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Examining Nursing Presence in the Acute Care Setting as an Indicator of Patient Satisfaction with Nursing Care

Wendy Hansbrough PhD, MSN, RN
University of San Diego

UNIVERSITY OF SAN DIEGO

Hahn School of Nursing and Health Sciences

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EXAMINING NURSING PRESENCE IN THE ACUTE CARE SETTING AS AN INDICATOR OF PATIENT SATISFACTION WITH NURSING CARE

By

Wendy Hansbrough, RN, MSN

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Jane M. Georges, PhD, RN

Linda Urden DNSc, RN, CNS, NE-BC, FAAN

Linnea Axman, DrPH, MSN, APRN, BC

Abstract

Nursing presence is conceptualized as occurring within the nurse-patient relationship when the nurse acknowledges the uniqueness of the patient, within his or her context of being and chooses to intervene on the patient's behalf with a patient who allows the nurse into a reciprocal relationship. Nursing presence is described as occurring in varying levels and nurse expertise is suggested as one antecedent. Quantification of nursing presence would be useful in examination of nursing care outcomes, quality management and research. The Presence of Nursing Scale, PONS (Kostovich, 2002) was used in this study to test its reliability and determine its validity against a single-item measure of patient satisfaction with the care given by a particular nurse. In the 75-patient sample, the PONS was found to be reliable (Cronbach's alpha = .937). The correlation between the PONS and patient satisfaction with care scores was tested using a Spearman's rho and found to be large and statistically significant, $p < 0.01$. The relationship between the PONS scores and levels of nurse expertise was explored to explain PONS scores along the scale continuum. A nurse expertise level (NEL) was calculated for the 24 registered nurse participants based on a peer-reported novice to expert skill acquisition level (Benner, 1982), specialty certification, longevity of practice and leadership duties.

Qualitative data from participant interviews helped to explain the quantitative findings. In the lower quartile of PONS scores, patients felt as objects of the nurses' work, attended to only when called by the patient. Toward the middle of the scale continuum, patients experienced a professional relationship with their nurse and had

confidence in the nurse's skill and knowledge. Nurses reported professional satisfaction in helping patients achieve health care goals. At the higher end of the scale, patients felt watched over and experienced stress reduction and encouragement.

The PONS appeared to measure levels of nursing presence in the context of the daily work of the bedside nurse. Specific nursing behaviors were associated with levels of presence, suggesting it is possible to teach a nurse to be present with patients.

Dedication

The potential for my PhD journey began many years ago when John believed in my ability to do intellectual inquiry. Marguerite evolved the "potential" into the "possible" when she encouraged me by saying, "Time passes. You might as well be in school". And the "possible" became the "reality" when Dr. Patricia Roth designed the curricular road map for me to follow and set me out on this wonderful journey. Along the way I have been cheered by friends and family who lined my path. I am humbled and grateful for the confidence you all have had in me.

Most of all, this work is dedicated to John and Elizabeth. Thank you for your patience when the road was bumpy and your steadfast enthusiastic support through it all. You are my bedrock. I love you for always.

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CHAPTER I

INTRODUCTION

Statement of the Problem

Despite substantial investments in nursing care quality management initiatives, no equivalent, consistently reproduced correlations have been made between specific quality initiatives and significant improvements in nursing-related patient outcome measures (Dunton, 2008; Griffiths, 1995). This problem suggests the existence of a longstanding fundamental challenge for professional nursing in matters of quality management: the essence of nursing care which has power to protect and promote the patient's well being is insufficiently understood within the context of direct patient care. Too often, nurse leaders reply after-the-fact to undesirable outcomes or adverse events which drive focused error reduction strategies unlikely to effect substantial, long lasting changes in nursing practice. While acknowledging the obligation to make these post-event responses, greater consideration must be given to a proactive positive approach to nursing care quality management. Nurses must identify the essential aspects of nursing practice which form the foundation for the delivery of excellent patient care. The effects on the patient's well being when these aspects are present or when they are absence in nursing care must be examined and explained. And there must be a discernable

relationship established between aspects of nursing care and their value to the patient's well being and health care outcomes. Valuation is a judgment driven by perspective and laden with meaning for the individual. Thus, in matters of health, the value of health care outcomes cannot be solely measured by the achievement of goals set within a scientific/curing model. Rather, the value of care and the outcome of that care are uniquely determined by each patient. A better understanding of the facets of nursing practice which are valued most by patients and have the potential to directly affect the quality of care is needed. Nursing presence is suggested as one such facet and is the subject of this proposed study.

Background and Significance

The availability of high quality, appropriate and affordable health care has become a national priority. At the time of this writing, a simple search of the Library of Congress for current pending legislation regarding health care returned one hundred-sixty-nine bills before the 112th Congress of the United States ("The library of congress: Thomas," 2011). Many of these introduced bills aim to repeal or to reform the Patient Protection and Affordable Care Act (PPACA), passed by Congress and signed into law by the President in March of 2010 (Patient protection and affordable care act, 2010). Amidst the ongoing debate over the availability of health care, is the need to ensure the quality and appropriateness of care for the individual patient. Responding to the passage of the PPACA, the United States Health and Human Services Secretary, Kathleen Sebelius, has outlined the actions that will be taken to implement the law and transform health care, including measures to improve patient safety and health care quality (U.S.

Department of Health and Human Services, 2011). The necessity of attention to the serious gaps in the quality of health care is evidenced by the alarming rate of occurrences of avoidable adverse events. Deaths of Americans from medication errors is estimated to be between 44,000 and 98,000 annually ("The Chasm in Quality: Select Indicators from Recent Reports ", 2006). Data from the National Database of Nursing Quality Indicators show nearly 6% of hospitalized patients develop a hospital acquired pressure ulcer. This trend is down only slightly from 2005 despite widespread nursing staff education addressing pressure ulcer prevention interventions (Dunton, 2008). The problems of quality control in healthcare continue to demand attention from all who have influence to improve patient care outcomes and avoid adverse events.

