Fall 12-10-2020

Meaningful Recognition and the Effect on a Medical-Surgical Unit's Staff Satisfaction and Retention

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A Paper Submitted in Partial Fulfillment of the Requirements

For NURS 5382: Capstone

In the School of Nursing

The University of Texas at Tyler

by

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December 6, 2020

Contents

Acknowledgments

This project is the culmination of many months of work. I would like to extend my heartfelt appreciation to my former instructors at UT Tyler, who laid the path for my educational journey until this point. I sincerely appreciate the time and attention of Dr. Danice Greer during this semester. Her positive energy and true dedication to her students' needs are unmistakable. Finally, I would like to thank my husband, William, for his support, encouragement, and understanding. Simultaneously navigating graduate school, the many demands of my career, and a global pandemic has been easier with him by my side.

Executive Summary

The current state of the American healthcare system is riddled with challenges. Nurse administrators are faced with the formidable tasks of decreasing operating costs; improving the patient experience; delivering high-quality and safe patient care; and decreasing the mounting rates of nurse turnover. Nurse leaders must understand the complexities of their work environment, including the key drivers for nurse satisfaction and retention. In 2005, the American Association of Critical Nurses developed six standards for creating a healthy work environment. (American Association of Critical Care Nurses, 2016). An adult, medical-surgical unit at a South Texas hospital was faced with rising rates of turnover from 2018 to 2020. Unit leaders faced two important challenges: understand why staff were leaving, and how to retain their nurses for the future.

Upon the review of several sources of data, it was determined that the unit was suffering from a key link to their healthy work environment: meaningful recognition. A review and synthesis of the current research on meaningful recognition was completed, and interventions were implemented. A three-tiered meaningful recognition program was employed over a two-month period on the unit. The results of this program were evaluated and recommendations for the future were made to continue improvement.

Meaningful Recognition and the Effect on a Medical-Surgical Unit's Staff Satisfaction and Retention

The American Association of Critical Care Nurses recognizes meaningful recognition as a vital component of a healthy working environment for nurses (American Association of Critical Care Nurses [AACN], 2016). Decades of research on human needs, organizational behavior, and professional development have shown that recognition is not only important but also necessary for the success of individuals and corporations. This paper examines key findings from existing research about nursing recognition, and how these standards were implemented in a medical surgical unit to improve staff satisfaction and turnover. Implementation of these standards will be evaluated, and further recommendations for the future will be considered.

Project Rationale

In a medical-surgical unit at a South Texas teaching hospital, nursing turnover rates in 2019 and 2020 saw a steady increase, at times reaching 18%, according to the human resources department (A. Casas, personal communication, 2020). Unit leaders met to consider the current turnover rates and what potential improvements were needed. Based on exit interviews with staff and interviews with current unit employees, over 50% of staff voiced that they did not feel recognized for their contributions or that their work did not make a difference to leadership. Unit staff also mentioned the recognition of important milestones such as their first day on the unit, successful completion of unit orientation, annual milestones, and important contributions to patients and the health system, among others, was not consistent or timely. Annual employee engagement surveys issued by the National Research Corporation (NRC) and nurse satisfaction survey results conducted by The National Database of Nursing Quality Indicators (NDNQI) revealed that the unit was not performing well in meaningful recognition.

The medical-surgical unit has meaningful recognition system in place, including the Daisy Award (The DAISY Foundation, 2020); however, these systems are significantly under-utilized on the unit. The human resources department also allocates monetary awards each year, but nominations to staff have been minimal. Unit leadership has also observed a lack of peer recognition between the staff members in the unit. This concern led the leadership team to inquire whether a robust and structured meaningful recognition program implemented at the unit level would help to increase staff satisfaction and retention.

Nurse leaders are frequently burdened by the effects of high turnover rates and nursing shortages on their units and organizations. A nationwide nursing shortage is projected to continue through 2030 (Zhang, et al., 2018). Nursing units often struggle with the financial consequences of the continual process of hiring and training new employees. Employee satisfaction and engagement are important elements of an overall healthy working environment (AACN, 2016).

It is important for nurse leaders to understand the influence of dissatisfied nurses and high turnover on nursing care and patient outcomes. Staff members who are not satisfied or engaged often leave their job or the nursing profession entirely. A recent systematic review with meta-analysis found that nurses in healthier work environments had a lower risk of dissatisfaction, burnout, and intention to leave their jobs; these environments also demonstrated significantly improved odds of better patient satisfaction and lower mortality rates (Lake et al., 2019). Fostering a healthy work environment for nurses is vital for improving turnover rates and patient care.

Literature Synthesis.

In nursing, meaningful recognition was emphasized in the first edition of the *AACN's Standards for Establishing and Sustaining Healthy Work Environments: A Journey to Excellence* (AACN, 2005). Years of research led to the organization's development of six critical standards to promote a healthy work environment. Along with meaningful recognition, the standards include skilled communication, authentic leadership, true collaboration, appropriate staffing, and effective decision making (AACN, 2005). Research on meaningful recognition continues and has important implications for nursing practice.

A cornerstone of meaningful recognition is that it should be delivered in a manner which facilitates the staff's understanding of the importance of the hospital's organizational goals. This insight would increase the staff's awareness of their effects on both patients and the organization. This reciprocity could help unit leaders with organizational commitment in their teams. Researchers have found that it is also crucial for leadership teams to compare the forms of recognition and praise that are most important to their team so that when recognition is given, it has value to the intended person (AACN, 2016; Cherian, 2016; Clavelle, et al., 2019; Sveinsdóttir, et al., 2015).

In a quasi-experimental study, Adams et al. (2019) found that meaningful recognition was a significant predictor to decreased burnout through the implementation of a meaningful recognition program in an emergency room. Kelly et al. (2015) and Kelly and Lefton (2017) discovered that meaningful recognition was a significant predictor of both decreased burnout and higher compassion satisfaction. It is imperative for leadership teams to support staff who may be at an increased risk for burnout and compassion fatigue. This is especially true for millennial-generation nurses (Kelly et al., 2015; Kelly & Lefton, 2017). Nurses with more work experience,

regardless of age, are also at an increased risk for burnout (Kelly et al., 2015); therefore, their job satisfaction deserves further attention.

