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Caring Beyond Constraint: A Nursing Model of Presence in a Time Limited Procedural Practice

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Caring Beyond Constraint: A Nursing Model of Presence in a Time Limited Procedural Practice

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This is to certify that **Laura Becker** has successfully defended her Graduate Project entitled **"Caring beyond constraint: A nursing model of presence in a time limited procedural practice"** and fulfilled the requirements for the Master of Arts in Nursing degree.

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Abstract

The purpose of this paper is to support the value of maintaining presence within a time limited procedural practice. Specifically, it presents the significance of a nursing presence model based on Jean Watson's human caring theory within an outpatient procedural endoscopy unit which has high patient volumes and time limited processes. It describes the process for developing a care model of nursing presence and methods used to integrate this model into practice. It also includes an evaluation of the methods to determine themes and make comparisons to determine effectiveness of theory integration into nursing practice.

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Chapter One: Introduction

Background

"Caring is the essence of nursing and the most central and unifying focus for nursing practice" (Watson, 1985, p. 33). Many healthcare organizations still support this core identity of nurses by ascribing to Jean Watson's theory of transpersonal caring as the supporting philosophy of their various nursing care models. One such institution is a large Midwest tertiary healthcare facility. Within this model is the nursing role of caring healer with multiple modalities identified including utilizing an "intentional therapeutic presence" and exploring "the meaning of illness within the context of the patient's life" (Mayo Foundation for Medical Education and Research, 2006, para. 2).

While these are very logical and appropriate modalities in caring, the challenge lies in implementing them in an outpatient gastrointestinal endoscopic procedural practice within a large tertiary healthcare facility where literally "moments" of caring are all that exist between a nurse and patient. The current nursing practice functions within an environment comparable to an assembly line that must function efficiently to accommodate the approximately 100 patients per day for diagnostic endoscopic procedures. As with any business, the focus is on standardization to improve efficiency and to conserve valuable resources. To maintain the large volumes of patients, time is one of those valuable resources that, if inadequate, contributes to poor quality care and in excess contributes to the high cost of care (Aiken, 2008; Storfjell, Omoike, & Ohlsom, 2008).

Patient Flow and Timestamping Process

In a large practice such as this, the care model is very task and skill oriented much like functional nursing models of the past. In fact, each task is "timestamped" within a database as the patient moves through this assembly line process. A *timestamp*, is a device for recording the date and time of day that letters or papers are received or sent out. Other sources define timestamping in more recent terms as it is now a more common form of jargon used for documenting a variety of events including those measured in efficiency studies:

> "A sequence of characters, denoting the date and/or time at which a certain event occurred. This data is usually presented in a consistent format, allowing for easy comparison of two different records and tracking progress over time; the practice of recording timestamps in a consistent manner along with the actual data is called time stamping" (Timestamp, n.d.).

The process a patient follows for an endoscopy procedure illustrates the focus on timestamping. For example, the patient reports to the reception desk and the receptionist documents a timestamp into the database. The patient is asked to take a seat while waiting to be called for the procedure. Once called for the procedure, the patient is taken into a room to be interviewed by a nurse, who again documents a timestamp into the database. At the onset of the interview, the nurse introduces himself or herself to the patient and explains about asking questions related to the patient's health that will help determine if the person is prepared for the procedure. The goal is to complete this interview as quickly and accurately as possible while entering the information into a

computer. At the end of the interview, another timestamp is entered and the patient is moved to another room to wait for the procedure.

Once the patient is taken to this separate room to wait, he or she is given a gown, robe and bag for belongings. The patient is instructed to use the bathroom, change into the gown, and sit down with the other patients in their respective male or female waiting room until another nurse comes to escort him or her to a procedure room. When the patient is escorted to the procedure room, a different nurse greets the patient, helps the patient onto a cart, and documents another timestamp indicating the patient is in the procedure room.

Also, while the patient is in the procedure room, the nurses are connecting the monitoring equipment to the patient, documenting on the computer, and arranging other equipment for the procedure, they will dialogue with the patient regarding what to expect during the procedure and who the physician will be. This process may take 15 minutes, and then the nurse turns a light on alerting the physician the patient is prepared for the procedure. It is at this point another time stamp is entered. The physician speaks briefly with the patient prior to beginning to sedate the patient. Once the sedation is appropriate, the endoscope is inserted into the patient. At this point, the nurse documents another timestamp. This process of moving from one station to the next with timestamping occurring at various points continues all through the procedure and recovery through discharge.

Patient Perspective

To understand the patient perspective in this process it is necessary to understand what makes up a gastrointestinal endoscopic procedure. According to Cotton and Williams (as cited in Ylinen, Vehvilainen-Julkunen & Pietil, (2009),

> Endoscopy is a procedure to diagnose and treat diseases of the colon and/or esophagus, stomach and small bowel. It provides a visual diagnosis and gives the opportunity for biopsy or removal of lesions. Patients may consider the procedure painful when the scope is inserted and the bowel is widened with air. (p. 1937)

The patient may feel the cold gel on the end of the colonoscope as it is passed into the rectum in the case of a colonoscopy or the gagging reflex in the case of an endoscopic gastro duodenoscopy. The patient may feel some discomfort as the scope pushes through the various turns of the colon. Sometimes this process is aided by the nurse applying pressure to the patient's abdomen.

As the patient passes from one point to the next, many focused questions are asked and assessments are made related to their health history, medications, labs, and preparation for the procedure. They also receive teaching regarding what to expect and how to care for themselves after the procedure. Often they will ask further questions related to their individual health situation, need further assessment through labs, or have difficulty with intravenous placement. This process is a challenge to the nurse as these issues need to be addressed and take more than the allotted amount of time. This will result in a delay in the assembly line, cause production to slow down, and potentially cause everyone along the assembly line to wait. This is non-productive time for workers further down the line but very productive time for the careful, caring nurse. Also, like an

assembly line, the patient is handed off from caregiver to caregiver along the way only experiencing from a few moments to an hour of time with each.

It is here, within this time limited environment that the challenge lies to improve the ability of nurses to provide care. It is here that the concept of presence within Watson's caring theory is critical to understand and apply.

