| RESEARCH ARTICLE

Meaningful Recognition Factors Across Nursing Units Provided by Nurse In-Charge in an Omani Tertiary Hospital

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| ABSTRACT

This study examined preferences for meaningful recognition (MR) among registered nurses (RNs) in a tertiary hospital in Oman, guided by Hezberg's Two-Factor Theory. It aimed to identify the MR factors most valued by RNs and to explore differences in these preferences across clinical units. An exploratory descriptive cross-sectional design was employed using a modified recognition questionnaire. The 24-item instrument assessed four MR factors: verbal feedback, written acknowledgement, growth opportunities, and work scheduling. It demonstrated strong internal consistency (Cronbach's alpha = 0.92). Proportional stratified random sampling recruited RNs from the hospital between 13 and 31 May 2024, yielding 340 responses. Ethical approval was obtained from the Higher Institute of Health Specialties research ethics committee. Results showed strong preferences for verbal feedback and growth opportunities, with consistent preferences across hospital units, indicating that unit-specific demands did not influence recognition preferences. Baseline analyses revealed no statistically significant differences between hospital units. These findings highlight the need for nurse managers to incorporate these preferences into recognition strategies to promote a positive work environment and enhance job satisfaction. Further research should investigate the influence of demographic factors such as age and nationality to provide a more comprehensive understanding of MR preferences among nurses.

1. Introduction

Nursing is a demanding yet vital profession, with nurses serving as the backbone of healthcare systems worldwide (Cherian, 2016). In Oman, registered nurses (RNs) constitute the majority of healthcare professionals, numbering 21,268 (Ministry of Health, 2022). However, the physical and psychological strain associated with healthcare work can adversely affect nurses' well-being (Cherian, 2016).

Recognition is a key element in fostering a healthy working environment (HWE) for nurses. It encompasses acknowledging nurses' actions, performance, and contributions (Lefton, 2012). Meaningful Recognition (MR), one of the six essential HWE standards identified by the American Association of Critical-Care Nurses (AACN), refers to personally significant acknowledgment that aligns with nurses' values and needs (American Association of Critical-Care Nurses [AACN], 2005; Lefton, 2012). Evidence indicates that MR enhances job satisfaction, organisational climate, and patient outcomes, yet it remains frequently misunderstood and overlooked in nursing practice (Salvant et al., 2020; Sweeney, 2021)

Job satisfaction among nurses is closely linked to the recognition behaviours of nurse managers (NMs) (Blake, 2023, Leger et al., 2021). One study identified nurse leaders as the primary source of recognition, followed by colleagues, organisations, patients, and families (Cherian, 2016). How-ever, NMs often rely on personal assumptions rather than evidence-based approaches, highlighting a gap between ideal and actual recognition practices. While several studies have emphasised MR's role in job satisfaction (Al Ahmari et al., 2023; Alahiane et al., 2023 ; Cherian, 2016 ; Salvant et al., 2020). Early work by Blegen et al. and Goode et al. underscored the need for diverse recognition strategies to improve nurse satisfaction (Blegen et al., 1992; Goode & Blegen, 1993).

Between 2010 and 2023, multiple studies have associated MR with the AACN's HWE framework (Cherian, 2016; Lefton, 2012; *AACN, 2005)*. One study reported challenges in implementing MR due to limited resources and knowledge gaps (Cherian, 2016). In Oman, Al Touby found that nurses at the X Hospital and Khoula Hospital were dissatisfied with recognition practices, negatively affecting their job satisfaction (Al Touby, 2012). In response, the Ministry of Health's (MOH) Health Vision 2050 strategy emphasises improving employee engagement through recognition initiatives (Ministry of Health, 2022). However, research exploring nurses' preferred forms of recognition in Oman remains limited, highlighting the need for further investigation.

This study therefore, aims to identify the MR factors most valued by nurses and to examine potential differences in these preferences among nurses working in various units at a tertiary hospital in Oman. The study addresses two research questions: (1) Which factors of recognition do nurses value most? and (2) Do these preferences differ across hospital units within the tertiary hospital? The null hypothesis states that the preferred MR factors provided by NMs are consistent across units, whereas the alternative hypothesis posits that differences exist between units.