Both servant and transformational leadership styles have positive effects on staff. Gilbert and Kelloway (2018) found in their descriptive study that more meaningful recognition is provided by transformational leaders, and that meaningful recognition is highly related to employee's well-being. Regardless of the leadership style, managers should strive to develop trusting relationships with their staff and include meaningful recognition to improve staff's intent to stay at the organization (Sveinsdóttir et al., 2015; Gilbert & Kelloway, 2018).

Several articles on meaningful recognition reported that it should be genuine and directly linked to the effects of staff member on the person or organization (AACN, 2016; Cherian, 2016; Clavelle et al., 2019; Kelly & Lefton, 2017; Kelly et al., 2015). This is an important distinction from other forms of praise or gratitude. This goes beyond a simple thank you; meaningful recognition must demonstrate why the employee made a difference. The DAISY award is a significant meaningful recognition tool for leadership teams; however, many other meaningful recognition forms exist (Clavelle et al., 2019; Kelly & Lefton, 2017; Kelly et al., 2015;). Leaders should examine other avenues to provide meaningful recognition to their team members, such as opportunities for growth and development, financial compensation, schedule preferences, informal recognition, and verbal recognition (Cherian, 2016; Sveinsdóttir et al., 2015).

While quantitative research has provided important data regarding nurses' perceptions of meaningful recognition, qualitative research has also gleaned important information from those who provide recognition. Clavelle et al. (2019) and Lefton (2012) examined the language of meaningful recognition through DAISY award nominations. Patients and family members overwhelmingly listed compassionate and caring behaviors as the reason for nominating nurses.

Other frequently listed nursing behaviors included professionalism, helpfulness, and going above and beyond job requirements (Clavelle et al., 2019; Lefton, 2012). This is important for leadership issuing recognition to staff because we know what behaviors and actions are most important to patients. Encouraging and highlighting these behaviors will motivate the staff to continue providing high-quality and caring services.

From the current research, no single method of recognition is superior. Several descriptive studies have mentioned salary and other types of financial compensation as the most significant or preferred forms of nurses' recognition (Cherian, 2016; Seitovirta et al.,2016; Willingham, 2014). In contrast, a meta-analysis of studies on nurse turnover has shown that overall, salary is far less significant in predicting actual job turnover (Nei et al., 2015). These findings suggest that while financial awards may be beneficial, health systems have other cost-effective options that could affect nurse's satisfaction and their willingness to stay with an organization. While it is easy to imagine increasing pay or the provision of bonuses for nurses as forms of recognition, financial constraints of most health systems across the country may not allow for such implementation. What *can* [emphasis] be done is to individualize recognition, when possible, to the employee preferences.

The AACN (2016) declared that meaningful recognition must be structured and ingrained as part of the unit's culture. Although patients and family members are significant contributors, peer and leadership recognition is important and should be incorporated into recognition programs (AACN, 2016; Cherian, 2016; Sveinsdottir et al., 2015; Willingham, 2014). Through many years of research, the literature has shown that structured, meaningful recognition programs need to be timely; be relevant to the contribution to the individual or organization;

come from a variety of sources including patients, peers, and leaders; and be tailored as to the preferences of the employee.

Project Stakeholders

The meaningful recognition program has several stakeholders, including unit staff consisting of registered nurses, nursing assistants, unit clerks, nurse managers, and the unit director. The human resources department is also an important stakeholder, as it approves the budget for awards issued to staff. The health system also holds an important interest in the program because retention rates affect the unit and the organization. Finally, patients and their families are probably the most important stakeholders of the project. As a vital element of EBP, patient's preferences and well-being must be considered (Long et al., 2015). Nurses who are members of the unit's recruitment and retention committee were included in project planning. The nurse educator is also an important stakeholder, as they are key to disseminating new information to the unit via emails, one-on-one meetings, flyers, and the unit's monthly newsletter.

Implementation Plan

A meaningful recognition program was implemented for two months in an inpatient medical-surgical unit in South Central Texas. After reviewing the available research, a three-section intervention plan was implemented reflecting key research findings from recognition research. First, all staff was provided a personalized recognition information form to determine which types of recognition were important to individual employees and how they preferred to be recognized (public vs. private/written vs. verbal). New employees to the unit during this time also received a recognition preference form (Appendix D).

Leadership on the unit was also tasked with issuing online monetary awards budgeted to the unit each month. These "silver and gold awards" were worth $25 and $50, respectively. Employees could go online and redeem a gift after receiving the award. These awards were important for meaningful recognition because the nominator had to select an organizational goal that the employee achieved. The unit was budgeted for four silver awards and one gold award each month.

Finally, a peer recognition box named "Cheers for Peers" was created to address the need for peer recognition in the unit. This box was placed in the main lobby of the unit, where pre-shift huddles were held daily. "Kudos" cards were placed in the box where employees could write an appreciation note for a team member. Throughout the week, unit managers and staff would read aloud the appreciation messages to each other in pre-shift huddles. Since the DAISY award program is currently active within the health system, patient recognition of staff was not a focus of this initial project. As the planning portion of the project ensued, it was observed that the Daisy Award was only available via electronic version to patients. Management felt there was an opportunity for improvement in this area. To address this, paper Daisy and Bee (for ancillary staff) award nomination forms were inserted into each patient's admission folder so that they could complete a handwritten nomination if preferred.

Timetable/Flowchart

The planning, implementation, and evaluation phases of this project were completed over 13 weeks as shown in Table 1. Four weeks prior to project implementation, from September 7, 2020 to September 20, 2020, baseline data from the unit was reviewed and finalized. This data encompassed the results of the hospital's 2019 NDNQI and NRC surveys which comprised subscales related to meaningful recognition. Meetings were also held with members of the

recruitment and retention committee, nurse educator, and nurse managers to discuss the project details. The team also deliberated about which project measurement and evaluation tool would be most useful for the project.