Purpose of the Project

The purpose of this project is to develop a model of nursing care for use in a time-limited outpatient procedural practice. This model will be based on the concept of presence within Watson's theory of transpersonal care with her theory providing the foundation for this model. According to Watson (2008), " Caring begins with being present, open to compassion, mercy, gentleness, loving-kindness, and equanimity toward and with self before one can offer compassionate caring to others" (p. xviii). Therefore, it will focus on the nursing art of presence for nurses and their patients as a means to practice caritas in this procedural practice. Caritas, as Watson (2008) defined , "comes from the Latin work meaning to cherish, to appreciate, to give special, if not loving, attention to" (p. 39). It symbolizes giving of oneself freely, compassionately and generously. As compared to the term *Carative* from her original work, Caritas connects love to caring and therefore setting the stage for deep transpersonal caring. This model will also be filtered through the model of nursing care to which this large Midwestern tertiary care center ascribes. Presence within this model is appropriately embedded within the principle of relationship-centered care and the nurse's role of caring healer. As caring healer, the nurse's responsibilities are to "initiate and establish patient-centered relationships, use intentional therapeutic presence in patient care, know and share the

patient story, be culturally competent in individualizing care and be knowledgeable in the scientific basis of nursing" (Mayo Foundation for Medical Education and Research, 2006, para. 2). Understanding of Watson's Caring Theory's concept of presence will improve caring skills and behaviors of nurses when time is limited as is common within this procedural practice.

Historically, caring in nursing has been addressed and supported within the acute care inpatient settings but continues to need support and exploration within an ever increasing outpatient healthcare environment. Research shows that nurses who are not able to practice within a caring context are "hardened, oblivious, robot-like, frightened and worn down" (Swanson, 1999, p.361). Through integration of Watson's transpersonal caring theory within the outpatient endoscopy procedural practice, balance can be maintained between the mechanistic assembly, time limited process and the nursing processes to provide care, maintain safety, comfort and dignity of each patient. This nursing model, grounded in recognizing caring moments and being able to establish presence with patients, validates that caring does and can occur in spite of the brief amount of time allotted for patient interactions. In addition, this model has the potential to eliminate the nurse's perception that time is a constraint, since caring can truly occur in just moments. Presence continues to receive increased attention as a way of being, which can foster a therapeutic relationship between the patient and caregiver. According to Pettigrew, "presence does not require more time, rather it is a willingness to focus on really being there and being involved with another" (as cited by Melnchenko, 2003, p. 19). As Watson's colleague Dr. Marline Smith (1994) stated, "we have tension between

dominant scientific paradigms of what has been, in contrast with a vision that is open to what is possible" (Watson, 2005, p. xiii).

Conceptual framework

To continue to develop and advance nursing as a profession, it is imperative for nurses to broaden their understanding of theories and science that guide nursing scholarship. Watson's theory of transpersonal caring acknowledges the balance of science and humanities and seeks to integrate the two. It recognizes how the humanities "address themselves to deeper values of the quality of living and dying, which involve philosophical, ethical, psychosocial, and moral issues" (Watson, 2005, p. 2).

According to J.A. Cohen (1991), Watson's caring science model has "broad applicability" (p. 908) as it is derived from many disciplines. It addresses the core of nursing, the therapeutic nurse-patient relationship, rather than what is considered the trim of nursing such as procedures, tasks and techniques.

The mandate to use caring theory to guide practice is supported by multiple factors. First, the department of nursing in this healthcare facility ascribes to a model of nursing care based on Watson's theory of transpersonal caring. This theory and model has initially received support and integration in the in-patient setting where a stronger department of nursing's influence and representation exist. The principles and roles of this model are outlined as follows:

1) Relationship-centered practice is the role of caring healer
2) Accountability is the role of problem solver
3) Continuity is the role of navigator
4) Empowerment is the role of teacher

5) Synergy is the role of pivotal communicator
6) Safety is the role of vigilant guardian
7) Professional development is the role of transformational leader (Mayo Foundation for Medical Education and Research, 2006, pp. 1-4).

While in-patient nursing practice has long been grounded in the caring model of care, it is now time to promote a strong presence of this model in the outpatient setting, specifically the principle of relationship-centered nursing practice as this is the role of the caring healer that embodies the use of intentional therapeutic presence in patient care.

Second, grounding one's practice in nursing theory can help refocus nursing care on the humanistic and holistic care practice rather than the predominantly medical focus in health care that is traditionally practiced. Third, caring provides positive outcomes for patients and nurses. Isminger (2009) stated "caring nursing behaviors are directly related to patient satisfaction (p. 456). The benefits of recipients to caring and presence are an improvement to mental and physical well being. According to Swanson, (as cited by Watson, 2005) "in spite of the scientific facts and evidence that nursing care and caring are crucial variables that make a positive difference in patients' (and nurses') outcomes of health and well-being, nursing continues to be invisible" (p. 361).

Understanding Watson's theory of transpersonal caring holds implications for nurse leaders as they are "responsible for implementing the vision, mission, and values of the department for which they work as well as promote efficient, effective, safe, and compassionate nursing care" (Carter, 2008, p. 4). Some of the implications include promoting an environment that supports and values caring science and behaviors,

developing a self awareness of one's own caring behaviors, developing and modeling those behaviors, and implementing the model into practice.

The adaptation of this model of care to the outpatient setting highlights the necessity for a theory and research based practice. "Ultimately, the ability to resolve conflicts between what nursing is and what nurses do, may be the cutting-edge difference which dictates the discipline and profession's existence and survival into this new millennium" (Foster & Watson, 2003, p. 361).

In maintaining caring as the core of nursing, it is imperative that nursing remains visible and helps define what caring is and the value it brings to healthcare. It is also imperative that nursing defines itself as the professional experts in caring as it relates to health and well-being. This can be accomplished through the integration of a nursing care model based on the transpersonal caring theory of Jean Watson. Literature supports caring as improving patient outcomes, a primary goal of health care and the organizations that provide it. With the increased focus on day surgeries and procedures, numbers, and efficiency with limited time allotted, the aspect of presence is particularly of interest as it allows for a more holistic approach across the continuum of care from inpatient to outpatient practice in a timeless manner. With a trend toward shorter interactions with patients, literature supports the timelessness of presence and a way of being that would benefit modern healthcare trends and environments. Another challenge lies in developing a nursing model of care that is applicable to current and anticipated future healthcare environments and that complements the needs of the organization, providers, recipients and payers.

Chapter Two: Literature Review

Review of the literature reveals increasing trends in caring science based nursing research, practice models, and nursing program curriculum. Literature searches were conducted from Academic Search Premier, CINAHL and Ovid MEDLINE database, which had ample information and studies on multiple components of caring. This search was narrowed using peer reviewed journals to specify the concept of presence within nursing care models.