To underscore health care quality concerns and the recognition of patients' rights to self determination in matters of health care, the adoption of patient-centered care models is being promoted. In 2001 the Institute of Medicine (IOM) outlined a quality improvement strategy incorporating patient-centered care which is "respectful of and responsive to individual patient preferences, needs, and values and ensures that patient values guide all clinical decision"(*Crossing the quality chasm: a new health system for the 21st century*, 2001). This IOM report includes operational rules for the contemporary health system including the establishment of "continuous healing relationships" between clinicians and patients based on collaborative communication, "free flowing information" and "customized care according to patient needs and values" (p. 67). Patient-centered care has been promoted as a patient-provider partnership which may positively impact the quality of care (Anderson, 2007; Frampton, et al., 2008; Poochikian-Sarkissian,

Wennberg, & Sidani, 2008; Wolf, Lehman, Quinlin, 2008). Thus a paradigm shift is underway to move from a model of heath care planning and delivery which is unilaterally directed and evaluated by the health care provider, to one which assimilates the individual patient's health care preferences and recognizes the value of patient opinions about the quality of care that is delivered.

The clinical work of nurses to be with patients is done within a compounded system of health care organizations, insurance companies, related private industry and governmental agencies. Within this vast system, the processes, procedures, policies and desired physiological outcomes of care are defined and the quality of health care is judged. At the central core of the system, is a patient with a health care need interacting with a nurse who has the responsibility to give care. Their interaction will form a relationship ostensibly intended to meet the patient's physical needs and avoid adverse events associated with the provision of nursing care. This functional nurse-patient relationship serves to get the work of patient care done but lacks personal connectedness and a view of the person who is experiencing this health related event within the context of his or her whole being.

Conversely, the attentive nurse who encounters the patient from an existential view, with a desire to understand and respond to the patient's perceived needs and promote the patient's well being, experiences a phenomenon conceptualized as nursing presence (Covington, 2003; Fuller, 1991; Mohnkern, 1992). Certain nursing actions which reflect nursing presence within the nurse patient relationship have been described although they are not necessarily observable (Paterson & Zderad, 1976). These include

being physically and emotionally available, responsive to the patient's needs, authentic and genuine. In addition, elements of more experienced nursing practice are mentioned as being antecedents to nursing presence such as being clinically competence, affirming individuals' uniqueness, communicating verbally and nonverbally, possessing intuitive understanding of complex situations, being able to see the relative importance of aspects of a patient situation and possessing personal maturity (Anderson, 2007; du Mont, 2002; K. L. Melnechenko, 2003; Mohnkern, 1992). These actions describe nursing presence as a function of the expert nurse as defined by Benner (1982).

The concept of patient-centered care shares philosophical tenets with the concept of nursing presence. Doona, Chase and Haggerty (1999) collaborated in an analysis of their individual studies of nursing presence and define six features of nursing presence: uniqueness of viewing each patient as an individual; sensing of subjective information beyond the objective data available; knowing the patient as the subject of care, not the object; knowing what will work; knowing when to act; and being with the patient by experiencing the point in time with him. Both patient-centered care and nursing presence are grounded in a view of the patient as an individual human with unique needs and rights to self-determination. However, patient-centered care is generally understood to describe the broader view of a health care organization culture whereas nursing presence emerges within the intimate nurse-patient relationship. Moreover, nursing presence has been characterized as a nursing intervention, something nurses intentionally chose to do in the course of caring for patients (Gardner, 1985; Karen L. Melnechenko, 2003). Thus,

nursing presence could be considered as patient-centered care demonstrated by nursing action at the bedside.

While the concept of nursing presence supports the patient-centered care design, in practice, contemporary nursing has adopted the medical/scientific curing model in favor of their historical feminine/caring/healing model (Watson, 1999). The modern nurse, in possession of extensive knowledge of patho-physiology, adept at the manipulation of technologically advanced life-preserving devices, who remains calm and efficient in the event of a bedside crisis is valued in the medical/curing model. This emphasis on curing leaves a gap in the connectedness of nurses to patients, in the space where healing/caring would reside.

Associated Assumptions

An important source of health care quality monitoring data is the patient satisfaction survey. Achieving patient satisfaction with care as viewed from the patient's perspective has become a primary objective of healthcare organizations (Urden, 2002). In addition, consumer evaluations of hospital-delivered health care quality will be one determinate used to calculate the reimbursement rate paid to hospitals for patients who quality for Medicare or Medicaid services beginning with patients who are discharged in October 2012 (Reporting of Hospital Quality Data for Annual Hospital Payment Update, 2008). The Hospital Consumer Assessment of Healthcare Providers and Systems survey (CAPHS Hospital Survey) (Centers for Medicare and Medicaid Services, 2010) has been developed as the national standardized measure of consumers' opinions of the quality of

health care. The CAPHS Hospital Survey is being incorporated into the quality measures managed by outsourced companies routinely used by health care organizations to distribute, collect and analyze patient opinions on the quality of care they received during their hospitalization (Avatar, 2011; Press Ganey, 2011). The value of patient satisfaction surveys as a means to identify opportunities for quality improvement has been surpassed by the need for favorable survey outcomes to bolster reimbursement rates.

Innumerable studies have been undertaken to determine what patients value in care, and more specifically in the care they receive from nurses (Beck, 1996; Blizzard, 2005; Henderson, 2007; Yonge, 2002). Patients, the consumers of health care, are demanding attention as individuals who are cared about (Oermann, 1999). Yet when nursing care is driven by an adopted medical model of curing, without sufficient attention to caring/healing, the demands of the physicians and the health care institution may overshadow the true needs of the patient. It is the nurse who is present with the patient, perceiving the holistic view of the patient, acting to inform and facilitate the achievement of the highest level of health possible, who places the patient's desires and needs foremost in the scheme of healthcare.