Table 1

Meaningful Recognition Program Timeline

Week(s)	Phases & Milestones
1-2	Define all baseline data and outcome indicators. Conduct initial meetings with stakeholders. Search for survey tool.
3	Meet to discuss plans for gold/silver awards and peer recognition. Preference forms submitted to director for approval.
4	Issue recognition preference forms to staff. Management meeting to discuss gold/silver awards.
5-12	Launch project. Conduct Webex meeting on week 8 to discuss progress. Issue awards to staff. Identify barriers.
13	Distribute surveys to staff. Begin data collection. Sustain project processes. Discuss changes if needed

During the week of September 21 to September 27, project approval was obtained from the unit director. The employee recognition form was also finalized and submitted to the director for approval. After an extensive search for an appropriate project outcome measurement tool, it was decided to use Job Satisfaction Survey (JSS) (Spector, 1994) as a pre and post-project survey. The NDNQI and NRC surveys were not available to use. The JSS survey was available free for public use, and permission was granted on the author's website.

On week four, the recognition preference forms were distributed to staff members on the unit during pre-shift huddles. At the end of the shift, preference forms were collected from staff and compiled in a binder for the recruitment and retention committee to review. Copies were also given to unit managers for their reference. A meeting with the management team was held to discuss the expectations for unit management to participate in award nominations. A goal of two gold awards and 8 silver awards was established for the two-month period.

On the week of September 28, the JSS was distributed to staff and collected by management. There was a box located in the administrative assistant's office where staff could return their forms. No identifying information was available on the form or requested from staff. Data was entered into an excel document as surveys were collected to record pre-project satisfaction scores.

The project was launched on October 5, 2020 and continued through November 27, 2020. During this time, managers encouraged staff to participate peer recognition; they submitted gold and silver awards, and the staff received those awards privately or publicly based on their preferences. An example of this process is as follows. A registered nurse had a "good catch" for recognizing a stage one pressure injury when she received her new patient from ICU. The nurse placed proper interventions and protected the patient from further harm. The unit manager nominated the employee for a silver award based on patient safety. The nurse's preference was to receive recognition in publicly in verbal form, so the manager recognized the employee during pre-shift huddle and presented her the award.

The JSS tool was again issued to staff November 28 through December 2. A section for comments was also included on the survey for staff to provide feedback. After the survey information was received, data collection was completed, and final evaluation of the project was ended on December 4, 2020. Results were reviewed with the team. Discussions about the project's sustainability continued at the end of the 13 weeks. The project processes are listed in a flowchart (see Appendix B).

Data Collection Methods

Data was collected from two sources for this project: The Job Satisfaction Survey (JSS) before and after the project, and turnover rates from the human resources department. It is noted

that turnover rates were not likely affected in the two months this project was active, however, time constraints for the project limited long-term data collection. Turnover rates for the unit will be tracked over the course of one year by the leadership team. The JSS is a 36-item likert-style scale that measures 9 dimensions of work satisfaction (Appendix D). It includes a range of responses from *disagree very much* (1) to *agree very much* (6). This scale was chosen because of reported good internal consistency reliability (36 items; $\alpha = .91$) and access to free, public use for students.

Table 2 depicts the subscales and total survey score guide. A rating of 36 to 108 indicates dissatisfaction; between 109 and 143 indicates ambivalence; and from 144 to 216 indicates job satisfaction. A higher score indicates a higher level of job satisfaction. For each subscale, the scores follow the same trend: A score of 4 to 12 suggests dissatisfaction; 13 to 16, ambivalence; and 17 to 24 suggests satisfaction. There were 19 negatively worded items which required reverse scoring. The 9 subscale totals are added to compute the overall satisfaction score.

Table 2

Job Satisfaction Survey Results (Pre and Post Survey)

Satisfaction Level	Dissatisfied	Ambivalent	Satisfied
Total Score	36-108	109-143	144-216
Subscale Score	4-12	13-16	17-24

Note. Adapted from Job Satisfaction Survey by P. E. Spector, 1994, http://paulspector.com/assessment-files/jss/jss-english.doc

The recognition subscale, titled contingent rewards, contains 4 statements which are noted in Appendix C (Questions 5, 14, 23, 32). All staff members on the unit (*N*=83) were asked to complete the survey: 53 nurses and 30 nursing assistants. Surveys were completed by staff and returned in an enclosed box on the unit to ensure confidentiality. No identifying information was

included on the survey. A total of 83 staff members were surveyed pre and post intervention; responses from both JSS surveys were compared. An increase in the subscale for contingent rewards was expected if the intervention was successful. The unit's turnover rate was examined; however, it could not be determined if successful due to the short timeframe of the project.

Cost/Benefit Discussion

The total cost of the project for the two months was $500. Most of this cost ($300) was due to the silver and gold award nominations. If the same quota of awards were maintained over one year, the total cost would be $1,800. This cost is fortunately budgeted by the human resources department each year, so no additional costs from the unit's management team are required. The Cheers for Peers box and Kudos cards were purchased on Amazon for $50. The only future costs will be replenishing the kudos cards as needed, which is nominal. The unit did incur an increased cost of printing supplies with the addition of paper Daisy and Bee nomination forms, totaling $125 over two-months. This cost could be reduced by handing nomination cards to patients only when requested by the patient. A $25 gift card was issued to the staff member mentioned most by patients during bedside leader rounds each month.

The cost of nurse turnover is staggering. The most recent National Healthcare Retention & RN Staffing Report noted that the average nurse turnover cost is between $37,000 and $58,000 per nurse (NSI Nursing Solutions, Inc., 2016). The hospital's goal for this medical-surgical unit is to maintain turnover rates no higher than 14%. For a unit with turnover rate of 16% in 2020, action must be taken to mitigate these costs. This rate includes six registered nurses for the 2020 year. Although this statistic is concerning, it mirrors the national RN turnover rate of 17.2% (NSI Nursing Solutions, Inc., 2016). The potential savings are considerable and far outweigh the costs of implementing this project.

Discussion of Results

For both pre and post intervention groups, 83 staff members were surveyed. For the pre-intervention group, 76 staff responded, 72 responded for the post-intervention survey. For brevity, the total satisfaction score and meaningful recognition subscale scores are emphasized and listed in Table 3. After the intervention, there was an increase in both the rewards subscale and total job satisfaction rating. For the pre-survey, contingent rewards was the lowest-scoring of all subscales.

Table 3

JSS Survey Results

	Total Score		Reward Subscale	
	M	*SD*	*M*	*SD*
Pre-Intervention	135.75	11.3	11.64	3.61
Post-Intervention	138.47	11.25	12.94	3.10

Although the project was successful in increasing the overall satisfaction scores of staff on the unit, work environments are complex systems that have multiple variables influencing nurse satisfaction and turnover. It is important to note that meaningful recognition is only one part of a healthy work environment; the six essential standards of a HWE are all equal in value (AACN, 2016). It is important for leaders to examine all facets of their work environment.