Conceptual Framework

Watson's theory of transpersonal caring provides the conceptual framework upon which nursing care models may be built, updated, and evolve. Her work is one of the most flexible and timeless of theories as it has the ability to evolve and be applicable to changing healthcare patterns. Watson's theory of transpersonal caring is a model of caring science that allows nurses to approach the sacred in their healing-caring work. It is a personal journey into understanding deep caring and how this learning guides others into new perspectives on life and caring healing work. The concepts within this theory have been referred to as the core for professional health-healing practices and are considered timeless and able to evolve with new knowledge, skills and technology. This has allowed them "to convey a deep form of transpersonal caring and love as part of a caring-healing perspective guiding Caring Science" (Watson, 2005, p. 3).

Ten tenets of transpersonal caring were developed by Watson and are some of the basic concepts that are related to her caring science model. Of these ten tenets, the following three embody the concepts of presence and intentionality:

- A transpersonal caring relationship connotes a spirit-to-spirit unitary connection within a caring moment, honoring the embodied spirit of both practitioner and patient within a unitary field of consciousness;
- A transpersonal caring relationship transcends the ego level of both practitioner and patient, creating a caring field with new possibilities for how to be in the moment.
- Transpersonal caring is communicated via the practitioner's energetic patterns of consciousness, intentionality, and authentic presence in a caring relationship. (Watson, 2005, p. 6)

The concepts of presence and caring have been used interchangeably within the nursing literature as is evident in the following review of literature. It is apparent that caring and presence are very important to the essence of nursing and have been studied extensively. The concept of presence has varying yet similar definitions, prerequisites, requirements, characteristics and outcomes.

In an effort to decrease confusion between the concepts of caring and presence, Finfgeld-Connett (2008), a nurse educator from the University of Missouri, conducted a qualitative comparison study. Her study demonstrated many similarities between nursing care and presence but few differences. The similarities between these two concepts include intention, expert nursing practice and interpersonal relationship between the nurse and recipient of care, improved mental and physical well-being for the recipients, improved mental well-being among nurses; and recipient's need and willingness for presence and a nurse's willingness to be present. Finfgeld-Connet's findings also recognized that both concepts require an infrastructure of personal and professional

presence. She concluded that caring and presence are synonymous and should be further studied and delineated to provide greater clarity within nursing language and therefore improved practice, research and theory.

Whereas other literature describes presence as a way of being, Finfgeld-Connet (2008) described is as an enactment. This seems similar to the references of presence as a therapeutic use of self that Pettigrew (1990) criticized as devoid of actual self-giving. This author supports presence in its truest form as a way of being that supports a more authentic, intersubjective experience rather than motions taken towards a person as an object. This form of presence allows personal transformation to occur. for the persons involved.

Zyblock (2010) pointed out that nursing presence has been a component of care since the documented practices of Florence Nightingale during the Crimean War when she would stay in the hospital wards at night with the wounded soldiers. According to Pettigrew (1990), "it is not uncommon for one who is suffering to desire the presence of someone who is willing to be with him in the midst of wrestling" (p. 503). Although Pettigrew was addressing the intensive care environment, this may also describe the patient anxiously awaiting an endoscopy procedure. She described the patient's request for someone to "just be there" as very humbling for those prepared in technical and procedural skills and disconcerting when one is working in an environment that is short-staffed and time constrained. Pettigrew (1990) synthesized five distinguishing features of presence:

> Self-giving to the other person at the moment at hand, being available and at the disposal of the other person with all of self for that period of time, listening with a

> tangible awareness of the privilege one has in being allowed to participate in such an experience as well as in a way that involves giving of one's self, and finally being there in a way that the other person defines as meaningful. (p. 503)

Pettigrew holds that no previous relationship between the nurse and patient is required in order for an encounter of presence to occur. According to Paterson and Zederad (1976), "presence is revealed directly and unmistakably in a glance, a touch, a tone of voice" (p. 30). Pettigrew also spoke to presence enduring long after the encounter. In this example, patients who experience comfort and security through presence during endoscopy experience will less hesitantly return for future endoscopy experiences. Presence does not require large chunks of time. "On the contrary, presencing can occur in passing in a hallway or on a stairwell, through a glance or a brief hug. The emphasis in not on time but, instead, is focused on really being there when you are there" (Pettigrew, 1990, p. 504).

Pettigrew (1990) also supported the outcomes of presence which include "increased coping strength" (p. 504), a "sense of well-being" according to Paterson and Zderad (as cited by Pettigrew, 1990, p.504), and a "sense of caring and being heard" (p. 504) with a lessening sense of vulnerability.

Pettigrew (1990) identified critical components of presence. First is vulnerability and silence, which is the ability of the nurse to endure the patient's feelings of discomfort, anxiety, and awkwardness while exposing one's own humanness and offer comfort. The ability to endure awkward silences and resist trying to give pat answers allows the nurse to experience the pain and discomfort of the patient. It does not allow one to "hide behind the façade of professionalism or the technologies or traditions of her

role" (p. 505). The second component is invitation and privilege meaning that "presence is always a privilege for a nurse, never a right" (p. 505). Presence can only be requested or offered from another. The third component is spiritual needs of the patient, which the nurse can minister to by just being there. It does not take the place of trained spiritual guidance such as a chaplain, however. Finally, Pettigrew identified the ethical implications of presence: beneficence, non-malfeasance fidelity, and autonomy.

Iseminger, Levitt, and Kirk (2009) recognized the imbalance between the art and science of nursing and attributed the imbalance to "undervaluing emotional and spiritual care" (p. 448). However, nurses being present allow them to know the needs of their patients and therefore more efficiently meet the holistic needs of the patients. Iseminger et al. (2009) supported the outcomes of improved personal and professional satisfaction.

Through her human becoming theory, Parse (1992) defined presence as a way of being with people to experience their lived experiences from their perspective. It involves the intention and will to be present, requires the knowledge of the human becoming theory and choosing to live out its values, beliefs and principles with others, and also requires "attentiveness to the moment by centering of self and a focusing on the other" (Melnechenko, 2003, p. 20). It supports the patient centered model of care as it recognizes and supports the person as the authority on knowing their own personal way.

Mitchell (2010) senior lecturer, Faculty of Health and Social Care, University of Sanford validated that the international healthcare community in day surgery experiences similar environments as described in the procedural endoscopy environment described in this paper, one that has a physiological focus with short patient stays. Day procedures and surgeries are here to stay due to the economic benefits of quality, efficiency, and patient

benefits of rapid recovery and shorter stays. These changes have and will continue to require nursing practice to change as well.