Nursing presence within the nurse patient relationship may influence health care quality by opening a pathway to reveal previously undisclosed information about the patient. Being present requires an abandonment of prejudicial notions and assumptions within the nurse patient relationship (Liehr, 1989; Parse, 1998) enabling authentic communication. Paterson and Zderad (1976) describe nursing presence as what nurses do when they turn their "attention toward the patient, being aware of and open to the here

and now shared situation, and communicate their availability" (p.14). Within the connectedness of being present, the patient is central to nurse's work and the focus of the nurse's attention, thus the nurse is better able to understand what health care is of most value to the patient and provide that care. It is reasonable to hypothesize that persons with commonality of culture, ethnicity, gender, age group, and spiritual philosophy would be more likely to engage each other in a manner of being present however this has not been demonstrated. However, it has been suggested that when nurses are truly present within the nurse-patient relationship, the patient is more satisfied with nursing care and hence hospital care, and there may be a reduction in the occurrence of preventable adverse events related to nursing care (Bournes & Ferguson-Pare', 2007; Godkin, Godkin, & Austin, 2002).

Employing nursing presence may be considered a nursing skill which is learned, practiced and performed like nursing care skills used to provide physical care. Geller (2001) describes presence in the context of psychological therapy as being a chosen state of behaviors which the therapist must learn and practice in order to be present during sessions of patient care. Covington (2003) conceptualizes caring presence as a deliberate action and as a nursing intervention. In order to employ an intervention, including being present, a level of knowledge and skill is needed. This idea is supported by nurse scholars who conceive of nursing presence as a skill that may be developed with education and experience (Bournes & Ferguson-Pare', 2007; McKivergin & Daubenmire, 1994). And it is suggested that nursing presence is an attribute of the expert nurse as defined by Benner (1982) in the skill acquisition model (Doona, et al., 1999; Hines, 1991).

While nursing presence is well conceptualized in the literature, it is not easily discernible in nursing practice. Thus, little quantitative study of the concept of nursing presence has been attempted despite well described conceptualizations and qualitative study. A reliable instrument to measure patient's perception of nursing presence would be useful to quantify this nursing intervention and it's correlation to health care quality indicators. Therefore, the primary goal of this study is to test the reliability of the only tool available to measure nursing presence from the view of the patient.

Research Questions and Hypotheses

This explanatory mixed methods design study was undertaken to advance the understanding of measuring the occurrence of nursing presence within the patient-nurse relationship as perceived by hospitalized acute care patients and their nurses as it relates to patient satisfaction with nursing care. Potential contributing factors studied included nurse-patient commonality of ethnic background, race, gender and age. In addition, the influence of nursing expertise on the perception of nursing presence was explored. Qualitative data were collected after quantitative data collection to explain the quantitative results in more depth.

The aims of the study were:

Quantitative Approach

Test the reliability and validity of the Presence of Nursing Scale (PONS) developed by Kostovich (2002).

Identify the relationship between the PONS score and patient satisfaction with nursing care.

Explore the relationship between the PONS score and indicators of nursing expertise.

Explore the relationship between the PONS score and demographic characteristics of the participant nurses and patients.

The specific research questions and hypotheses tested were:

1. Is the Presence of Nursing Scale (PONS) developed by Kostovich (2002) a reliable and valid instrument to measure nursing presence?

If so,

2. Is there a relationship between the PONS score and patient satisfaction with nursing care?

   Research Hypothesis 1: There is a positive relationship between PONS scores and patient satisfaction scores.

3. Is there a relationship between the PONS score and personal/demographic characteristics of the patient?

   Research Hypothesis 2: There is positive relationship between PONS scores and personal/demographic characteristics of the patient.

4. Is there a relationship between the PONS score and personal/demographic characteristics of the nurse?

   Research Hypothesis 3: There is positive relationship between PONS scores and personal/demographic characteristics of the nurse.

5. Is there a relationship between the PONS score and commonality of personal/demographic characteristics between the patient and the nurse?

   Research Hypothesis 4: There is positive relationship between PONS scores and commonality of personal/demographic characteristics between the patient and the nurse.

6. Is there a relationship between the PONS score and the expertise of the nurse?

   Research Hypothesis 5: There is a positive relationship between PONS scores and the expertise of the nurse.

Qualitative Approach

The purpose of the qualitative approach in this study is to explore the following:

The characterization of the nurse-patient relationship in the words of patients and their nurses.

The nurses' description of their approach to establishing a connection with patients.

The patients' description of their satisfaction with nursing care.

Mixed Method Approach

The purpose of the explanatory mixed methods design is to:

Assess the validity of the PONS.

Explain the range of the PONS survey results.

Explain relationships between PONS scores and the independent variables.

CHAPTER II

REVIEW OF THE LITERATURE

This chapter delineates the concept of presence, particularly as it relates to the discipline of nursing. The philosophical foundation of presence, it's explanation as found in nursing theory and it's historical context will be discussed. A conceptual model of nursing presence as it emerges from the nurse-patient relationship will be presented in conjunction with a review of the supporting literature. Theoretical definitions and associated assumptions will be described as they relate to nursing presence.

Philosophical Foundation of Presence

A philosophical basis of presence, of being with another in a shared experience particularly without preconceived notions of meaning is found in a number of the philosophical traditions. To grasp a philosophical understanding of presence, it must be considered relative to beliefs of how one perceives the world, views human existence in relation to the world and how one encounters another. The notion of presence emerges in existential phenomenology and is supported in postmodern philosophy. It is important to reflect on the philosophical basis for presence to gain understanding of the concept as it relates to the practice of nursing.