Conclusions/Recommendations

There are several recommendations after this project was completed. It will be important for the unit to sustain the recognition interventions on the unit while they monitor turnover rates. Turnover rate improvements could not be seen within two months, but the unit's leadership team has a strong foundation of meaningful recognition interventions at their disposal. It is also recommended that the team review all aspects of their work environment with the next NDNQI

survey in 2021. Although meaningful recognition was a focus for this project, other domains of the work environment will need to be addressed to create a well-rounded HWE initiative. After the project was completed, the unit leadership team met to discuss how they can implement a "HWE Toolkit".

The recognition preference forms were a great conversation-starter for the unit's staff. Several team members wrote their own ideas about new ways to recognize staff. These ideas included meal vouchers to the hospital's café, movie tickets, gift cards, and additional paid-time-off. To support collaborative governance, the recruitment and retention committee team members will spearhead the future of recognition on the unit.

As an MSN student, the ability to make major changes to a hospital's reward system was not an option, but making small, effective changes at the unit-level was a rewarding possibility. This project was important as a future administrator. There are emerging forms of recognition for nurse leaders and their staff. It will take creative and transformational leadership to incorporate these promising ideas into the health systems of the future.

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Appendix A

Synthesis Table

Citation: (i.e., author(s), date of publication, & title)	**Conceptual Framework**	**Design/ Method**	**Sample/ Setting**	**Major Variables Studied and Their Definitions**	**Measurement of Major Variables**	**Data Analysis**	**Study Findings**	**Strength of the Evidence (i.e., level of evidence + quality [study strengths and weaknesses])**
Author, Year, Title	**Theoretical basis for study** **Qualitative** **Tradition**		**Number, Characteristics,** **Attrition rate & why?**	**Independent variables** **(e.g., IV1 =** **IV2 =)** **Dependent variables (e.g., DV =)**	**What scales were used to measure the outcome variables (e.g., name of scale, author, reliability info [e.g., Cronbach alphas])**	**What stats were used to answer the clinical question)**	**Statistical findings or qualitative findings (i.e., for every statistical test you have in the data analysis column, you should have a finding)**	• **Strengths and limitations of the study** • **Risk or harm if study intervention or findings implemented** • **Feasibility of use in your practice** • **Remember: level of evidence (See Melnyk & Fineout-Overholt, pp. 32-33) + quality of evidence = strength of evidence & confidence to act. http://www.ahrq.gov/clinic/3rduspstf/ratings.htm**
Adams et al., 2019, Implementation of a Cultural Change Toolkit to reduce nursing burnout and mitigate nurse turnover in the emergency department	None stated	Quasi – Experimental One-group pretest - posttest design	US – ER in SE TX. 41-bed *N*= 30 nurses RN=28 LVN=2 F=21 M=9 Age range: 20-60s Yr. exp: <5 - >30 BSN =20 ADN=8 Diploma=2	IV= (CCT) DV1=AT DV2=BO • Exhaustion • Disengagement	ATS (Hinshaw, Smeltzer & Atwood, 1987). α not given OBI (Halbesleben & Demerouti, 2005) α not mentioned	Descriptive: Range and Mean Student's *t* test - Descriptive: Range and Mean Student's *t* test	**ATS** Pre: Range = 1 to 5.83, mean = 3.133 Post: Range = 1 to 6, mean = 2.989. *P* = 0.170 (α=0.05) NS *no *t* value given **OBI** <u>Pre</u> • Exhaust mean = 2.563 • Diseng mean = 2.246 <u>Post</u> • Exhaust mean = 2.363 • Diseng mean = 2.246 <u>Post</u> • Exhaust mean = 2.363 • Diseng mean = 2.100 Overall BO Pre = 4.808 Post = 4.463 *P* = 0.004 (α=0.05) *no *t* value given	Strength: Study has an intervention. Limitations: Only one site studied, no comparison group, and uses a one group pretest – posttest design. Cannot determine causal inference & has possible internal validity threats (maturation, history). No risk of harm, very feasible in my setting. Level III Grade C, Low level of certainty, however no risk of harm. Difficult to determine if positive change was from MR interventions or others.

Appendix A: Continued

Kelly et al., 2015, Predictors of compassion fatigue and compassion satisfaction in acute care nurses.	Stamm 2010. ProQOL	Quantitative Descriptive, Cross-sectional	U.S. 700-bed teaching facility-acute RN *N* = 491 Mean age= 39yr Mean exp=10.9yr Mean tenure=6yr BSN=53.2 % F=88.6% FT = 93.1% MR(DA) = 25.3% JobSat = 77.1% AR = 65%. 1,400 nurses sent survey. 35% did not respond	IV1: Demographics IV2: Age range IV3: MR IV4: JobSat DV1: CS DV2: CF	ProQOL scale: Stamm 2010. Measures CF & CS. (Likert) BO: α = 0.75 ST: α = 0.81 CS: α = 0.88	ANOVA & Regression Analysis Descriptive – Mean & Range	**BO** Generation: β = -1.05, *p* = .010 Experience: β = 0.10, *p* = .001 MR (DA): β = -1.52, *p* = .05 Highly Satisfied: β = -4.06, *p* = <.001 **ST** Generation: β = -0.69, *p* = .010 **CS** MR(DA): β = 2.30, *p* = 0.14 JobSat: β = 5.02, *p* = <.001 BO: Mean = 25.63 (5.58) ST: Mean = 20.86 (5.27) CS: Mean = 40.51(6.42)	Strengths: Reliable scales used. Limitations: AR of 65%. Low sample size, however, is higher than previous studies. No risk of harm Feasibility = High Level – IV Cross-sectional descriptive. Makes predictions Grade B, Moderate Level of Certainty
Kelly & Lefton, 2017, Effect of meaningful recognition on critical care nurses' compassion fatigue.	Stamm 2010 ProQOL	Descriptive Cross-sectional Online Survey Convenience sample	24 hospitals with (n=14) and without (n=10) MRP 726 ICU nurses in hospitals	IV=MRP DV=Compassion Fatigue	ProQOL-5, Stamm, BO CA=0.72, ST CA=0.80, CS CA-0.87	Mean SD Percentages Chi Square	Mean scores for the ProQOL test and put into ranges of low, average, and high. BO=23.54 (low) ST=22.0 (average) CS=38 (moderate) $\chi 2 = 40.3$, p = < .0001 (NS for differences in demographics)	• Strengths: Large SS, MRP intervention =significant predictor of ↓ BO and ↑ CS, ↑ JS=↑ job related stress • Limitations: Survey responder bias & ↓ response rate, one form of MRP assessed • No risk for harm • Feasible to institute recognition program for bedside nurses • Level of Evidence: 6-Descriptive study