Nursing roles in endoscopy have continued to evolve as a means to assure patient safety and efficient procedural practices and workflow. However, similar to nursing practice in day surgery, it lacks an evidence-based approach, which threatens the art of caring in nursing within the modern procedural environments. Without an evidence base, caring will not be visible, and will be determined only by procedural skills and efficient workflow with the procedural schedule becoming the focal point of all operational decisions (Mitchell, 2010). "The importance of a patient-centered approach to modern surgical nursing care may therefore become lost (Flanagan, 2009, as cited by Mitchell, 2010, p. 41), "even though interaction with the nurse is often a key factor in patient satisfaction levels" (Mottram, 2009, as cited by Mitchell, 2010, p. 41).

Within the endoscopy practice, patients require intervention over a shorter period of time for pain, anxiety, nausea, patient falls assessment and intervention as well as coordination of transportation. Within his work Mitchell provided some practical examples of therapeutic use of self through interventions including social support, optimism enhancement, and cognitive coping strategies. Of interest is the social support intervention where "the close physical presence of the nurse may be one of the most effective methods of managing pre-operative anxiety" (Mitchell, 2010, p. 42).

Jost, Bonnell, Chacko, Suma and Parkinson (2010) addressed care delivery models in their writing. They acknowledged the abstract nature of models but indicated they are evolving and reality- based and help in defining other ways of practicing. Care models supporting relationship-based care also are associated with professional nurse

satisfaction, autonomy, and quality outcomes. They describe how the conceptual model within the University of Pennsylvania Hospital was actualized as a patient care delivery model that supported nurses in their role of caring healer. It was an integrated model of primary nursing and relationship based care. "Care has already become much more dependent on solid hand-offs, skilled communication, plans of care, and interdisciplinary relationships that bridge across multiple setting and care episodes" (Jost et al., 2010, p. 4). Care is dependent upon nurses' ability to adapt existing or new care models to changing care environments such as time- limited procedural, operating room, or emergency department settings (Jost et al., 2010). Nurses within these areas need to know that the traditional model of primary nursing is not necessary in order to provide the necessary care and still provide job satisfaction.

A Nursing care model based on the concept of presence can be achievable in the endoscopy setting and lead to a higher nurse satisfaction. Nurses in that area will be able to meet the model's expectations, which are the core of nursing. An example would be the adaptation of a relationship based model of care within the University of Pennsylvania Hospital. "Despite the multiple levels of care, short stays and complexities in care, whether the RNs realized it or not, they had developed knowledgeable relationships with their patients" (Jost et al., 2010, p. 5). Similarly, this model helps redefine and reframe nursing presence and expectations of care delivery in the time-limited procedural practice.

A comparison of individual studies by Doona, Chase and Haggerty (1999) on nursing judgment revealed phenomena determined to be consistent with the attributes of presence. In fact, nursing judgment could not occur without nursing presence. The

following six features of nursing presence were identified: "uniqueness, connecting with the patient's experience, sensing, going beyond the scientific data, knowing, and being with the patient" (p. 55).

To further understand these features of presence as identified by Doona et al. (1999), a brief review of each follows. First, uniqueness encompasses the nurse, patient, and moment in time and captures the intersubjectivity. At this moment, the nurse decides to participate in the uncertainty of the patient's experience. The nurse must encounter each patient as a unique person and be open to who each is as a person. Second, connecting with the patient's experience is going beyond the immediate situation and connecting with the person behind everything that is going on in the present moment. It means going beyond what a nurse would do routinely and finding out what the patient really needs in order to care for the whole person. Third, sensing is distinguishing between objective and subjective data. It is the ability of nurses to sift and weigh the various sources of data in conjunction with their experience to "determine what is really going on in the patient's situation" (Doona et al. p. 59). Fourth, going beyond the scientific data involves the nurse using his/her judgment to recognize subtle changes in the patient regardless of the technical data. It involves the knowledge that as a human being one has the ability to surpass scientific data. Fifth, knowing relates to knowing what will work. In other words, it captures the intersubjective nature of presence where the nurse immerses herself or himself into the patient's experience to understand the patient as a unique person. Knowing also relates to knowing when to act. It captures the difficulty of maintaining presence when other colleagues are focused on the objective

data. Lastly, being with the patient according to Doona et al. (1999) "is being exquisitely sensitive to the patient's subjective experience" (p. 64).

Through this review of literature, it is clear that presence is required in order to provide more effective and efficient healthcare as well as increased satisfaction and improved outcomes of patients and nurses regardless of the care environment. It is apparent that there is a need for an increased value and acceptance of this intangible, difficult to measure concept of presence within the outpatient practice. Especially when time constraints are structured into healthcare models as a means to manage time and increase efficiency.

Watson's theory of transpersonal caring has guided and provided the theoretical framework for much research and practice to explore and further develop caring processes and caritas within healthcare. An example of this is Swanson's (1991) development of a middle range theory of caring. Swanson, an associate professor at the Department of Family and Child Nursing, University of Washington developed a theory of caring involving five specific nursing actions: knowing, being with, doing for, enabling, and maintaining belief.

Knowing represents understanding the lived experience of the other from their context. This is accomplished by avoiding assumptions, focusing on the patient and assessing thoroughly to understand what the patient is saying or not saying, and looking for physiologic cues such as altered breathing patterns. Finally, knowing is that a nurse becomes engaged with the patient, just "one human being relating to another" (Jakobsen, 1998, p. 3).

Once you become engaged interpersonally, you are moving on to the next action of being with on an emotional level. Being with the patient in this way helps him or her feel valued as the nurse is giving time even if it is an extra minute (Swanson, 1991). It can be something as simple as waiting in a procedure room with the patient rather than standing in the hallway visiting with other peers until the procedure is to begin. Being there for patients doesn't mean having to give extraordinary amounts of time but at least lets them know of nurses' availability and how to reach them. It is better for nurses to let patients know that they are limited for time but that they matter to them and that nurses have an understanding of what they are going through. Patients need to know that nurses will be there with them for their procedure.

Recently, I had the opportunity to speak with a patient post procedure, and the one thing uppermost in the patients' mind was the fact that the nurse who was going to be there for the procedure met with the patient before the procedure, introduced herself and told her, "I will be with you the entire time during your procedure." This reduced her anxiety greatly as there were many people involved in the procedure, but this one nurse assured her and made her feel that she was there just for her. Another way of being with patients is to share feelings. It is a willingness to feel what they are feeling and experience what is happening to them such as happiness, frustration, and uncertainty while maintaining limits so as not to burden the other with the nurse's experience of it.

The next process is doing for the patient what he or she would be able to do in normal circumstances. It is not the goal to do more than that as nurses do not want to teach patients dependency yet do want to provide them intentional care and comfort since they are not in their normal circumstances within the procedural area. The intent is to

allow patients to be in charge of their life experience at the moment, whatever it may be. Doing for also includes anticipating the other's needs and meeting these competently (Swanson, 1991). This provides for their safety, dignity, and well-being.

