to 20 years | 12 | 3.75 | 0.83937 | | | |
| | 21 years to 30 years | 6 | 3.9583 | 1.1556 | | | |
| Public acknowledgement | Less than 1 year | 5 | 4 | 0.82685 | 83 | 0.54 | 0.71 |
| | 1 year to 5 years | 39 | 3.4579 | 1.00759 | | | |

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| | 6 years to 10 years | 22 | 3.539 | 0.72834 | | | |
| | 11 years to 20 years | 12 | 3.619 | 1.02534 | | | |
| | 21 years to 30 years | 6 | 3.2619 | 0.81525 | | | |
| Schedule | Less than 1 year | 5 | 4.2667 | 0.72265 | 83 | 0.43 | 0.79 |
| | 1 year to 5 years | 39 | 3.8462 | 0.93922 | | | |
| | 6 years to 10 years | 22 | 4.0606 | 0.69493 | | | |
| | 11 years to 20 years | 12 | 3.9444 | 0.74986 | | | |
| | 21 years to 30 years | 6 | 3.9444 | 0.82776 | | | |
| Salary | Less than 1 year | 5 | 4.2 | 0.83666 | 83 | 0.54 | 0.71 |
| | 1 year to 5 years | 39 | 4.0769 | 1.17842 | | | |
| | 6 years to 10 years | 22 | 4.3182 | 1.17053 | | | |
| | 11 years to 20 years | 12 | 4 | 1.04447 | | | |
| | 21 years to 30 years | 6 | 4.6667 | 0.5164 | | | |

**9. Years of Experience in the unit.**

| Years of experience in the unit ANOVA TABLE | | | | | | | |
|---|---|---|---|---|---|---|---|
| | **Years of experience in the unit** | **N** | **Mean** | **SD** | df | **F** | **Sig.** |
| HWE | Less than 1 year | 12 | 3.8889 | 0.70671 | 90 | 2.11 | 0.08 |
| | 1 year to 5 years | 51 | 3.2996 | 0.68952 | | | |
| | 6 years to 10 years | 15 | 3.4111 | 0.67645 | | | |
| | 11 years to 20 years | 9 | 3.1481 | 0.54149 | | | |
| | 21 years to 30 years | 4 | 3.4167 | 0.82838 | | | |
| MR | Less than 1 year | 12 | 3.8611 | 0.80977 | 90 | 2.07 | 0.09 |
| | 1 year to 5 years | 51 | 3.2026 | 0.75448 | | | |
| | 6 years to 10 years | 15 | 3.5111 | 0.78545 | | | |
| | 11 years to 20 years | 9 | 3.2963 | 0.45474 | | | |
| | 21 years to 30 years | 4 | 3.5 | 1.03638 | | | |
| Overall recognition | Less than 1 year | 10 | 3.8867 | 0.76323 | 82 | 0.64 | 0.64 |
| | 1 year to 5 years | 46 | 3.5232 | 0.81898 | | | |
| | 6 years to 10 years | 15 | 3.6405 | 0.66466 | | | |
| | 11 years to 20 years | 8 | 3.7875 | 0.60157 | | | |
| | 21 years to 30 years | 4 | 3.425 | 0.82119 | | | |
| Opportunities for growth and development | Less than 1 year | 10 | 3.8769 | 0.84281 | 82 | 0.88 | 0.48 |
| | 1 year to 5 years | 46 | 3.3395 | 0.83852 | | | |
| | 6 years to 10 years | 15 | 3.5343 | 0.86628 | | | |
| | 11 years to 20 years | 8 | 3.3942 | 0.62821 | | | |
| | 21 years to 30 years | 4 | 3.4423 | 1.22011 | | | |
| Written acknowledgement | Less than 1 year | 10 | 3.6 | 1.06342 | 82 | 0.63 | 0.64 |
| | 1 year to 5 years | 46 | 3.5217 | 1.24653 | | | |