Appendix A: Continued

			without program, MA= 39, 85% F, 15% M Setting: ICUs in USA Attrition: N/A as cross-sectional study			t-test Multiple linear regression	t-test conducted with no similar differences between nurses in hospitals with or without program burnout: t=0.28, p=.77 ST: t=-1.35, p=.17 CS: t=0.60, p=.55 All values in Table 3 were significant predictors.	• Strengths: Large SS, MRP intervention =significant predictor of ↓ BO and ↑ CS, ↑ JS=↑ job related stress • Limitations: Survey responder bias & ↓ response rate, one form of MRP assessed • No risk for harm • Feasible to institute recognition program for bedside nurses • Level of Evidence: 6-Descriptive study • USPSTF Grade: B • Moderate level of certainty
Sveinsdóttir, et al., 2015, Praise matters: The influence of nurse unit managers' praise on nurses' practice, work environment, and job satisfaction: A questionnaire study	Servant Leadership – Parris and Peachey, 2013.	Quantitative Descriptive, Cross-sectional.	University Hospital – Iceland. Unit managers N=383. Surg. RNs % > 40 y.o.= 66.3 % married = 79.6% >10 yr. experience = 70.0 % AR – 51%	IV1: Praise IV2: Demographics DV1:Job Sat DV2: PP DV3: Workload DV4: Work Climate DV5: Org. Comm.	**Praise** – Likert scale **Job Sat** – (JSS) Likert scale. Thotoddsen et al. 1992. α = 0.75-0.88 **PPS-O** - Sveinsdottir & Blondal 2014 α = 0.70-0.92 **PPS-IO** Sveinsdottir & Blondal Likert scale α = 0.74-0.90 **WLS** Sveinsdottir & Blondal 2014 α = 0.62-0.67 **Work Climate** – RTA-Scale Sveinsdóttir, Ragnarsdóttir& Blöndal, 2015. **Org. Comm** – Author did not mention α=0.83 **Demographics** –	*t*-test Odds ratio (*OR)* *OR* *OR* χ2, Fisher's exact test.	Prof. Recog ***t*** **(**117)= -8.555; *P<0.001* ***OR*** = 11.03 *OR* = 11.03 value prof. recog. if received praise often *OR* = 3.72 prof. collaboration important if received praise often *OR* = 15.49 ITS if received praise often *OR* = 3.86 RN found communication satisfying if received praise often *OR* = 15.49 more likely ITS if received praise often All were NS. *P*<0.001	• Strengths: Well-validated tools. Conceptual framework mentioned (servant leadership) measures concept of praise as opposed to only Daisy Recognition. Incorporated odds ratios. • Limitations: Small sample size, Only praise was measured. Low-level of evidence. Small setting. Only surgical nurses included. • No risk of harm. No intervention. • Feasibility: High. Low risk for intervention. Praise / recognition is easy, affordable. • Level VI evidence. Grade B, Moderate Level of Certainty.

Appendix A: Continued

Cherian, 2016, Impact of Meaningful Recognition on Nurses' Work Environment in ICU: A Comparative of Nurse Leaders' and Staff Nurses' Perception	Theory of Human Motivation (Hierarchy of Needs) – Maslow 1943 Theory of Organizational Culture Development – Edgar Schein 1992	Mixed methods – Qualitative & Descriptive	*N*= 93 ICU RN F= 73% BSN = 73% SN = 62% Non H/W= 85% Cert = 85%. 31-40 yr. old = 35.9%, Intent to stay = 77%. FGI: *n*= 26 Surveys: *n*= 93 41.3% response rate. 2 not completed UNCH	IV1: Demographics DV1: MR DV2: HWE	•**FGI -** Appreciative Inquiry format. Cooperrider (1986). **HWE** – Author: AACN (2005). 18 questions. Likert scale α= 0.80 **Recognition Survey** – Qualitative Data. Author: Blegen and Colleagues (1992). α= 0.64-0.89	Descriptive statistics ANOVA Levene's test Bonferron	**Intent to stay:** (F 6.76, df (1,90), p 0.002) **Exp @ UNCH:** 3.33, df (1,90), p 0.01) **Female:** mean = 3.43, SD 0.75,*p* = 0.019 **Cert:** (p 0.029) for HWE **Cert**: (p 0.039) for MR Intent to stay: HWE & MR *F* = 5.93 (1,90), *p* =0.004 HWE: (mean = 3.53, SD 0.65) 0.8 higher than not stay MR: (mean = 2.50, SD 0.69) 1point higher than not stay **Female**: Mean=3.43. *p*=0.054 - MR **Salary increase** - Mean 4.2, SD 1.09) **Schedule** - Mean 3.96, SD 0.82 **Private verbal feedback** - Mean 3.86, SD 0.80 **Written acknowledge –** Mean 3.57, SD 1.14 **Public recognition –** Mean 3.52, SD 0.9 **Growth & Develop –** Mean 3.45, SD 0.83	•Strengths – Mixed methods approach – Qualitative data added dimension/depth to quantitative data. •Limitations – Convenience sample and small sample size for quantitative design, only ICU nurses included so results may not be generalized to population, PI was colleague, conducted during work hours, lack of diversity among participants •Low risk of harm, no intervention in place. •Feasibility - Low feasibility for salary increase or changes to scheduling. High feasibility for private verbal feedback, written feedback and opportunities for growth and development. •Level VI evidence – Mixed methods. Grade B, moderate level of certainty.