Martin Heidegger's major philosophical thesis, *Being and Time*, concerns man's

existence and his being-in-the-world (Magill, 1990). His sense of the world is not limited by the tangible entity of the physical world but is conceived as the whole of the experience. Reflecting this philosophical stance, his principal method of study was phenomenology, an attempt to reveal meaning within an experience. Heidegger philosophized that a person's existence cannot be removed from his or her being-in-the-world, meaning the context of his or her life (Sheehan, 1998, 2003). According to this belief, the meaning of a health event is held within the unique individual's existence within the world. Each scientifically defined health event, while physiologically factual with a predictable physiological result, is uniquely experienced by the individual within his/her way of being in the world. The complexity of Heidegger's theory is vast and well beyond the scope of this work. Yet a basic understanding of Heidegger's philosophy of existence is meaningful for exploration of the concept of nursing presence and it's attribute of acknowledgement of the uniqueness of each patient.

Maurice Merleau-Ponty was a contemporary of Heidegger using existential phenomenology to enable an analysis of a concept beyond a scientifically determined absolute truth. In his *Phenomenology of Perception* he postulates that man's consciousness is determined through his perception of his body as it is situated in the world and this determines his concept of existence (Magill, 1990, p. 619-627). Meaning is gained from the perspective of one's body and its position in the world, thus each person's truth is different than another's. He states, "All my knowledge of the world, even my scientific knowledge, is gained from my own particular point of view, or from some experience of the world, without which the symbols of science would be

meaningless" (Merleau-Ponty, 1945; Polifroni & Welch, 1999, p. 329). This is an important philosophical view of human existence to consider in regards to the delivery of health care where there is an attempt to apply absolute (scientific) truths to bodily conditions and expect patients to accept those truths without regard for their own perception. It is important to acknowledge each person's existence as uniquely positioned in a body in the world thus each person's body must be perceived as inclusive of their lived experience.

Merleau-Ponty's philosophical stance raises important considerations for health care providers, particularly nurses who give physical care to the body. The physical contact of nursing care is an intimate encounter of the patients' consciousness of being, formed by their perception of their body in the world. A person's consciousness is altered in situations of illness or injury when, as a patient, physical boundaries are relinquished to some extent and lived experiences are expanded. As perception of the body in the world is altered, so is the person's consciousness and his or her truth.

One notable existential philosopher and spiritual leader whose work is foundational to nursing presence is Martin Buber. In his theory of human existence, he describes man's being in the world in relation to human encounters as existing in one of two states of pairs. He identifies these pairs as I-You (or I-Thou) and I-It (Buber, 1970). Simply stated, when a person interacts with the world from an "I-Thou" position every encounter is mutually authentic without presumptions or objectification of each other. This position opens the path for truly being with another as life is experienced. In contrast, "I-It" encounters are void of genuine connection. A person only relates to others

as objects, the "It". From this position, there is no experiencing of the other as a being and presence in the sense of being with cannot exist. Buber theorizes that "I-It" becomes "I-You" only when there is a relationship between the two persons. He states, "Only as the You becomes present does presence come into being" (p. 61). And he notes that the "You" must resort back to the "It" when the relationship is over (p. 68).

Nurse-patient encounters are situated in the "I-It" state when the patient is the object of care. In this state, the tactile, physical demands and technologically directed work of nursing is being done. "I-It" objectifications of patient encounters are evident in the language of nurse's work. Consider the reference to patients by their chief complaint or diagnosis or the giving of a direction to "answer the call light". This language objectifies and denies the human need that caused the nurse to be called. Only when the nurse and patient form a relationship does the "It"-patient become the "You"-patient and nursing presence may emerge.

A discussion of the philosophical foundation for understanding presence would be incomplete without consideration of postmodernism and the work of Michel Foucault. The postmodern philosophy assumes the existence of multiple truths and the relativity of truth to the view of the individual. Knowledge is advanced by seeing what is beyond the obvious, the visible, the main text. When one looks to the margin to see what cannot be easily seen, one finds other meanings, other views, other ways of being. From the postmodern view, one explores what is said as well as the meaning of the words within their context and also considers what is not said (Porter, 1998). Research in this tradition

advances understanding. It does not prove facts upon which to build structured realities (Cheek, 1999).

Foucault posits that knowledge, or reality comes from power (Porter, 1998). Data are interpreted by a dominating power entity who dictates the knowledge that is professed. In any given context there will be multiple views of reality, but the dominating power entity will dictate which reality is acceptable. Foucault particularly notes the power of the medical profession which "exercises an uncontrolled power over people's bodies, their health, and their life and death" (Foucault, 1982). This notion is evident in health care outcome models, largely dictated by the western patriarchal scientific model of health care with the predominate directive to cure which is accepted as the goal of health care (Watson, 1999).

Consideration of the relationship between knowledge and power is paramount to understanding nursing presence which is founded in the acceptance of the patient as a unique individual who possesses the power of self-determination within the reality of his/her life and the health related event. The embodiment of this philosophical stance in the practice of nursing care is challenged by the power structures present with the institution of healthcare. The constructed reality of the health care system is built on the knowledge of the clinicians, their language of medicine and their culturally dictated roles which form the structure of the power hierarchy. Within that hierarchy, nurses assume a position of powerful clinician over the less powerful patient and in so doing, participate in dictating the patient's reality. Prescribed interventions are carried out by nurses to achieve medically determined outcomes. This is not to say that the resultant outcome is

good or bad. The important question to consider is whether or not it is the outcome desired by the patient. Awareness of the power relations within the health care provider / patient relationship is an important first step to being present.

Nursing Theory as Foundational to Nursing Presence

The humanistic nursing practice theory of Paterson and Zderad (1976) forms the basis for much of the research undertaken to study nursing presence. They characterize nursing as being founded in the relationship between the nurse and a person whereas the nurse is a guide, illuminating possibilities and helping the person to achieve self-determined health goals. Humanistic nursing is recognized in authentic, dialogical and reciprocal connections between nurses and their patients. It is a relationship of receptivity and availability, of response to the need of another with one's whole self (pg 31). The work of Buber is foundational to this theory in that presence becomes known only when there is relationship and the other is viewed as the subjective "you". Humanistic nursing calls upon the nurse to philosophically believe in the uniqueness of each man's being in the world and his right to self-determination. Paterson and Zderad emphasis that to be able to genuinely relate to the patient with the wholeness of the nurse's being, with the intention of helping the patient to reach wellness as is possible in his given situation, the nurse must first attend to authenticity with self. "Our self-awareness, in-touchness, self-acceptance, actualization of our potential allows us to share with other so they can become in relationship with us" (p. 4). The humanistic nursing practice theory provides us with a clear understanding of the meaning of nursing presence and it's use in the practice of the discipline.