Last is the process of enabling. Through enabling, the nurse helps the patient come through difficult experiences such as the endoscopic procedure. Examples of enabling within the procedure are assisting the patient with deep breathing through coaching and giving them assurance as to the progress of the procedure. Finally, the nurse helps the patient maintain belief and or find meaning in their life experience.

Ryan (2005) described the process of integrating Watson's caring theory with clinical practice and discussed various strategies used to transition the theory from a conceptual level to a departmental operational level. Ryan, director of nursing quality, research and professional development, Nursing Administration at Resurrection Medical Center, Chicago, Illinois, described the barriers to this integration as "nothing more than challenges to overcome" (p. 29). One such challenge was the concern that nursing would not have enough time to enact this model within the fast-paced healthcare environment. The outcomes of this process demonstrated that nurses enact caring everyday despite fast-paced activities or short time frames. It also demonstrated that diversity within the workforce contributed to the progress of this initiative by creating a common bond among nurses of all backgrounds.

Caring science and Watson's transpersonal caring theory represents timeless principles and a framework from which contemporary care models have been and can continue to evolve. It is adaptable to the changing health care environments and applicable to all facets of healthcare. As a result of this evolutionary process, a nursing

model of care has been developed for the procedural outpatient practice environment utilizing Watson's transpersonal caring theory as the philosophical framework.

Chapter Three: Model Development

Development of a nursing model of care for the time- limited procedural practice included determining the philosophical framework on which it is based , definitions of concepts, identification of underlying assumptions and values, and review of the major concepts of time and presence through the lens of the chosen framework. Other important processes are review of related research and implementation into the procedural nursing practice.

Theoretical Framework

Utilizing Watson's theoretical framework of transpersonal caring as actualized through the work of Swanson (1991), a nursing care model focusing on nursing presence can be developed and actualized within the outpatient procedural practice. A nursing presence model is a phenomenological conceptual model that depicts what nursing presence could look like within a time limited procedural practice. It includes an existential and spiritual orientation to guide nursing practice, research, and interventions. It would be a structural design promoting nursing values, beliefs, knowledge and goals within the practice.

Basic Nursing Concept Definitions

The initial step in the process of creating this model was to define its basic paradigm concepts of person, nursing, health and environment. It also includes the definition and description of its primary concepts of presence and time limitations.

Person. Within the nursing presence model, a person is any human who, existing within the universe, has thoughts, feelings, and a spirit. This is congruent with Watson's view of person as being comprised of a mind, body and soul.

Nursing. Nursing is defined as phenomena much like presence that is existential and metaphysical in nature. It is relationship based to address health on a holistic level. Within this model, nursing is viewed as both a science and an art, where both contribute to a transformative interpersonal relationship for both the nurse and the patient. The science of nursing is the basis of the artful acts of human to human contact (Watson, 1985).

Health. Health is the patient's lived reality along the continuum of well-being including the psychosocial, spiritual, and physical domains of health. Health is a subjective, perceived reality of the lived experience of the individual. According to Fitzpatrick (1996), health "is a balance between the person's perception of self and reality of lived experiences" (p. 291).

Environment. Environment is comprised of internal and external components. It is viewed as having the same domains as person -physical, psychosocial and spiritual. Through caring or presence the nurse is part of the person's experience influencing an environment that is supportive and potentially comforting and transforming within the person's lived experience.

Model Specific Concept Definitions

Human care. Human care is described by Watson (1985) as the moral ideal. The nurse approaches the intersubjective human-to-human event with the intention of being present for the patient. Through empathy, the nurse "experiences the phenomenal field of the patient" and shares "his/her perceptions of the encounter to support the self-awareness and spiritual evolution of the patient" (Morris, 1996, p. 293). Watson (1985) defined

caring as becoming a way of being for the nurse potentially transcending, human-to-human-contact that are the necessary conditions for the transpersonal caring process.

Transpersonal caring relationship. A transpersonal caring relationship is described as a professional, human-to-human encounter with the goal of restoring the patient's experience of inner harmony. The nurse gives of her or himself and shares her or his perceptions of the experience. If the other chooses to engage in the phenomenal field of the nurse, a new phenomenal field is developed between the two.

Self. Self is described as a subjective process, in which one synthesizes experiences and transforms what is perceived into knowledge. The highest sense of self is one's spirit (Watson, 1985). It is through this process that the individual develops their unique identity, character and essential qualities. A person's phenomenal field is described as a subjective experience also. It is one's frame of reference of being in the world (Watson, 1985). One's phenomenal field can only be known by others through empathy.

Caring occasion. A caring occasion is an event resulting from a transpersonal caring relationship and has the ability to extend beyond the actual caring occasion. Both the nurse and patient learn more about themselves, their humanness, and the humanness of others.

Presence. Presence is defined as being with, giving of oneself and willingness to be vulnerable and experience the patient's experience of health. As a result of this intersubjective experience, both the nurse and patient have the potential to come away with an increased sense of well-being. According to Zyblock (2010), presence has the

ability to transcend all patient interactions. It is intersubjective, maintaining the being of the other to be interacted with and not upon.

Time. Time is the" measured or measurable period during which an action, process, or condition exists or continues" (time, n.d.). From a procedural practice perspective, time is limited for each activity based on time studies. Time studies are the study of operational or production procedures and the time consumed by them for the purpose of devising methods of increasing efficiency or productivity of workers (time studies, n.d.). Management of this valuable resource is a fine balance between meeting fiscal performance goals and maintaining quality care in that inadequate time may contribute to poor quality care and excess time contributes to higher costs of care.

Caritas processes are also a component of Watson's Transpersonal Caring Theory on which the Nursing Presence model is grounded. Caritas processes used in a transpersonal caring relationship are:

1. Embrace altruistic values and practice loving kindness with self and others.
2. Instill faith and hope and honor others
3. Be sensitive to self and others by nurturing individual beliefs and practices.
4. Develop helping-trusting-caring relationships.
5. Promote and accept positive and negative feelings as you authentically listen to another's story.
6. Use creative scientific problem-solving methods for caring decision making.
7. Share teaching and learning that addresses the individual needs and comprehensive styles.