Appendix A: Continued

Gilbert & Kelloway, 2018, Leadership, recognition, and well-being: A moderated mediational model	Social Exchange Theory (Blau, 1964) TL – (Bass, 1985)	Descriptive cross-sectional	Atlantic Canadian large health system. Convenience sample *N*= 8,000 Final *n*= 3,132 F =87.6% 40-49 yr.old = (40.6%) 30-39 yr. old = (24.7%) 50-59 (24.2%) Nurses = 34% 27.1% = social worker or dietician 15.5% = office and clerical	IV Mod V: TL Med V: Recognition DV: Well-Being	**TL**: Global Transformational Leadership Scale (Carless, 2000). Seven item scale, Likert. α=.97 **Recognition:** (Kelloway & Barling, 1994). Canadian Forces Occupational Stress Questionnaire. α=.83 **Well-Being**: General Health Questionnaire (Goldberg & Williams, 1988). 12 item Likert scale. α= .90.	Moderated mediated regression	TL: *b* =.49, *SE* = .01, p<.01 Age: *b* = .06, *SE*=.02, *p*=<.01 Position: *b* = .09, *SE*=.01, *p*=<.01 Rcognition: *b* = .16, *SE*=.02, *p*=<.001 TL: *b* = .10, *SE*=.01, *p*=<.001	• Large sample size, well validated tools. • Limitations: Does not study RNs specifically, measures all hospital staff except for MDs. Does not focus on types of recognition. • Little to no risk of harm. • Easily feasible, study TL more on-depth compare to servant style • Level VI evidence, grade B, mod level of certainty
Willingham 2014, Meaningful recognition in a healthy work environment for nurse engagement in a critical care setting	Herzberg Two-Factor Theory (Herzberg, 1987) Motivation vs. Hygiene factors	Descriptive Correlational, cross-sectional	US, SE urban, 500 bed acute hospital. Critical Care 200 RNs, 36% return rate. (email only) N = 74	IV: MR DV1: HWE DV2: Engagement	**NRS - Blegen et. al. (1992) 30 item likert. α = 0.922**	Descriptive (Freq., %, mean, SD)	Growth : (M = 3.55, SD =.65) Written : (M = 3.84, SD =.92) Private : (M = 3.75, SD =..76) Public : (M = 3.83, SD =..73) Schedule : (M = 4.04, SD =.66) Salary : (M = 4.50, SD =.76) Global Recog. : (M = 2.82, SD =.66)	• Limitations: Low sample size. 84 n needed with power analysis, only 74 participated. Single hospital setting. • No risk of harm with implementation. • Level VI evidence, Grade B, low level of certainty.

Appendix A: Continued

			Mean age= 39 F = 90.5% White = 54% A.A = 36.5% Mean yr. exp. = 14.22 BSN = 62.2% Cert = 44.6%	IV: MR DV1: HWE DV2: Engagement	**HWE** - AACN (2014). 18 questions. Likert scale α= 0.80 **UWES – Schaufeli** & Bakker (2003). 9-item likert. α = 0.85-0.92	Inferential: Correlational analysis	MR : (*M* = 3.40, *SD* =.61) Authentic Leadership : (*M* = 3.65, *SD* =.54) Decision making : (*M* = 3.69, *SD* =..56) Vigor : (*M* = 3.88, *SD* =.65) Dedication : (*M* = 4.78, *SD* =.86) Absorption : (*M* = 4.14, *SD* =.98) Global recognition & HWE : *r* (74) = .510, *p* = <.01 Global recognition & engagement : NS HWE & Engagement : NS	• Limitations: Low sample size. 84 *n* needed with power analysis, only 74 participated. Single hospital setting. • No risk of harm with implementation. • Level VI evidence, Grade B, low level of certainty.
Clavelle et al., 2019, Leveraging technology to sustain extraordinary care	None stated	Qualitative-Descriptive, retrospective	Total Daisy nom. N=52711 IPC = N=1,577 Final n = 971 3 hospital: 2 large, 1 small. Non-federal.	IV: None DV: None Concept: Meaningful recognition Themes: 1.Courtesy/Respect 2. Skill & knowledge, 3. Reliability & scheduling, 4. Explanation, 5. Listening	**AI - Language processing** **& machine learning techniques for** **Sentiment classification** **Expert linguistics experts (not a scale but was used to examine data)**	Naïve Bayes approach Maximum Entropy	1.Courtesy/Respect = 64% 2. Skill & knowledge = 10% 3. Reliability & scheduling = 6% 4. Explanation and 5. Listening - % not listed. Total was 20% of remaining.	• Strengths: New research material utilizing AI. Uses human experts to validate and review findings, large sample size. • Limitations: Large sample size, but small number of hospitals. Study did not mention findings from non IPC nominations. • No risk of harm • Easily feasible because UHS utilizes GetWell Networks for Daisy nominations. • Level VI evidence, grade B, moderate level of certainty. *There is no intervention to patients studied, so it is difficult to say not to offer use of this service – All behaviors listed are positive and would not affect patients in a negative way (courtesy and respect).