In her Human Becoming School of Thought, Parse (1998) adds to the understanding of presence as she describes the nurse in true presence who joins "the reality of others at all realms of the universe and is available to bear witness without judging or labeling (p. 72). This theory is grounded in the human science model of nursing focused on "qualification of the human's total health experience" (p. 2). This paradigm "identifies the unitary human as one who co-participates with the universe in creating becoming, and who is whole, open and free to choose ways of becoming (p. 6). Parse professes the goal of nursing in true presence is to enhance the quality of the patient's life by illuminating potential views of reality then facilitating the patient's chosen journey in becoming. Hallmarks of the human becoming school of thought are an absence of presumptions or judgment toward the other, acceptance of the other's view of reality and sensing the patient as the subject of care. The nurse living human becoming experiences an existential awareness of self and the other. Parse calls upon the nurse to prepare for being present and to accept the responsibility to be in a condition to be able to be present, be aware and respond to the patient's becoming.

The human science and human care theory of nursing by Watson (1985) proposes nursing as a subjective human science, designed to explore the whole person within his or her particular situation of being. Human science does not elicit absolute truths to be generalized, but rather suggests a working hypotheses for a given context. Accordingly, Watson supports qualitative study or mixed methods approaches as more suited to the study of nursing than quantitative study. Watson's theory addresses the concept of caring, which is built, in part on a foundation of nursing presence. The caring nurse is described

as perceiving the others' feelings and their uniqueness (p. 34). The patient is viewed as the subject of care, an individual experiencing the health event within his personal context. The nurse enters into a relationship with the patient as a co-participant in the health care process, as a knowledgeable facilitator promoting the patient's chosen health care goals. In a more recent work, Watson (1999) describes a theory of transpersonal caring-healing which is inclusive of being with, of being present, but is focused toward a deep spiritual connectedness which has the force to potentiate healing. Within a transpersonal relationship, each person is changed for having had the encounter.

Newman (2008) describes a theory of health as expanding consciousness in which people are continually moving through their being relative to varying health states, which are experienced as part of their whole. Events of disease and illness cannot be separated from the whole. Thus healthcare and particularly nursing care, aims to help a person by promoting the highest achievable health state for that person, at that time, within the context of that person's whole being. According to Newman, this is accomplished through the use of nursing presence. She suggests that as nurses are present with patients, element of the patient's being which are affecting health may be revealed which could not have been expected, but which once known, may raise conscious awareness and perhaps enhance the patient's health. These "transforming relationships" which serve to reveal the whole, only occur when there is presence.

Historical Evidence of Nursing Presence

Evidence of nursing presence is found in Florence Nightingale's nursing practice and her teachings of nursing care (Nightingale, 1859). She was attentive and genuine in

her care of the soldiers during the Crimean War, providing competent and compassionate care (Donahue, 1985). A war correspondence's report of the time stated, "her benignant presence is an influence for good comfort even amid the struggles of expiring nature . . . . and as her slender form glides quietly along each corridor, every poor fellow's face softens with gratitude at the sight of her." (M. W. Macdonald in Donahue, 1985, p. 32). This account suggests that she was intentionally being with the soldiers in their plight and they perceived her attentive engagement in their existence.

Nightingale taught the importance of careful observation of each patient's condition within the context of the patient's particular situation (Sandelowski, 2000). In her famous "Notes on Nursing" Nightingale (1859) states, "The most important practical lesson that can be given to nurses is to teach them what to observe—how to observe—what symptoms indicate improvement—what the reverse—which are of importance—which are of none . . ." (p. 59). Nightingale's directions for collection of detailed observations required the nurse to be in close physical proximity to her patients and be attentive to the uniqueness of each patient's condition in order to determine what care the individual patient needed. Her lessons on observation and relative importance of findings for the purpose of providing individualized care reflect elements of nursing presence.

As well, Nightingale's instructions for communication with patients convey notions of nursing presence. She stated, "Sit down, do not rush, position yourself for the patient to easily see your face, give your full attention" (p. 28). In addition, she instructed nurses to question patients so as to not lead them into any particular answer and to refrain

from assuming conclusions from information. Nurses are to seek clarification from the patient (p. 61) and respect the patient's idiosyncrasies and choices (p. 66).