8. Create a healing environment for the physical and spiritual self which respects human dignity.
9. Assist with basic physical, emotional, and spiritual human needs.
10. Open to mystery and allow miracles to enter. (Watson, 2007)

Underlying Values

The Nursing Presence Model also ascribes to the values underlying the caring science philosophy of Watson's Transpersonal Caring Theory. They are as follows:

1. Having deep respect for the wonders and mysteries of life.
2. Recognizing the power of humans to grow and change.
3. Acknowledging a spiritual dimension of life
4. Acknowledging the internal power of the human care process.
5. Having high regards and reverence for the spiritual – subjective center of the person.
6. Placing high values on how the person (patient and nurse) is perceiving and experiencing health-illness conditions.
7. Holding non paternalistic values that recognize human autonomy and freedom of choice.
8. Emphasizing helping a person gain more self-knowledge, self-control, and readiness for self-healing regardless of the present health-illness condition.
9. Placing high value on the relationship between the nurse and the person.
10. Recognizing the nurse as a co participant in the human care process. (Watson, 1985, pp. 34-35)

Underlying Assumptions

Assumptions undergirding the Nursing Presence Model are those that are made about Watson's (1985) human care model:

1) Care and love are the most universal and the most mysterious of cosmic forces: they comprise primal and universal psychic energy.
2) Often the need for love and care is overlooked; or we know that people need each other in loving and caring ways, but often do not behave well toward each other. If we are to sustain our humanity, however, we need to become more caring and loving, to nourish our humanity and evolve as a civilization.
3) Because nursing is a caring profession, its ability to sustain its caring ideal and ideology in practice will affect the development of civilization and determine nursing's contribution to society.
4) We first have to impose our will to care and love upon ourselves. We have to treat ourselves with gentleness and dignity before we can respect and care for others with gentleness and dignity.
5) Nursing has always held a human care and caring stance in regard to people with health-illness concerns.
6) Caring is the essence of nursing and the most central and unifying focus of nursing presence.
7) Human care, at the individual and group levels, is receiving less and less emphasis in the health care delivery system.
8) The quality of caring has been devalued; therefore, sustaining human care ideals and a caring ideology in nursing practice and in society is critical. The

human care role is threatened by increasingly sophisticated medical technology and bureaucratic-managerial institutional constraints. At the same time radical treatment techniques have proliferated often without regard to costs.

9) Preservation and advancement of human care as both an epistemic and a clinical endeavor is a significant issue for nursing today and in the future.

10) Human care can be effectively demonstrated and practiced only interpersonally. The intersubjective human process keeps alive a common sense of humanity; it teaches us how to be human by identifying ourselves with others, whereby the humanity of one is reflected in the other.

11) Nursing's social, moral and scientific contributions to humankind lie in its commitment to human care ideals in theory, practice and research (pp. 32-33).

Another assumption which can be blended into the transpersonal caring assumptions is nursing's ability to recognize, be knowledgeable and appropriately apply cultural influences on the model. Although this assumption is from a transcultural perspective, it supports and enriches the nursing presence model.

Model Description

The nursing presence model utilizes Watson's foundation of transpersonal caring theory, but is actualized through incorporating and expanding upon Swanson's five caring processes. It is also filtered through the Mayo nursing care model principle of caring healer with role behaviors relevant to the endoscopy procedural specialty. Key concepts identified by Doona et al. (1999) also help in further delineating what presence looks like from a practical perspective.

The focus on presence in this model is due to Watson's support of presence as a prerequisite of caring. Watson (2008) infers that presence is the core of caring which in turn is the core of nursing. Without presence, true caring, caring which goes beyond prescribed actions and makes a connection with the patient cannot occur. But actions that may not fully meet the needs of the patient holistically would occur on a superficial level. Nursing would be acting on the patient as an object and not becoming involved with the patient as a unique subject or being. Without presence, there may not be a sense of wellbeing for either the nurse or the patient. Of all the concepts which comprise caring science, presence appears to be the essential element which must precede all other elements for true caring to occur.

Presence within the Mayo Nursing Model of Care (2006), which is based on Watson's transpersonal caring theory, includes interventions of a calming voice, appropriate touch to soothe, undivided attention when possible and communication skills to explore, affirm and enlighten. These interventions and behaviors can be modified for specialty nursing practice areas as appropriate and are included in the nursing presence model.

Swanson's five caring processes were used to further identify interventions and key processes of the nursing presence model. Swanson describes very practical examples of how to actualize each of her caring processes. Four of her processes were incorporated into the nursing presence model along with ways of actualizing them applied to the endoscopy practice patient care processes. The processes identified within Swanson's theory closely mirror the attributes of presence as identified through the work of Doona et

al. (1999) which provide further definition to only enrich and bring further practical applicability to each one.

The process of self care resonated from the work of Watson (2008) as a prerequisite enabling the nurse to practice presence. She acknowledges the amount of energy and holistic health which presence requires and thus self care warrants enough attention to be part of this model as it plays a vital role in not only sustaining but helping presence thrive.

The nursing presence model consists of five categories or processes: (a) self care, (b) knowing, (c) being there, (d) doing for other, and (e) enabling. Self care means the caregiver is able to care for self to remain healthy and able to provide the level of presence that care requires. Presence takes a great deal of energy and commitment. Therefore, the nursing presence model requires the nurse to practice self care in order to maintain and develop physical, emotional and spiritual health. One self care practice which can be done during the time- limited day is to pause momentarily for quiet moments to remember: why we are here, what our intentions are, and what our focus of control is. Another practice is to take some deep breaths in the midst of stressful situations (Watson, 2008). Centering is another form of self care which is the intentional act of refocusing energy to develop greater self awareness. This is accomplished throughout the day whenever needed by the nurse. An example would be taking a moment prior to approaching each patient to notice the sensations he/she is feeling at that moment. The resulting self awareness helps the nurse be more aware of the other's verbal and non-verbal signals.

Being there is being emotionally present to the patient. In practicing being there, the nurse utilizes therapeutic touch, calm verbal and nonverbal communication, and physical presence; nurses are not just bystanders but participate in the experience of patients. Examples would be the procedural nurse waiting in the procedure room with explaining to the patient that it is his or her job is to assure it is safe for the patient to have a procedure; the procedural nurse informing the patient the nurse will be with the patient for the entire procedure; and the recovery nurse explaining that a team of nurses will be caring for the patient while in recovery. Each nurse assures the patient that the person's welfare is the nurse's number one priority. Each team member expresses confidence and respect for their team members as he or she helps the patient throughout the entire procedural process. The nurse can also share empathy with the patient. Empathy allows the nurse to share feelings with the patient without being a burden. This may require help from peers to call nurses out when they are becoming too engaged with a patient. This is part of being human and requires coworkers to support each other to know and maintain limits.