2. Materials and Methods

A quantitative approach with an exploratory descriptive cross-sectional design was employed. Data were collected using a modified Recognition Questionnaire (RQ) developed by Blegen et al. (1992). The questionnaire comprised 24 items representing four factors. The target population included RNs employed under MOH at the X Hospital in Muscat, Oman, which has 1,564 nurses across diverse units (Al-Yaqoubi & Arulappan, 2023; Ministry of Health, n.d.). Eligible participants were RNs with more than one year of experience, including both Omani and non-Omani nurses, to capture diverse recognition preferences. Nurses applying for retirement or resignation were excluded to ensure consistent motivation, and those from newly es-tablished units were included to avoid bias linked to unit novelty (Critical Appraisal Skills Programme, n.d.).

Proportional stratified random sampling ensured representation from general nursing, critical care, and critical support sections, each comprising multiple units and wards (Critical Appraisal Skills Programme, n.d.). Proportional allocation across strata was applied, and randomisation was conducted using Microsoft Excel, Version 365 (Microsoft, Redmond, Washington, USA) to minimize selection bias. With a 95% confidence level, 5% margin of error, and a population size of 1,564, the required sample size was calculated as 323; to accommodate non-response, this total was increased by 10%.

Two instruments were used in this study: (a) the RQ and (b) a Demographic Questionnaire (Blegen et al., 1992). Permission to modify and use the RQ was obtained. Both instruments were administered in English, which participants could understand based on their professional and educational requirements. The demographic questionnaire captured age, gender, marital status, nationality, work shifts, unit, qualifications, years of experience, and duration of employment—variables commonly examined in prior research (Bamford et al., 2013; Gaki et al., 2013).

The original RQ was designed to assess nurses' perceptions of recognition by their managers and has demonstrated construct validity through factor analysis and good internal consistency (Cronbach's alpha = 0.64 to 0.89) (Taber, 2017). For this study, the instrument was adapted to the local cultural context and to emphasise manager-specific recognition. Six subject-matter experts assessed the revised tool for clarity and relevance.

Face and content validity were examined for the modified RQ, and rater reliability was evaluated. Data were entered into Microsoft Excel (Microsoft), and the Content Validation Index (CVI) and Face Validation Index (FVI) were calculated following the framework described by Yusoff (2019). The instrument showed high internal consistency (Cronbach's alpha = 0.92 across all four factors) and strong content validity (Scale-level FVI Average [S-FVI/Ave] = 0.9). Item-level CVI exceeded 0.78 for most items, with two items scoring 0.5 and 0.6. Despite these exceptions, overall content validity was considered satisfactory. Rater reliability,

assessed using percent agreement, was 70%. A pilot study was subsequently conducted to refine the instrument and confirm applicability to the target population.

Analyses were performed using the Statistical Package for the Social Sciences (SPSS), Version 25.0 (IBM Corp., Armonk, New York, USA). Categorical variables (gender, marital status, nationality, shift pattern, and unit/ward) were summarised using frequencies and percentages. Qualification was treated as an ordinal variable. Age, years of experience, and tenure in the unit/ward were treated as continuous variables, with distributions described using appropriate measures of central tendency and dispersion; for Likert-type items, response distributions were tabulated, and summary statistics reported as appropriate (Kaur et al., 2018).

For the first research question ("What factors of recognition do nurses value most?"), Likert-scale responses were handled as ordinal categories to respect potential unequal intervals; descriptive summaries were produced, and where informative, means and standard deviation (SD) were also reported to characterise typical values and variability (Kaur et al., 2018).
For the second research question ("Do preferences differ across hospital units?"), inferential analyses compared responses between units. Distributional assumptions were examined using Shapiro-Wilk and Kolmogorov-Smirnov tests (Kaur et al., 2018). As the data were non-normal, non-parametric methods were applied (Built In, n.d.). The Kruskal-Wallis test was used to compare preferences across units, appropriate for ordinal or non-normal continuous outcomes and as a generalisation of the Mann-Whitney U test (Cooksey, 2020). Statistical significance was assessed at $\alpha = 0.05$ (two-sided). A comprehensive data-cleaning workflow (range checks, missingness screening, and duplicate-response checks) was conducted prior to analysis.
External validity was supported through proportional stratified random sampling to ensure fair representation of nursing units; a 10% oversample was used to offset non-response. The cross-sectional design avoided pre- and post-test effects (Hoe & Hoare, 2013). Inter-nal validity was reinforced through the use of an established instrument, expert review, and a pilot study; participants were informed that withdrawal carried no consequences.