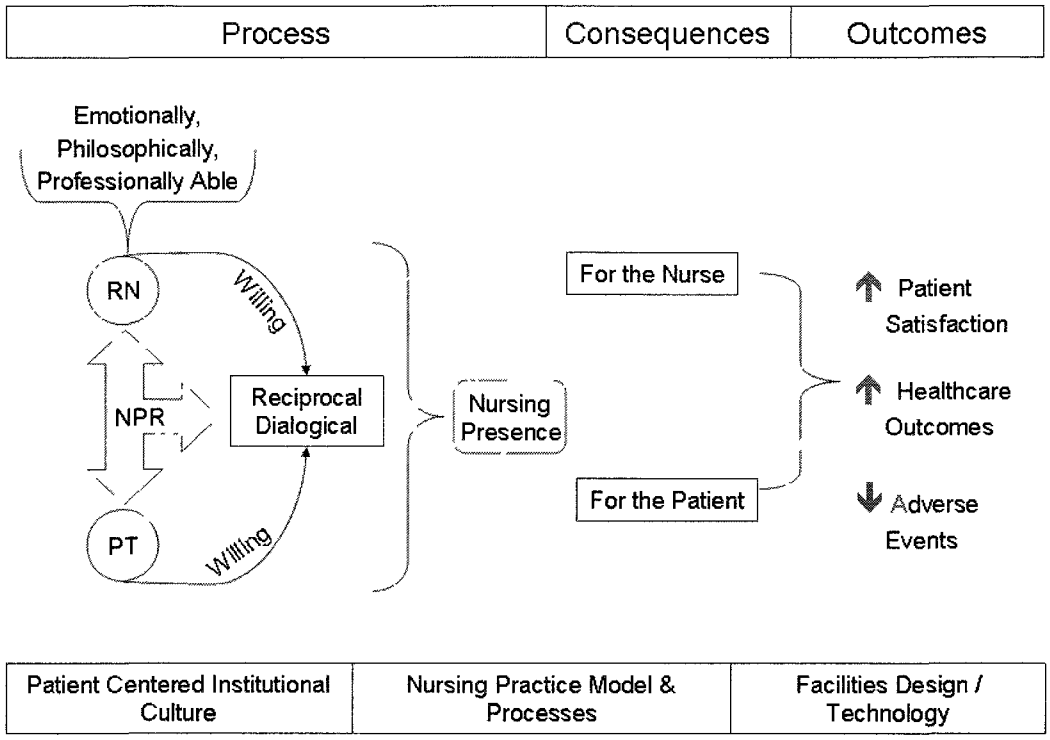
Careful thought must be given to an extrapolation of Nightingale's nineteenth century nursing instructions to the complexity of present day nursing. Her context was unencumbered by the technological distractions of contemporary nursing. Today's nurses utilize technology to gather much of the information upon which plans of care are based. But there is the risk of distancing within the nurse patient relationship as nurses attend to the devices employed at the bedside and the patient is only the object of care. There is no relationship. One could argue that the applicability of Nightingale's teachings to modern day nurses is limited because she lacked technology and was solely reliant on her observations made during close personal encounter with her patients. Yet, her works reflect attributes of nursing presence such as absence of presumptions, belief in uniqueness of patient, acceptance of other's view as a reality, focused attention, seeing the relative importance of factors and observation of the patient's gestalt which are described in present day concept analyses of nursing presence (Covington, 2003; Duis-Nittsche, 2002; Hessel, 2009; Zyblock, 2010)

Conceptual Model

The proposed conceptual model of the emergence of nursing presence as shown in Figure 1, demonstrates the process, consequences and presumed outcomes associated with the concept. This model suggests that between the nurse (RN) and the patient (PT) there exists a nurse-patient relationship (NPR). During the process phase, there are factors which determine if the relationship may evolve to include nursing presence. The

nurse must have the emotional, philosophical and professional abilities to engage in nursing presence as described in Figure 2. The nurse and the patient must be willing for a reciprocal and dialogical relationship to develop. If so, the nurse uses her/himself as the intervention to be with the patient and nursing presence emerges. The experience of nursing presence holds consequences for both the nurse and patient and may result in improved quality outcomes as measured by improved patient satisfaction, improved healthcare outcomes and decreased incidence or severity of adverse events. The emergence of nursing presence is supported in a health care institutional culture of patient-centered care, within a nursing practice model that places registered nurses at the bedside providing direct care and in facilities whose architectural design and technology systems promote nurse-patient physical proximity. The factors which influence the emergence of nursing presence will be presented in more detail.

Figure 1. Emergence of Nursing Presence



Conceptual Definition

The concept of nursing presence has been the subject of analysis and study by numerous nursing scholars. Descriptive phenomenology is often found as the method of inquiry as researchers attempt to generate descriptions of the concept (Holloway & Wheeler, 1996, 2002). The following literature has been selected as representing significant contributions to advance the understanding of the conceptual definition of nursing presence.

The collaborative work of Doona, Chase and Haggerty (1997) resulted in a commonly accepted and oft referenced definition of nursing presence. They had conducted independent studies of nursing judgment in different clinical settings and recognized commonalities in their results. The nurses in the studies spoke of being with patients as they talked about their own nursing judgment. The authors collaborated to conduct a secondary data analysis of the three data sets to explore the common features within the context of nursing judgment and to delineate the features of the nurses' connection with the patient that contributed to nursing judgment. The narratives of thirty nurse informants were included in the combined analysis. From this work, the authors defined nursing presence as

> An intersubjective encounter between a nurse and a patient in which the nurse encounters the patient as a unique human being in a unique situation and chooses to spend her/himself on the patient's behalf. The antecedents to presence are the nurse's decision to immense her/himself in the patient's situation and the patient's willingness to let the nurse into that lived experience. As a consequence to nursing presence, both the nurse and the patient are changed. Both are affirmed as

> unique human beings, and the nurse is affirmed as a professional and the patient as a person in need. (Doona, et al., 1999, p. 56).

In further analysis of their combined data, Doona, Haggerty and Chase (1999) identify six features of nursing presence. These features are uniqueness, connecting with the patient's experience, sensing, going beyond the scientific data, knowing what will work and when to act and being with the patient. Of particular note are the author's premises that presence is an "all or none phenomenon" (p. 57) and that it is a function of the expert nurse as defined by Benner (1982). Their conceptual model of presence supports the requisite need for patient and nurse to relate in a way that allows for the more intimate connection found in presence.

Marsden (1990) describes presence from a review of the literature and offers a list of antecedents, attributes and outcomes. She describes presence as signifying a commitment made within relationships where there is a giving of oneself as well as receiving from the other. Presence is born out of availability to be with another, emerging in a spirit of quietness with an openness and respect for the life situation of the other. She promotes the notion of preconditions for presence to include self knowledge, sensitivity and receptivity to culture, beliefs and traditions of others. As a result of nursing presence, the patient is assisted toward self-determination. Of particular note, this author presents the view that being present is a skill that may be learned. She lists actions that promote the emergence of nursing presence such as being comfortable with silence, making eye contact, using touch judiciously to comfort or communicate concern and being respectful in speaking quietly without interrupting the patient.