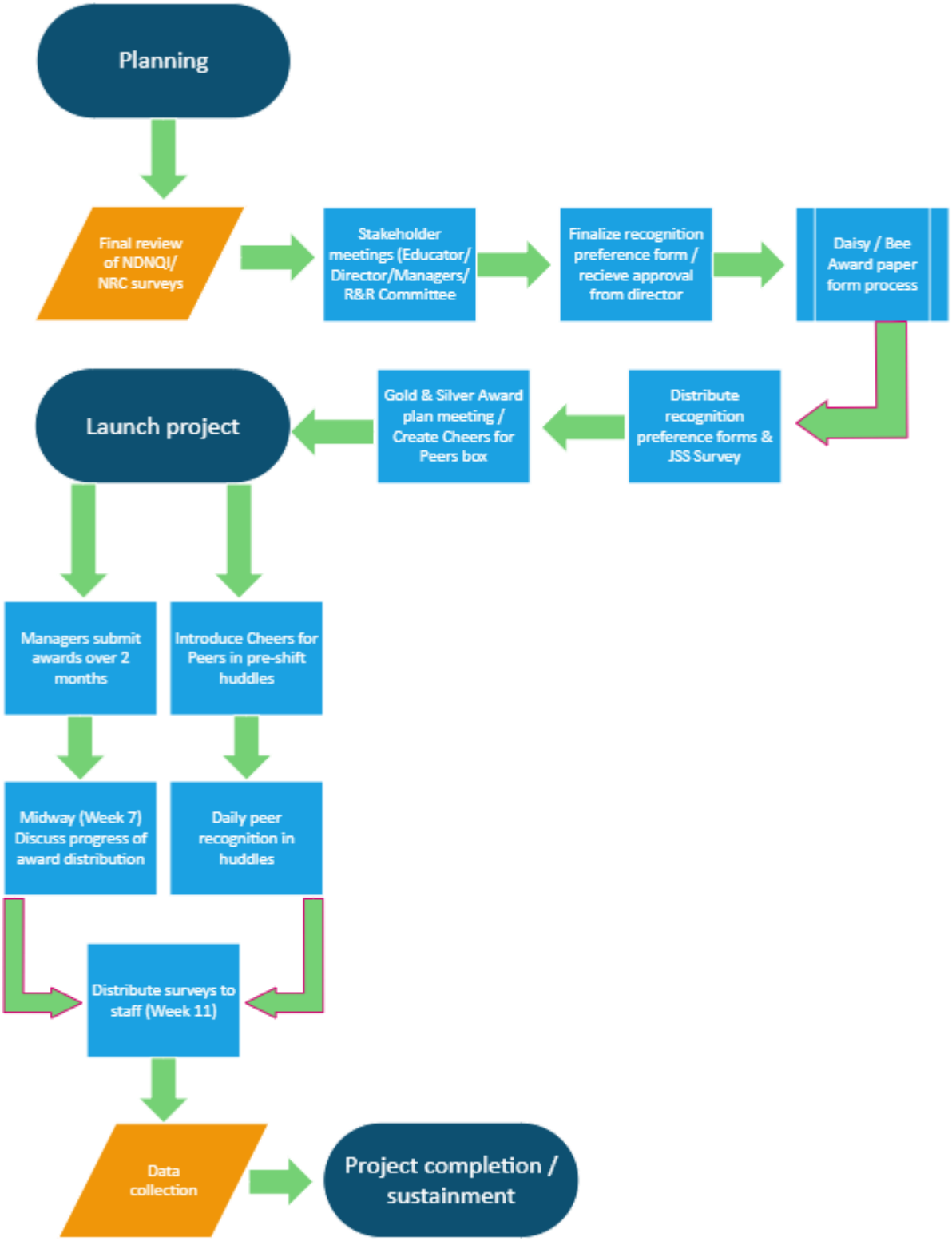
Appendix A: Continued

Seitovirta et al., 2016, Attention to nurses' rewarding – An interview study of registered nurses working in primary and private healthcare in Finland	Total rewards: several authors (Henderson, 2000; Kerr & Slocum, 2005; Armstrong, 2006, 2010)	**Qualitative** – Cross sectional	Finland, Private and Primary care RNs. *N* = 20 F= 18, M= 2.	IV: None DV: None **Concept:** Total Rewards (Meaningful Rewards)	No scales. Questions derived from previous literature findings	No statistics	**Themes:** 1. $ and benefits 2. Work-Life balance 3. Work Content 4. Prof. Develop. 5. **Recognition** 6. Supportive leaders **Consequences:** 1. Guides work of RN 2. Job sat. reinforcement 3. Envy & stress	• New research to different settings other than university settings. Adds different dimension: what can be a negative impact of recognition? • Limitations: Very small sample size. One setting, cannot generalize for all RNs. No causal inference. • Level VI evidence, grade C, low level of certainty. Changes would be easily implemented, no risk of harm.
Nei et al., 2015, Promoting retention of nurses: A meta-analytic examination of causes of nurse turnover	Organizational Theory (March & Simon, 1958). Met expectations theory, expanding on Vroom's Expectancy Theory, (Porter & Steers, 1973) Mobley's Model of Employee Turnover (1977) Hypothesis: Model of turnover - antecedent variables lead to voluntary turnover: Distal→Proximal→Attitudinal reactions→ Turnover	**Meta-analysis of quantitative, descriptive studies**	k = 106 studies examining voluntary turnover of RNs with reported sample size & correlation 13 countries All quantitiatve 1971-2010	54 antecedent variables to predict turnover Distal personal characteristics, role states, job characteristics (recog), group/leader relations, org/environment perceptions Proximal / attitudinal reactions job sat, commitment, involvement. Intrinsic & extrinsic motivation Turnover	Hunter & Schmidt (2004) meta-analytic procedures. Path analysis Effect sizes	Estimate of population correlation corrected for unreliability Path analysis (chi-square, GFI, AGFI, RMSEA)	**Turnover Cognitions:** Job strain: ρ = .36 Role tension: ρ = .23 Job control: ρ = -.24 Recog./rewards: ρ = -.24 **Voluntary Turnover** Leadership: ρ = -.29 Network centrality: ρ = .21 High commitment: ρ = -.20 Four models tested for fit. Partial mediated model D = best fit: χ = 39.68 χ^{2df} = 6 GFI = .997 AGFI = .980 RMSEA = 0.43	• Strengths: Exhaustive search of many studies, correlational, Level V. Many facets of recognition can improve other areas of importance. Ties importance of leadership. • No risk for harm • Grade B, High level of certainty. • Weakness: Only 4 studies focused on recognition, however effect size adequate.

Appendix A: Continued

Lefton, 2012, Strengthening the workforce through meaningful recognition	Meaningful recognition defined by AACN. No specific theory: Mentions feedback, comm. & collab (humanistic)	Qualitative – Cross-sectional	U.S: 20 HCO with DA program. 14 states 3 Phases DA Nom: *N* = 2,195 Honorees: *N* = 42 CNO: *N* = 21	IV: None DV: None Concept: Meaningful recognition	No scales	No stats. Themes ranked. Content analysis of surveys: RN /CNO interviews	22 behavioral themes of nominees 1. Genuine compa & caring 2. Professionalism, 3. Positive attitude 4. Above & beyond [1]Ordinary is extraordinary, [2]Builds Teamwork/Spirit, [3]Motivating, [4]Reaffirms culture/ministry of nursing, [5]Pride/Shock & Awe	• Strengths: Adds personal experiences of RNs who received M.R. which quant. research cannot provide. Large # of surveys, multi-site. Shows connection of M.R. between CNO & RNs. • Limitations: Only HCO with DA programs. No other form of M.R. • Level VI • Grade B, Moderate level of certainty, no risk of harm.
AACN, 2016, AACN Standards for establishing and sustaining healthy work environments (2nd. ed).	None stated	Expert Opinion	No setting. Critical Care focus, but applies to all nursing per AACN	No variables. Established 6 standards for HWE: • Authentic leadership • Skilled comm. • True colab. • MR • Effective Decision-Making • Appropriate staffing	None	None	None Expert Opinion: AACN	• Strengths: AACN seminal publication, 2nd ed. 9-person panel, updated In 2016 with updated research. Aligns with NAM and ANA's Code of Ethics for Nurses. • Limitations: Low level of evidence (Level 7), not a SR or MA. • No risk for harm • Very feasible • Grade B, Moderate level of certainty, no risk of harm.