Data were collected via a self-administered online questionnaire. The participant information sheet outlined the study purpose, minimal risks, and rights, including the option to withdraw at any time. Follow-up reminders were issued as needed to reach the target sample size (with the planned 10% increase to accommodate non-response). The survey period was 13 to 31 May 2024, yielding 340 responses.

3. 3. Results
3.1. Participant Characteristics
Nearly half of respondents were aged ≥37 years (48.8%); the remaining age groups were 33–36 years (24.4%), 29–32 years (17.9%), and ≤28 years (8.8%; Table 1). The sample was predominantly female. Gender can influence research outcomes by affecting experiences, perspectives, and potential biases within nursing (Gauci et al., 2023). Most nurses were non-Omani (76.5%). Participants represented multiple clinical areas according to the stratified sampling plan (Figure 1).

Table 1. Demographic characteristics of the study participants (N = 340).

		n (%)
Age in yrs.	≤28	30 (8.8)
	29–32	61 (17.9)
	33–36	83 (24.4)
	≥37	166 (48.8)
Gender	Male	19 (5.6)
	Female	321 (94.4)
Marital Status	Single	41 (12.1)
	Married	294 (86.5)
	Divorced	4 (1.2)
	Widowed	1 (0.3)
Nationality	Omani	80 (23.5)

|	Non-Omani	260 (76.5)
Academic Degree	Diploma	167 (49.1)
	Bachelor's degree	148 (43.5)
	Postgraduate in nursing	22 (6.5)
	Other	3 (0.9)
Working experience in yrs.	1–5	52 (15.3)
	6–10	73 (21.5)
	11–15	95 (27.9)
	≥16	120 (35.3)
Name of unit nurse	Medical unit nurse	36 (10.6)
	Surgical unit nurse	40 (11.8)
	Adult critical care unit	52 (15.3)
	Paediatric unit nurse	41 (12.1)
	NICU nurse	36 (10.6)
	Paediatric critical unit nurse	29 (8.5)
	Main OT unit nurse	29 (8.5)
	Maternity unit nurse	77 (22.6)
How long have you worked in the unit?	<1 year	32 (9.4)
	1-5 Years	131 (38.5)
	6-10 Years	63 (18.5)
	11-15 Years	52 (15.3)
	≥16 Years	62 (18.2)
Duty Shift	Daytime (morning only)	15 (4.4)
	Shift Duty (morning, afternoon, night)	325 (95.6)
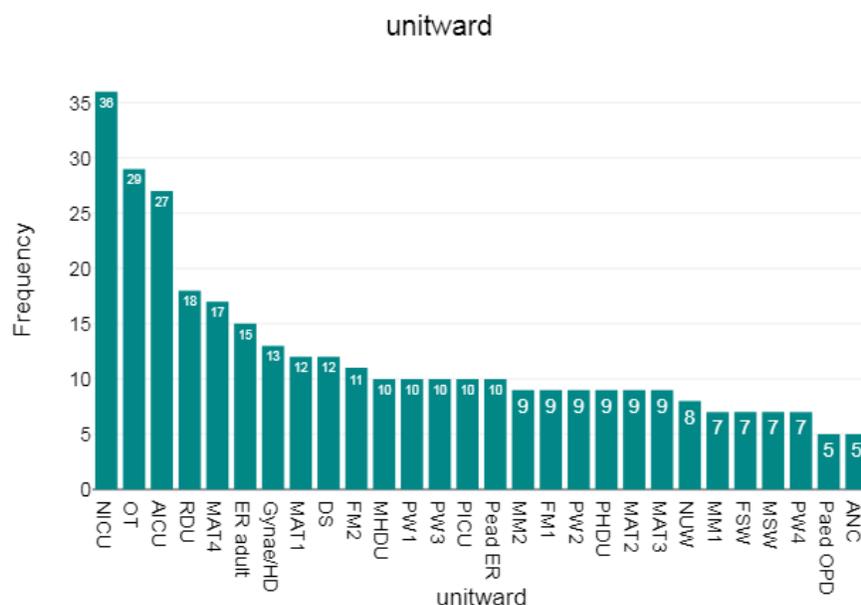
Figure 1. Distribution of participants across hospital units (N = 340).