In her doctoral dissertation study of nursing presence, Duis-Nittsche (2002) conducted a descriptive qualitative study to describe the lived experienced and impact of nursing presence within the nurse patient relationship. Her methodology was Cowling's Unitary Appreciative Inquiry which is distinguished for including the participants at each stage of the exploratory process. She developed interview questions using Baldwin's Peer-Spirit Circle Process to guide individual interviews of seven nurse / patient participant dyads. Questions in the interviews addressed how to describe nursing presence from both the view of the patient and the nurse, how it is demonstrated and sustained and the consequences for both nurses and patients. The nurse participants volunteered for the study because they believed they experienced nursing presence in their work with these patients. From her analysis, a list of aspects of nursing presence within the nurse patient relationship was generated. It included personal traits of the nurses to be compassion, self-knowledge, self-awareness, self-confidence and openness to others. Nursing clinical knowledge and competence emerged as factors along with communication skills, intuitive understanding and subjective sensing. Finally, the nurses demonstrated a commitment to help and the intention to be with the patients.

The afore-mentioned study confirms elements of the definition and features of nursing presence from Doona, Haggerty and Chase (1997). In particular, intentionality to be with, intuitive sensing, connecting and being with are reflected in Duis-Nittsche's work. In addition, she found that physical proximity of the patient to the nurse and touch encounters were important to the patients. The reported findings include consequences of presence for the nurse to be a sense of satisfaction, joy, happiness, spiritual fulfillment

and being energized. Consequences for the patients who experienced nursing presence included hope and encouragement. Six of the seven patients believed nursing presence contributed to their recovery or remission by giving them hope and encouragement. The also believed their positive outcomes were directly affected by nursing presence because the nurse knew them well and they trusted the nurses' faith in their recovery.

Duis-Nittsche (2002) makes significant contributions to the body of knowledge of nursing presence. The results of her study add the attributes of knowing the patient, being encouraging and being honest to the list of nursing traits which contribute to the nurse's capacity to be present. She confirms the need for the patient to be willing to engage the nurse before an emergence of presence. Importantly, this work supports the notion that levels of presence exist. This is contrary to the analysis of nursing presence by Doona, Haggerty and Chase (1997) in which presence exists in the nurse-patient relationship, or it does not. Duis-Nittsche found the level of nursing presence to be dependent upon the patient's need as assessed by the nurse. Additionally, patients recognized that nursing presence was not demonstrated by all nurses. Acknowledgement that patient are able to perceive nursing presence and that it is expressed at varying levels supports attempts to quantify it. The importance that these patients put on nursing presence underscores it's value to patient satisfaction with care.

Osterman and Schwartz-Barcott (1996) support the notion of nursing presence occurring in different ways. In their conceptual analysis of presence, they identified the following four progressively intense ways of being there: presence, partial presence, full presence and transcendent present. They support this differentiation of nursing presence

based upon a review of the literature and previously conducted field observations made by Osterman of nurses who provided care to respiratory-support-dependent patients. They define the ways of being there according to descriptions in five categories: quality of being there, focus of energy of the nurse, nature of nurse-patient interaction, positive outcomes and negative outcomes for both the nurses and the patients.

Easter (2000) conducted a construct analysis of four modes of being present based upon her previous explorations of the concept of nursing presence. Her purpose was to articulate the process of being present in order to facilitate the teaching of presencing to student nurses. She perceives of the four ways of being there described by Osterman and Schwartz-Barcott (1996) as differentiated by the amounts of presence offered by the nurses. She describes mode of being present as physical presence, therapeutic presence, holistic presence and spiritual presence. She suggests a conceptual framework in which each mode is differentiated by nurse attributes, nurse consequences, patient attributes and patient outcomes. She defines the mode of physical presence as a body to body relation requiring spatial proximity. Nurse attributes cited include regard for another, commitment to helping and ability to use one's senses. Patient attributes include a health care need and a willingness to engage in an open nurse-patient relationship. Consequences for the nurse are hopefulness, comfort and reassurance of ability to enhance care. Patient outcomes are a sense of being heard, being encouraged, being motivated and having a decreased feeling of isolation/loneliness. The mode of therapeutic or mind to mind presence is an intervention of the expert nurse, using therapeutic communication skills to give support, hope and comfort to patients. As a result, the patient experiences comfort, relaxation and

an increased ability to cope as outcomes. Nurses in the therapeutic mode of presence experience consequences of ease and efficiency of nursing care, confidence, competence, job satisfaction and joy. The mode of holistic presence reflects the nursing practice view of the integrated whole as more than the sum of the parts. Nurses who demonstrate this mode of presence have a belief in a simultaneous action world view and possess expertise in holistic nursing practices such as healing touch, visual imagery and meditation. Consequence for the nurse include increased purpose, sense of meaning, well being, optimism. Patient outcomes may be decreased anxiety, pain or diastolic blood pressure. This mode of presence requires patients who desire holistic care and a reciprocal relationship with their nurse. The mode of spiritual presence is related to transcendent awareness and is possible only when the nurse has a valued spiritual belief and the patient has a desire for a spiritually reciprocal nurse patient relationship and a need for spiritual presence. In this mode, the nurse gains a sense of support for her nursing practice. Both the nurse and the patient experience self-affirmation and hopefulness.