Enabling is supporting the patient through the procedural experience (Swanson, 1991). This entails educating the patient prior to the procedure, explaining what to expect during the procedure, coaching the patient through the procedure via deep breathing and swallowing, assisting with pain management, helping with relaxation and encouraging the patient along as the exam progresses; it also entails communicating with family or the person(s) waiting in the lobby and communicating about any upcoming appointments.

Knowing is trying to understand the patient's perspective of the event.

The five categories of the nursing presence model along with the related nursing interventions at each time- stamped event are listed in Table 1.

Table 1. Five Categories of Nursing Presence

Timestamped Event	**Self Care**	**Being There**	**Doing For**	**Enabling**	**Knowing**
1) Patient arrival	Pause: remember your purpose, intentions, focus on what's in my control; deep breaths	Use of calm verbal and nonverbal communication; assurance of well being; empathy; physical presence; Availability	Maintain privacy; provide comfort and assistance	Patient education; coaching; pain management; progress report; communication	Patient is center of conversation; direct eye contact
2) Patient waiting in lobby	Pause: remember your purpose, intentions, focus on what's in my control; deep breaths	Use of calm verbal and nonverbal communication; availability	Maintain privacy; provide comfort and assistance	Progress report; communication	Direct eye contact
3)Patient Check In	Pause: remember your purpose, intentions, focus on what's in my control; deep breaths; center by refocusing energy; assure patient of safety screening	Physical presence; availability ; use of calm verbal and nonverbal communication; assurance of well being; empathy	Maintain dignity; privacy; speak up on patient's behalf; provide comfort and assistance	Patient education; coaching; pain management; Progress report; communication	Patient is center of conversation; direct eye contact; no assumptions; treat patient as individual; holistic assessment

Timestamped Event	Self Care	Being There	Doing For	Enabling	Knowing
4)Patient waiting for procedure	Pause: remember your purpose, intentions, focus on what's in my control; deep breaths; center by refocusing energy; assure patient of safety screening	Physical presence; availability; use of calm verbal and nonverbal communication; assurance of well being; empathy	Maintain dignity; privacy; anticipate needs; provide comfort and assistance	Patient education; coaching; pain management; progress report; communication	
5)Patient roomed	Pause: remember your purpose, intentions, focus on what's in my control; deep breaths	Physical presence; assurance of well being; empathy	Maintain dignity; privacy; speak up on patients behalf; provide comfort and assistance	Patient education; coaching; pain management; progress report; communication	Patient is center of conversation; direct eye contact; holistic assessment
6) Physician in room	Pause: remember your purpose, intentions, focus on what's in my control; deep breaths	Physical presence; assurance of well being; empathy; therapeutic touch	Maintain dignity; privacy; speak up on patients behalf; provide comfort and assistance	Patient education; coaching; pain management; progress report; communication	Patient is center of conversation; direct eye contact; holistic assessment
7) Procedure start	Pause: remember your purpose, intentions, focus on what's in my control; deep breaths	Physical presence; assurance of well being; empathy; therapeutic touch; use of calm verbal and nonverbal communication	Maintain dignity; privacy; speak up on patients behalf; provide comfort and assistance	Patient education; coaching; pain management; progress report; communication	Patient is center of conversation; direct eye contact; no assumptions; treat patient as individual; holistic assessment

Timestamped Event	Self Care	Being There	Doing For	Enabling	Knowing
8) Procedure end	Pause: remember your purpose, intentions, focus on what's in my control; deep breaths; center by refocusing energy	Physical presence; assurance of well being; empathy; therapeutic touch	Maintain dignity; privacy; speak up on patients behalf; provide comfort and assistance	Patient education; coaching; pain management; progress report; communication	Patient is center of conversation; direct eye contact
9) Patient in recovery	Pause: remember your purpose, intentions, focus on what's in my control; deep breaths	Physical presence; assurance of well being; empathy; therapeutic touch; use of calm verbal and nonverbal communication	Maintain dignity; privacy; speak up on patients behalf; provide comfort and assistance	Patient education; coaching; pain management; progress report; communication	Patient is center of conversation; direct eye contact; no assumptions; treat patient as individual; holistic assessment
10)Patient discharged	Pause: remember your purpose, intentions, focus on what's in my control; deep breaths; center by refocusing energy			Patient education; coaching; pain management; progress report; communication	

When practicing knowing, the nurse does not assume the patient will have typical responses to the processes within the procedural experience. Each patient is treated as a unique individual. The nurse focuses on the patient being cared for by making him/her the center of the conversation through direct eye contact and shifting the conversation back to him/her them. The nurse also assesses the patient in a holistic manner by listening to what he/she is saying and not saying by helping one find the words to describe what he/she is feeling (Swanson, 1999).

Related Nursing Research

A variety of nursing research explains, defines and applies presence to humanistic interpersonal relationships in nursing practice. It is a concept within nursing theory and an intervention within nursing practice that appears to be gaining more attention. The concept of time is also intertwined within the research but is more difficult to define and quantify. The following nursing research has helped guide and develop the nursing presence model as it relates to a time- limited procedural practice.

A qualitative study by Baldursdottir and Jonsdottir (2002) conducted in an emergency department in Iceland revealed that high workload and time constraints do not necessarily render insufficient caring by nurses. Rather, " a caring moment can be created when the nurse is morally conscious and authentically present with patients in fulfilling their unmet needs, utilizing his or her knowledge base and clinical competence" (p. 7). This research lends to the evidence base necessary for eliminating time as a perceived barrier to caring.

Swanson's (1991) development of a Middle Range Theory of Caring is an example of the outcome of phenomenological investigative research utilizing Watson's

Transpersonal Caring Theory to describe caring from the patients' perspectives. Swanson's caring theory supports the practical application of caring science and research into nursing practice. The nursing presence model adapted four of Swanson's five caring processes in order to apply presence to the procedural outpatient practice.

The work of Doona et al. (1999) is a hermeneutic study that identified six features of presence. These are described in the previous review of literature and support the major concept of presence within the Nursing Presence Model. Again, this research adds to the evidence base supporting the value of presence in nursing.

Model Implementation

The following methods could be used to implement a model within the outpatient endoscopy procedural practice. The subjects in this project are experienced registered nurses and licensed practical nurses. On a volunteer basis, they would participate in 30 - minute educational sessions during monthly staff meetings over the next 6 months. These sessions would focus on the elements of Jean Watson's theory of transpersonal caring with a primary focus on the concept of presence. The modes and interventions identified within the nursing presence model would be described and handouts provided. Each session would be taped for those who could not participate in the live sessions.