3.2. Preferences for recognition (descriptive)

The first research question examined which forms of recognition nurses value most. Descriptive results by factor show the highest overall mean for verbal feedback (3.950 ± 0.7568), followed by opportunities for growth and development (mean = 3.858 ± 0.7516; Tables 2 and 3). Scheduling ranked third (mean = 3.721 ± 0.8467), and written acknowledgment ranked fourth (mean = 3.544 ± 0.8838).

Table 2. Descriptive statistics on the staff nurses' preference toward factor 1 (N = 340).

		Mean ± SD
1.	Praise you in private	3.66 ± 1.027
2.	Receive positive feedback for the quality care given in private	3.88 ± 1.046
3.	Receive positive feedback for the quality of care given in the unit in front of your colleagues	4.02 ± 0.968
4.	Congratulate you in front of peers for clinical achievement (For example, engaging in evidence-based practice projects at the unit or institutional level, Engaging in quality improvement programs, ext.	3.95 ± 0.964
5.	Acknowledge your commitment to your profession	4.24 ± 0.926
	Factor (1): Verbal Feedback	3.950 ± 0.7568

Table 3. Ranking forms of recognition (N = 340).

Factor	Mean ± SD	Rank
(1) Verbal Feedback	3.950 ± 0.7568	**1**
(2) Opportunities for growth and development	3.858 ± 0.7516	**2**
(3) Written acknowledgement	3.544 ± 0.8838	**4**
(4) Scheduling	3.721 ± 0.8467	**3**

3.3. Inter-unit differences
Normality testing using K-S and S-W indicated non-normal distributions (K-S = 0.060, P = 0.006; S-W = 0.980, P <0.001). Consequently, non-parametric tests were applied. For Factor 1 (verbal feedback), the Kruskal-Wallis test across 28 units was not significant (H = 35.907, df = 27, P = 0.117; Table 4). Visual inspection showed broadly similar central tendencies and spreads across units, with no substantive outliers driving the null result (Figure 2).

Table 4. Differences in staff nurses' preference toward all factors of recognition for 28 wards/units (N = 340).

	Frequency	Mean ± SD	SE	95% CI	Minimum	Maximum
MM1	7	4.127 ± 0.5764	0.2178	3.594–4.660	3.2	4.6
MM2	9	3.757 ± 0.7541	0.2514	3.177–4.337	2.5	4.7
FM1	9	3.76 ± 0.3864	0.1288	3.463–4.057	3.0	4.2
FM2	11	4.009 ± 0.601	0.1812	3.605–4.413	3.1	5.0
FSW	7	3.934 ± 0.8871	0.3353	3.114–4.754	3.0	5.0
MSW	7	4.239 ± 0.3769	0.1425	3.891–4.588	3.8	4.9
NUW	8	3.944 ± 0.6414	0.2268	3.408–4.480	2.8	4.8
RDU	18	3.843 ± 0.6188	0.1459	3.535–4.151	2.9	5.0
AICU	27	3.676 ± 0.8167	0.1572	3.353–3.999	1.7	5.0
MHDU	10	3.804 ± 0.8099	0.2561	3.224–4.383	2.3	4.7
ER adult	15	3.626 ± 0.8813	0.2276	3.138–4.114	2.2	4.7
PW1	10	3.353 ± 0.6889	0.2178	2.860–3.845	1.9	4.4
PW2	9	3.961 ± 0.6126	0.2042	3.490–4.432	2.9	5.0
PW3	10	3.556 ± 0.9061	0.2865	2.908–4.204	1.7	4.9
PW4	7	3.943 ± 0.516	0.1950	3.466–4.420	3.4	4.6
Paed OPD	5	3.000 ± 0.2269	0.1015	2.718–3.282	2.7	3.3
NICU	36	3.893 ± 0.5964	0.0994	3.691–4.095	2.6	5.0
PICU	10	3.979 ± 0.672	0.2125	3.498–4.459	2.8	4.8
PHDU	9	3.86 ± 0.7159	0.2386	3.309–4.410	2.8	4.8
Pead ER	10	3.738 ± 0.6916	0.2187	3.243–4.232	3.0	4.8
OT	29	3.766 ± 0.6106	0.1134	3.534–3.999	2.0	4.9
MAT1	12	3.625 ± 0.6452	0.1863	3.215–4.035	2.5	4.8
MAT2	9	3.537 ± 0.8925	0.2975	2.851–4.224	1.5	4.4
MAT3	9	3.608 ± 0.6551	0.2184	3.105–4.112	2.5	4.6
MAT4	17	3.74 ± 0.5037	0.1222	3.481–3.999	2.3	4.6
Gynae/HD	13	3.688 ± 0.6041	0.1676	3.323–4.054	3.0	4.9
DS	12	3.881 ± 0.6014	0.1736	3.499–4.263	3.0	5.0
ANC	5	3.285 ± 0.8653	0.3870	2.211–4.359	2.6	4.8