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| | 6 years to 10 years | 15 | 3.5556 | 1.09593 | | | |
| | 11 years to 20 years | 8 | 4.1667 | 0.89087 | | | |
| | 21 years to 30 years | 4 | 3.25 | 0.5 | | | |
| Private verbal feedback | Less than 1 year | 10 | 4.1 | 0.86763 | 82 | 0.74 | 0.57 |
| | 1 year to 5 years | 46 | 3.7826 | 0.8021 | | | |
| | 6 years to 10 years | 15 | 3.7333 | 0.72251 | | | |
| | 11 years to 20 years | 8 | 4.1875 | 0.51322 | | | |
| | 21 years to 30 years | 4 | 3.875 | 1.45057 | | | |
| Public acknowledgement | Less than 1 year | 10 | 3.7143 | 0.96421 | 82 | 1.18 | 0.33 |
| | 1 year to 5 years | 46 | 3.441 | 0.99924 | | | |
| | 6 years to 10 years | 15 | 3.5429 | 0.71876 | | | |
| | 11 years to 20 years | 8 | 3.9821 | 0.75376 | | | |
| | 21 years to 30 years | 4 | 2.8929 | 0.47201 | | | |
| Schedule | Less than 1 year | 10 | 4.2667 | 0.66295 | 82 | 0.61 | 0.66 |
| | 1 year to 5 years | 46 | 3.8478 | 0.9315 | | | |
| | 6 years to 10 years | 15 | 4.0222 | 0.6722 | | | |
| | 11 years to 20 years | 8 | 4.0833 | 0.72921 | | | |
| | 21 years to 30 years | 4 | 3.9167 | 0.68718 | | | |
| Salary | Less than 1 year | 10 | 4.4 | 0.5164 | 82 | 0.41 | 0.8 |
| | 1 year to 5 years | 46 | 4.1087 | 1.15909 | | | |
| | 6 years to 10 years | 15 | 4.2 | 1.37321 | | | |
| | 11 years to 20 years | 8 | 4.125 | 0.99103 | | | |
| | 21 years to 30 years | 4 | 4.75 | 0.5 | | | |

**APPENDIX L: PEARSON PRODUCT-MOMENT CORRELATION COEFFICIENT (PPMCC OR PEARSON'S *R*) OF RECOGNITION FACTORS AND NURSES' AGE, YEARS OF EXPERIENCE AS A NURSE, YEARS OF EXPERIENCE AT UNCH AND YEARS OF EXPERIENCE IN THE UNIT.**

Pearson Correlation of the **Factor 1, Opportunity for Growth and development** to Number of Years as Nurse, at UNCH, in the Unit, and Age

| | | Opportunities for growth and development | Number of years as a nurse | Years at UNCH | Number of years in the unit | Nurses age range |
|---|---|---|---|---|---|---|
| Growth and development | Pearson Correlation | 1 | -.086 | .003 | -.020 | -.020 |
| | Sig. (2-tailed) | | .439 | .981 | .856 | .855 |
| | N | 86 | 84 | 84 | 83 | 84 |
| Number of years as a nurse | Pearson Correlation | -.086 | 1 | .681** | .599** | .829** |
| | Sig. (2-tailed) | .439 | | .000 | .000 | .000 |
| | N | 84 | 92 | 92 | 91 | 92 |
| Years at UNCH | Pearson Correlation | .003 | .681** | 1 | .806** | .631** |
| | Sig. (2-tailed) | .981 | .000 | | .000 | .000 |
| | N | 84 | 92 | 92 | 91 | 92 |
| Number of years in the unit | Pearson Correlation | -.020 | .599** | .806** | 1 | .583** |
| | Sig. (2-tailed) | .856 | .000 | .000 | | .000 |
| | N | 83 | 91 | 91 | 91 | 91 |
| Nurses age range | Pearson Correlation | -.020 | .829** | .631** | .583** | 1 |
| | Sig. (2-tailed) | .855 | .000 | .000 | .000 | |
| | N | 84 | 92 | 92 | 91 | 92 |

**Correlation is significant at the 0.01 level (2-tailed).

Pearson Correlation of the **Factor 2, Written acknowledgement** to Number of Years as Nurse, at UNCH, in the Unit, and Age

**Correlations**

| | | Number of years as a nurse | Years at UNCH | Number of years in the unit | Nurses age range | Written acknowledgement |
|---|---|---|---|---|---|---|
| Number of years as a nurse | Pearson Correlation | 1 | .681** | .599** | .829** | -.162 |
| | Sig. (2-tailed) | | .000 | .000 | .000 | .142 |
| | N | 92 | 92 | 91 | 92 | 84 |
| Years at UNCH | Pearson Correlation | .681** | 1 | .806** | .631** | -.003 |
| | Sig. (2-tailed) | .000 | | .000 | .000 | .978 |
| | N | 92 | 92 | 91 | 92 | 84 |
| Number of years in the unit | Pearson Correlation | .599** | .806** | 1 | .583** | .043 |
| | Sig. (2-tailed) | .000 | .000 | | .000 | .700 |
| | N | 91 | 91 | 91 | 91 | 83 |
| Nurses age range | Pearson Correlation | .829** | .631** | .583** | 1 | -.103 |
| | Sig. (2-tailed) | .000 | .000 | .000 | | .349 |
| | N | 92 | 92 | 91 | 92 | 84 |
| Written acknowledgement | Pearson Correlation | -.162 | -.003 | .043 | -.103 | 1 |
| | Sig. (2-tailed) | .142 | .978 | .700 | .349 | |
| | N | 84 | 84 | 83 | 84 | 86 |