Appendix B


Planning
Final review of NDNQI/ NRC surveys
Stakeholder meetings (Educator/ Director/Managers/ R&R Committee
Finalize recognition preference form / recieve approval from director
Daisy / Bee Award paper form process
Distribute recognition preference forms & JSS Survey
Gold & Silver Award plan meeting / Create Cheers for Peers box
Launch project
Managers submit awards over 2 months
Introduce Cheers for Peers in pre-shift huddles
Midway (Week 7) Discuss progress of award distribution
Daily peer recognition in huddles
Distribute surveys to staff (Week 11)
Data collection
Project completion / sustainment

Appendix C

	JOB SATISFACTION SURVEY Paul E. Spector Department of Psychology University of South Florida 	
	PLEASE CIRCLE THE ONE NUMBER FOR EACH QUESTION THAT COMES CLOSEST TO REFLECTING YOUR OPINION ABOUT IT.	Disagree very much / Disagree moderately / Disagree slightly / Agree slightly / Agree moderately / Agree very much
1	I feel I am being paid a fair amount for the work I do.	1 2 3 4 5 6
2	There is really too little chance for promotion on my job.	1 2 3 4 5 6
3	My supervisor is quite competent in doing his/her job.	1 2 3 4 5 6
4	I am not satisfied with the benefits I receive.	1 2 3 4 5 6
5	When I do a good job, I receive the recognition for it that I should receive.	1 2 3 4 5 6
6	Many of our rules and procedures make doing a good job difficult.	1 2 3 4 5 6
7	I like the people I work with.	1 2 3 4 5 6
8	I sometimes feel my job is meaningless.	1 2 3 4 5 6
9	Communications seem good within this organization.	1 2 3 4 5 6
10	Raises are too few and far between.	1 2 3 4 5 6
11	Those who do well on the job stand a fair chance of being promoted.	1 2 3 4 5 6
12	My supervisor is unfair to me.	1 2 3 4 5 6
13	The benefits we receive are as good as most other organizations offer.	1 2 3 4 5 6
14	I do not feel that the work I do is appreciated.	1 2 3 4 5 6
15	My efforts to do a good job are seldom blocked by red tape.	1 2 3 4 5 6
16	I find I have to work harder at my job because of the incompetence of people I work with.	1 2 3 4 5 6
17	I like doing the things I do at work.	1 2 3 4 5 6

Appendix C: Continued

18	The goals of this organization are not clear to me.	1 2 3 4 5 6
	PLEASE CIRCLE THE ONE NUMBER FOR EACH QUESTION THAT COMES CLOSEST TO REFLECTING YOUR OPINION ABOUT IT. 	Disagree very much Disagree moderately Disagree slightly Agree slightly Agree moderately Agree very much
19	I feel unappreciated by the organization when I think about what they pay me.	1 2 3 4 5 6
20	People get ahead as fast here as they do in other places.	1 2 3 4 5 6
21	My supervisor shows too little interest in the feelings of subordinates.	1 2 3 4 5 6
22	The benefit package we have is equitable.	1 2 3 4 5 6
23	There are few rewards for those who work here.	1 2 3 4 5 6
24	I have too much to do at work.	1 2 3 4 5 6
25	I enjoy my coworkers.	1 2 3 4 5 6
26	I often feel that I do not know what is going on with the organization.	1 2 3 4 5 6
27	I feel a sense of pride in doing my job.	1 2 3 4 5 6
28	I feel satisfied with my chances for salary increases.	1 2 3 4 5 6
29	There are benefits we do not have which we should have.	1 2 3 4 5 6
30	I like my supervisor.	1 2 3 4 5 6
31	I have too much paperwork.	1 2 3 4 5 6
32	I don't feel my efforts are rewarded the way they should be.	1 2 3 4 5 6
33	I am satisfied with my chances for promotion.	1 2 3 4 5 6
34	There is too much bickering and fighting at work.	1 2 3 4 5 6
35	My job is enjoyable.	1 2 3 4 5 6
36	Work assignments are not fully explained.	1 2 3 4 5 6

Appendix D

Recognition Preference Form

Name **Title**

Birthday (Month & Day only) **Hire Date:**

1. Please share some of your favorite things so that the team may get to know you better.

a) Favorite snack_____

b) Favorite retail store_____

c) Favorite dessert_____

d) Favorite fast food_____

e) Favorite restaurant _____

f) Favorite drink _____

g) Favorite flower _____

h) Favorite sports team _____

i) Hobbies _____

2. Please list your preference of the setting in which you receive recognition. Most preferred is 1, least preferred is 3.

____ Private ____ Small Group ____ Public ____ No preference

3. What would you find meaningful in being recognized for work achievements and/or contributions? (select all that apply).

- ☐ Verbal acknowledgement
- ☐ Lunch/coffee with PCC / Director
- ☐ Other, please describe:
- ☐ Silver / Gold Award
- ☐ Personal note or card
- ☐ Gift Card
- ☐ Daisy/Bee Nomination

4. What are some work achievements and/or contributions you would appreciate being recognized for by your manager or supervisor?

- ☐ Patient experience / Customer care
- ☐ Innovative ideas or processes
- ☐ Taking on extra responsibilities or special projects
- ☐ Other, please describe:
- ☐ Consistent job performance
- ☐ Collaboration or support of a team effort

5. Please provide any additional information you would like us to know.