Each participant would be asked to develop his or her personal plan of how to use the information learned in his or her daily practice. Participants will be encouraged to journal their caring experiences. And finally, an important vehicle for promoting connection of this theory to practice is dialogue among professional nurses to share caring exemplars. This would occur at subsequent staff meetings as a planned agenda item.

From a leadership perspective, the concepts of presence would be incorporated into appraisals, orientation, competencies and mandatory annual education. Nursing leadership would also participate in leadership- focused training of presence and act as role models of presence within the practice.

It is important to note that the development and maintenance of this model will continue to evolve as the healthcare environment changes. It is currently a coalescence of the theories of Watson, Swanson and Mayo Nursing Care Model to enhance the element of presence within the outpatient procedural practice. It is essential that this process of building upon the underlying philosophical framework to develop a specialty focused model continue and perhaps be adopted by other specialties.

Evaluation

Evaluation of participants would occur prior to the education and again after completion of all educational sessions. It will consist of open- ended questions. The questions prior to education would be: What is presence to you? How would you describe presence within your role? Have you ever experienced a sense of being cared for in a minute or a moment? The questions after sessions are complete will be: What is presence to you? How do you practice presence within your role? What kind of impact has this educational process had on your nursing practice and work experiences?

Themes will be determined and comparisons made between pre and post evaluation to determine the effectiveness of this project. In understanding the transpersonal theory concept, the outpatient nursing culture may identify caring differently and in ways that will enhance or change their caring approach in the time-

limited outpatient procedural environment. An example of this would be recognition of the 'caring moment' and presence tenets of transpersonal caring within their daily work.

Understanding the caring philosophies of the nursing subculture of the outpatient procedural nursing staff will assist the nursing leadership in promoting an environment that supports, maintains, and celebrates caring. It also identifies staff needs for education in caring theory and the underpinning concepts of presence and intentionality within transpersonal caring. This project would support the strategic plan for the participating unit. Therefore, results and findings would be shared via Power Point presentation to participants and unit management. They would also be disseminated through the final project publication.

A potential limitation to this project is the participants' ability to attend the educational and discussion sessions due to workload demands characteristic of the unique procedural practice. Unique to this practice is the continuous workflow with no stoppage throughout the day. Lunch breaks are the best time for attendance to occur but the rotation of lunch coverage causes variability in who and how many participants can attend on any given day.

Another limitation is the participants' potential for not being fully authentic in their sharing due to the fact that the project coordinator is their direct supervisor. This is a potential limitation despite the use of consent forms stating that participation will not affect relationships with the employer or supervisor. Another limitation would be any barriers to the introduction of new concepts such as the introduction of new technology into the practice during this project time line.

The anticipated time to implement this model is approximately 6 months beginning in January 2011 and being completed by July 2011. This time line may need to be adjusted due to competing priorities of the unit practice.

Analysis

Although this project focused on the concept of presence alone, it was apparent that it overlapped or reciprocated with the term caring within the supporting literature. In the future it would be more beneficial to focus on the characteristics of presence within the literature. Based on the complexity of presence, it would also be beneficial to identify a longer period of time in which to implement it.

In all, the continued melding and molding of nursing care models should be encouraged to continually adapt to changing needs of the healthcare environment. Nursing should never be satisfied with their current status within healthcare and models will continue to drive further practice, education, and research. However, it is imperative for nursing to develop one common language to strengthen those three components.

Chapter Four: Reflection

Implications

The development of the Nursing Presence Model for use within the time -limited procedural practice holds implications for professional nursing practice and leadership within and outside of nursing.

Implications for professional nursing practice include the need for development of a caring curriculum within nursing programs and orientation programs based on the theoretical foundations of caring science phases of novice to expert nursing, mentoring of presence within nursing practice, standard nursing language, which differentiates the difference between concepts of presence and caring in research and literature and connecting measureable nursing sensitive outcomes to the model.

Implications for leadership in healthcare include the provision of an environment that supports the concept of presence within nursing practice, role modeling presence, and meeting accreditation requirements through use of a standard nursing language. A supportive environment would value presence as a way of being, which improves patient outcomes and workflow efficiency and promotes nursing satisfaction and retention. "Embracing presence as a way of being in nursing practice requires a change in the present focuses, routines, values, beliefs, and attitudes" (Melnechenko, 2003, p. 23). Role modeling by leadership emphasizes the need for change to occur in leadership first to affect the change in the rest of the practice. With presence as the starting point for all caring events, the rest of the established nursing model of care for this institution will unfold naturally.

The model of nursing presence within the outpatient practice also addresses disparities related to the practice of presence. It will further develop and maintain

professional nursing across the continuum of care from inpatient to outpatient environments. As a result, the disparity of support and practice of the established model of care within the institution will be minimized or resolved. Mentoring in presence, as mentioned previously, will also address the disparity in the practice of presence along the continuum of novice to expert nurse. According to Iseminger et al. (2009), "effective nurse-patient interaction is easier for some nurses than others because of different personalities, education, beliefs, self-awareness and communication styles" (p. 449).

The anticipated consistency of professional nursing presence across the caring continuum will also help address the disparity in care for those patients who are marginalized such as the elderly who process slowly in the intake interview and may recover from sedation more slowly or the non English speaking patient who requires an interpreter. In a time limited practice these patient needs can cause delays which interrupt the routine workflow and in some cases decrease efficiency. With a strong professional nursing presence nurses can more readily focus on and anticipate the unique needs of humans the practice will meet the needs of the patient rather than attempting to create a system where the patient needs to fit the practice. As the previous literature review points out, presence allows nurses to more readily identify the needs of their patients and be a part of their journey. Perhaps timestamping will always be a part of the procedural practice as a means to measure productivity. However, timestamping cannot measure nursing care, patient satisfaction, wellbeing and outcomes. To address the patient needs more fully in the outpatient procedural practice, especially those with special needs, nursing administrators, clinic administrators and physician leadership all need to come to the table to look more holistically and comprehensively assess the

diverse needs of their clients, the appropriate number and mix of staff and resources to meet those needs, appropriate support personnel that need to be established within the outpatient setting, and perhaps a workload measurement system.

Future implications include the need for an increasing body of evidence to support the value of presence and a continued inclusion of caring curriculum into nursing programs, orientations and competencies, performance evaluations and development of preceptors. Patient perceptions of quality nursing care within the procedural setting needs further study. Related studies in EDs and other day hospitals has been done from patient and nurse perspectives but more needs to be done with the endoscopy setting and other procedural outpatient practices.

Perhaps the greatest insight I have gained through the process of developing a nursing presence model is that this work will never be complete or finished. However, it is infinite and the possibilities it creates related to the art and science of nursing are limitless.

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