** Correlation is significant at the 0.01 level (2-tailed).

Pearson Correlation of the **Factor 3, Private verbal feedback to** Number of Years as Nurse, at UNCH, in the Unit, and Age

**Correlations**

| | | Number of years as a nurse | Years at UNCH | Number of years in the unit | Nurses age range | Private verbal feedback |
|---|---|---|---|---|---|---|
| Number of years as a nurse | Pearson Correlation | 1 | .681** | .599** | .829** | -.062 |
| | Sig. (2-tailed) | | .000 | .000 | .000 | .577 |
| | N | 92 | 92 | 91 | 92 | 84 |
| Years at UNCH | Pearson Correlation | .681** | 1 | .806** | .631** | -.034 |
| | Sig. (2-tailed) | .000 | | .000 | .000 | .755 |
| | N | 92 | 92 | 91 | 92 | 84 |
| Number of years in the unit | Pearson Correlation | .599** | .806** | 1 | .583** | .051 |
| | Sig. (2-tailed) | .000 | .000 | | .000 | .650 |
| | N | 91 | 91 | 91 | 91 | 83 |
| Nurses age range | Pearson Correlation | .829** | .631** | .583** | 1 | -.073 |
| | Sig. (2-tailed) | .000 | .000 | .000 | | .508 |
| | N | 92 | 92 | 91 | 92 | 84 |
| Private verbal feedback | Pearson Correlation | -.062 | -.034 | .051 | -.073 | 1 |
| | Sig. (2-tailed) | .577 | .755 | .650 | .508 | |
| | N | 84 | 84 | 83 | 84 | 86 |

**Correlation is significant at the 0.01 level (2-tailed).

Pearson Correlation of the **Factor 4, Public Acknowledgement** to Number of Years as Nurse, at UNCH, in the Unit, and Age

**Correlations**

| | | Number of years as a nurse | Years at UNCH | Number of years in the unit | Nurses age range | Public acknowledgement |
|---|---|---|---|---|---|---|
| Number of years as a nurse | Pearson Correlation | 1 | .681** | .599** | .829** | -.084 |
| | Sig. (2-tailed) | | .000 | .000 | .000 | .449 |
| | N | 92 | 92 | 91 | 92 | 84 |
| Years at UNCH | Pearson Correlation | .681** | 1 | .806** | .631** | -.046 |
| | Sig. (2-tailed) | .000 | | .000 | .000 | .678 |
| | N | 92 | 92 | 91 | 92 | 84 |
| Number of years in the unit | Pearson Correlation | .599** | .806** | 1 | .583** | -.028 |
| | Sig. (2-tailed) | .000 | .000 | | .000 | .799 |
| | N | 91 | 91 | 91 | 91 | 83 |
| Nurses age range | Pearson Correlation | .829** | .631** | .583** | 1 | -.069 |
| | Sig. (2-tailed) | .000 | .000 | .000 | | .534 |
| | N | 92 | 92 | 91 | 92 | 84 |
| Public acknowledgement | Pearson Correlation | -.084 | -.046 | -.028 | -.069 | 1 |
| | Sig. (2-tailed) | .449 | .678 | .799 | .534 | |
| | N | 84 | 84 | 83 | 84 | 86 |

**Correlation is significant at the 0.01 level (2-tailed).

Pearson Correlation of the **Factor 5, Schedule** to Number of Years as Nurse, at UNCH, in the Unit, and Age

| | | **Schedule** | Number of years as a nurse | Years at UNCH | Number of years in the unit | Nurses age range |
|---|---|---|---|---|---|---|
| Schedule | Pearson Correlation | 1 | -.096 | .018 | .019 | -.105 |
| | Sig. (2-tailed) | | .383 | .870 | .865 | .343 |
| | N | 86 | 84 | 84 | 83 | 84 |
| Number of years as a nurse | Pearson Correlation | -.096 | 1 | .681** | .599** | .829** |
| | Sig. (2-tailed) | .383 | | .000 | .000 | .000 |
| | N | 84 | 92 | 92 | 91 | 92 |
| Years at UNCH | Pearson Correlation | .018 | .681** | 1 | .806** | .631** |
| | Sig. (2-tailed) | .870 | .000 | | .000 | .000 |
| | N | 84 | 92 | 92 | 91 | 92 |
| Number of years in the unit | Pearson Correlation | .019 | .599** | .806** | 1 | .583** |
| | Sig. (2-tailed) | .865 | .000 | .000 | | .000 |
| | N | 83 | 91 | 91 | 91 | 91 |
| Nurses age range | Pearson Correlation | -.105 | .829** | .631** | .583** | 1 |
| | Sig. (2-tailed) | .343 | .000 | .000 | .000 | |
| | N | 84 | 92 | 92 | 91 | 92 |