Total	340	3.768 ± 0.677	0.0367	3.696–3.840	1.5	5.0

4. Discussion

The concept of MR has gained prominence as organisations seek to improve job quality, retention, and the experiential meaning of work among nurses. Recognition is consistently associated with a positive work environment, higher retention, and better job satisfaction (Al Ahmari et al., 2023 ; Joseph et al., 2023 ; Salvant et al., 2020; Seitovirta et al., 2016). Empowerment is another reinforcing pathway, linked to greater accountability, autonomy, critical thinking, and communication among staff nurses (Van Bogaert et al., 2015). When nurses feel appreciated by leadership, engagement increases with downstream benefits for care quality and safety (Leger et al., 2021).

There remains limited literature—particularly since 2016—examining which spe-cific forms of recognition nurses prefer. The present study addressed this gap using a modified version of the RQ originally developed by Blegen et al. (1992), which has been used in contemporary work examining recognition and nurse outcomes (Salvant et al., 2020; Sweeney & Wiseman, 2023). The original instrument encompassed six factors (growth opportunities, written and verbal recognition, public acknowledgement, working scheduling, and salary). To align with the study's objective of identifying manager-controllable recognition, the revised tool focused on four factors—growth opportunities, written recognition, verbal recognition, and work scheduling—excluding public acknowledgement and salary, which typically fall outside NMs' direct remit. This emphasis reflects evidence that leadership practices shape which forms of recognition are valued and operationalised within teams and are central to cultivating a HWE (Alahiane et al., 2023 ; Joseph et al., 2023; Leger et al., 2021; Salvant et al., 2020).

4.1. Demographic Context

Demographic variables are important to consider in the context of the research, as they provide valuable context and potential confounding factors (Wunsch, 2007). Although demographics were not primary outcomes, they contextualise the findings and may confound associations between unit context and preferences for recognition. The sample included a sizeable proportion of older nurses (≥37 years), suggesting an experienced workforce. Prior research indicates generational patterns in recognition, with older cohorts (>35 years) rating several recognition forms more highly than younger (≤35 years) groups, who may emphasise extrinsic rewards to support work-life balance (Joseph et al., 2023; Salvant et al., 2020). Consistent with regional and international trends, the workforce was predominantly female, a distribution that can shape experiences and perceptions relevant to recognition (Alahiane et al., 2023; Gauci et al., 2023; Krishnamoorthy et al., 2020). Krishnamoorthy et al. conducted a cross-sectional study and found that work environments and manageable workloads highly influence nurses' intentions to stay (2020). The high proportion of non-Omani nurses in the sample underscores the salience of cultural and social factors for recognition practices and their reception in daily work (Mensah, 2019). Finally, the study's breadth—covering 28 units across med-ical, surgical, critical care, paediatrics, and maternity—extends a literature that often focuses on single specialities (e.g., intensive care, trauma, or inpatient surgery) and strengthens the relevance of the findings across diverse clinical areas (Cherian, 2016 ; Kelly & Lefton, 2017; Leger et al., 2021; Salvant et al., 2020).