** Correlation is significant at the 0.01 level (2-tailed).

Pearson Correlation of the **Factor 6, Salary** to Number of Years as Nurse, at UNCH, in the Unit, and Age

**Correlations**

| | | Number of years as a nurse | Years at UNCH | Number of years in the unit | Nurses age range | Salary |
|---|---|---|---|---|---|---|
| Number of years as a nurse | Pearson Correlation | 1 | .681** | .599** | .829** | -.109 |
| | Sig. (2-tailed) | | .000 | .000 | .000 | .324 |
| | N | 92 | 92 | 91 | 92 | 84 |
| Years at UNCH | Pearson Correlation | .681** | 1 | .806** | .631** | .091 |
| | Sig. (2-tailed) | .000 | | .000 | .000 | .412 |
| | N | 92 | 92 | 91 | 92 | 84 |
| Number of years in the unit | Pearson Correlation | .599** | .806** | 1 | .583** | .074 |
| | Sig. (2-tailed) | .000 | .000 | | .000 | .507 |
| | N | 91 | 91 | 91 | 91 | 83 |
| Nurses age range | Pearson Correlation | .829** | .631** | .583** | 1 | -.138 |
| | Sig. (2-tailed) | .000 | .000 | .000 | | .210 |
| | N | 92 | 92 | 91 | 92 | 84 |
| Salary | Pearson Correlation | -.109 | .091 | .074 | -.138 | 1 |
| | Sig. (2-tailed) | .324 | .412 | .507 | .210 | |
| | N | 84 | 84 | 83 | 84 | 86 |

** Correlation is significant at the 0.01 level (2-tailed).

## APPENDIX M

**Figure A1.**
**Theory of Human Motivation (Abraham Maslow, 1954)**

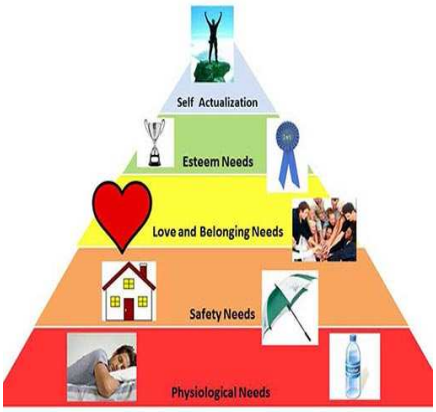
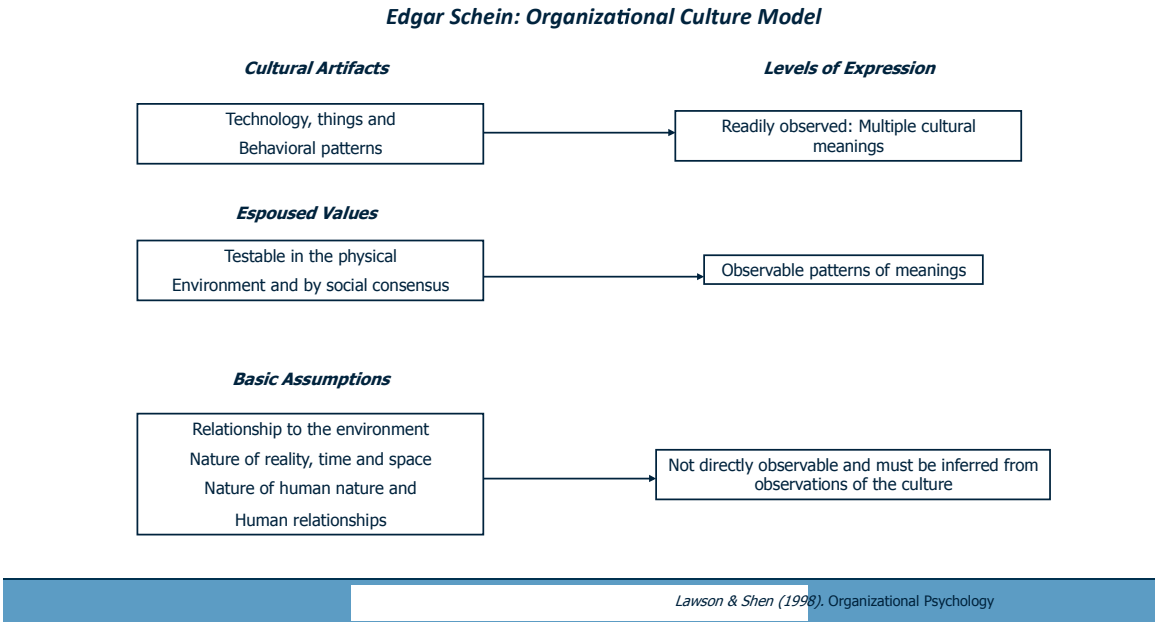



**Figure A2.**
**Theory of Organizational Culture (Schein, 1984)**



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