4.2. Research Question One: Value of recognition by factor

Empirical work directly identifying which forms of recognition nurses value most remains limited, highlighting the need for context-specific evidence. Our findings show clear heterogeneity in how nurses perceive and respond to recognition, reinforcing that MR is highly individual and shaped by team environment and local context (Leger et al., 2021). In the current study, verbal feedback emerged as the most valued factor, followed by opportunities for growth and development. The latter contrasts with Salvant et al., who ranked growth and development lowest, and diverges from Cherian, yet aligns with reports emphasising personalised acknowledgement and career development as central to perceived recognition (Cherian, 2016; Leger et al., 2021; Salvant et al., 2020). The close ranking between verbal feedback and growth/development suggests that nurses prioritise day-to-day appreciation alongside opportunities that enhance competence and career progression, both of which contribute meaningfully to motivation and job satisfaction (Mcleod, n.d.; Sweeney & Wiseman, 2023).

Scheduling ranked third, indicating that recognition of staff scheduling needs (e.g., fair allocation of shifts, consideration of preferences) is valued but secondary to inter-personal and developmental forms of recognition. In line with established motivation theory, such contextual conditions may not strongly motivate when present, yet their absence is dissatisfying [36]. Finally, written acknowledgement ranked fourth, contrasting with Salvant et al. (second-highest) but consistent with qualitative findings reporting it as least preferred; variation in implementation quality may partly explain this discrepancy, as head-nurse practice regarding written acknowledgement is often suboptimal before training (Allam et al., 2021; Cherian, 2016; Salvant et al., 2020). Together, these results highlight that recognition perceived as personal, proximate, and developmental carries more weight than purely documentary or logistical forms (Table 3).

4.3. Research Question One: value of recognition by form

Across the 24 item-level forms, most (20) showed elevated ratings across the sam-ple indicating broad endorsement of the recognition content assessed. Within factor 1 (verbal recognition), the highest-ranked item was acknowledgment of commitment to the profession, followed by positive feedback in front of colleagues, and congratulating nurses for clinical achievements; private feedback on quality of care and private praise ranked fourth and fifth, respectively. These patterns highlight a preference for verbal expressions that affirm dedication and visible contributions while still valuing private, relationship-centred feedback (Table 2). Such preferences cohere with evidence on the importance of affirmation in professional identity and may reflect cultural norms that shape comfort with public versus private recognition (Adamovic, 2023; Karaferis et al., 2022).

4.4. Research Question Two: hypothesis

Evidence comparing preferred forms of MR across multiple clinical units is scarce, as most studies examine single specialties or settings. Addressing this gap, the present study used proportional stratified random sampling across 28 units/wards and tested between-unit differences with Kruskal-Wallis test. Findings indicated no significant differences in nurses' preferences either for factor 1 (verbal feedback; $P = 0.117$) or across all four factors combined ($P = 0.403$). Therefore, preferences were broadly consistent irrespective of clinical area.

These results align with work suggesting that the perceived value of recognition depends more on relational and developmental qualities than on unit-specific demands (Leger et al., 2021). They also complement observations from multi-site work on MR programme effects, where outcomes have sometimes appeared similar across environments despite structural variation (Kelly & Lefton, 2017). A practical implication is that hospital-wide recognition initiatives prioritising timely verbal feedback and growth/development opportunities are likely to be well received across units; local tailoring can then address scheduling constraints or documentation practices without altering the core emphasis on interpersonal and developmental recognition. Two caveats merit note. First, the absence of significant differences may reflect genuinely similar preferences, and/or limited between-unit effect sizes; reporting an effect-size metric would clarify this point in future work. Second, while the instrument focused on manager-controllable forms (verbal, written, growth/development, sched-uling), preferences for excluded domains (e.g., public acknowledgement, salary) could still vary by unit context; these were intentionally out of scope for this study but remain relevant for comprehensive recognition strategies.

5. Conclusions

This study shows that nurses in Oman most value verbal feedback and opportunities for growth and development, with scheduling and written acknowledgement rated lower. Preferences did not differ significantly across clinical units, suggesting that core MR needs are largely shared. These findings support implementing organisation-wide recognition programmes led by nurse managers that emphasise timely, specific verbal appreciation and accessible career development, supplemented by fair scheduling practices and consistent written acknowledgement. Future research should quantify effect sizes for between-unit comparisons, examine demographic moderators, and evaluate implementation fidelity to determine how delivery quality influences the reception and impact of MR.

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