Fredriksson (1999) conducted a synthesis of qualitative or concept analysis studies of presence published in nursing or caring journals written in English or Scandinavian, as an exploration to further develop an understanding of presence, touch and listening in the caring conversation between nurse and patients. Three phenomenological studies with a total of 79 informants and seven concept analyses describing presence were included in the synthesis. She identified being there and being with as opposite ends of a continuum representing levels of being present. At one end, being there is a physical state and related to communication and understanding. It is

being attentive and using body language such as touch, eye contact, physical proximity and comfortable silence to display comforting. Being there serves to facilitate coping, diminish feelings of fear, loneliness, anxiety, and encourages and motivates the patient. At the other end of the continuum, being with is a gift of self expressed by being available and at the disposal of the other. It represents acceptance of the uniqueness of the other, reciprocal giving and receiving, and emerges within the context of a threatening experience as a connectedness that is deeply relational. Being with serves to alleviate suffering, lesson feelings of vulnerability and increase understanding of self. Fredriksson concludes that the continuum of being there to being with represents levels of engagement much the same as a continuum of hearing what words are said to actually listening to what is being said (or not said), and a continuum of touch from being task-oriented to representing a connection and caring. She suggests that presence, touch and listening are inter-related along a continuum of the nurse-patient relationship represented by contact at one end and connection at the other. She emphasizes the roles of both the nurse and the patient to move their interaction along the continuum and the necessity of mutually desired levels of interaction.

As her doctoral degree dissertation, Mohnkern (1992) undertook a qualitative descriptive study of nursing presence using fifteen selected nurses as informants. The study sampling method was purposeful in order to interview nurses who were likely to offer information to this subject. In the analysis of her data, she found several personal trait antecedents to nurses engaging in presencing. They included self-confidence, maturity, openness to others, affinity for the patient, knowing the patient and seeing his

or her inherent strengths, possessing intuitive understanding, a commitment and desire to help and intentionality to be with the patient. From the nurse informants' view, the patient's psycho-socio-spiritual-emotional function improved and there was a definite physical progression. The nurse informants appraised themselves as being mature, self-confident, altruistic and practicing as proficient, if not expert, nurses as described by Benner (1982). Mohnkern found varying descriptions of the character, duration, intensity, frequency and consistency of presencing across patient contacts. Some informants described a metaphysical connection and exchange of energy occurring at times and feelings of being companions in the patient's experience. This study suggests a relationship between the nurse's affinity for a patient, specifically directed toward the patient's perceived strengths, and the nurse's use of presence in caring for the patient. This finding supports the conception of presence as a chosen intervention. Mohnkern further states that nurses are able to be taught to use nursing presence. She articulates the case for nursing educators to incorporate teaching and modeling presencing behaviors to students in order to better prepare them as professional nurses. She also stresses the need to promote nursing students personal sense of self in order to be able to be present.

Fuller (1991) created a concept analysis of presence from the nurse's perspective. She used a review of the literature and interviews with eighteen medical / surgical nurses who she believed would be able to articulate their experience with being present with patients. Themes emerged from her data and she compared them to descriptions of presence she identified in her literature review. The findings revealed that for this group of nurse informants, being present was not a subject taught to them during their nursing

education. They learned how to be present by example from other nurses, by evolving in their own practice and by using their intuition to give the patient the care that was needed. They found having the knowledge and skill to be present was valuable to their patient care. Once learned, they purposefully practiced presencing. Some informants stated they intentionally chose to uses presencing as an intervention with a particular patient directed goal in mind. Others said presence was not always intentionally planned. Sometimes it just happened. Some describe themselves as always being present to some degree but most believed they used presencing during particular situations, usually when there was more distress or crisis for the patient. In general, the nurse informants associated using presence with patients with identified needs, pain or more acute illnesses. Of particular note is the finding that the nurses used presence when they didn't have anything else to do to help the patient. In this study, touch and listening emerged as actions which were associated with being present. The nurses believed their use of presence resulted in positive effects for the patients however specific outcomes were difficult to describe and validate. This study supports the notion that being present is an intentional action occurring in the nurse-patient relationship. It also provides evidence to believe that learning to be present is possible, but not a part of nursing school education.

Measuring Nursing Presence

Two instruments designed to measure nursing presence were located after an exhaustive search of the literature. The first, developed by Hines (1991) appears to be based on qualitative study reports in the literature and a secondary data analysis of the phenomenological study of nursing presence done by Pettigrew (1988). Hine's instrument is the Measure of Presence Scale (MOPS) consisting of 60 questions aimed at nurses' self appraisal of being present. This work finds nursing presence as being relational, not necessarily dependent on physical proximity, expressed at differing levels and foundation to nursing practice. However the instrument measures nursing presence from the view of nurse, not from the perspective of the patient. It is the position of this researcher that the patient's experience is of paramount value in assessing the expression of nursing presence within the nurse patient relationship.

The instrument selected for use in this study was developed by Kostovich (2002). It is the only instrument found designed to measure nursing presence from the patient's perspective. She conducted a concept analysis by literature review to arrive at a definition of nursing presence which she validated with ten nurses. This definition served as the basis for her instrument development. She designed the Presence of Nursing Scale (PONS) and tested it using 330 acute care inpatient study participants who had been hospitalized for a minimum of two days before they were discharged. Surveyed participants answered "yes" when asked if they could identify one or more registered nurses whose presence made a difference (either positively or negatively) to them during their hospitalization.

Validity and reliability of the PONS were evaluated by Kostovich (2002) as follows. Content validity was established by a panel of experts including Dr. Josephine Paterson, Dr. Loretta Zderad and Dr. Diane Gardner. Construct validity was established using a biserial correlation comparing the construct of nursing presence (as measured using the PONS) to patient satisfaction with nursing care (dichotomous variable). This resulted in a strong positive correlation of 0.801. A Cronbach's alpha reliability coefficient of 0.95 supported internal consistency of the tool. She also performed a test/retest reliability with the result of a Spearman's rho test of 0.729, significant at 0.05 with both one and two-tailed tests. Secondary analysis of various groups within the sample showed no significant differences. Thus construct and internal reliability were demonstrated in the instrument development.

Associated Assumptions

The Expert Nurse

There are differing opinions of the potential for nursing presence to emerge according to the level of the nurse's practice expertise. Some contend that nursing presence is solely the function of the expert nurse (Doona, et al., 1999; Newman, 2008) while others conceptualize presence as a skill which develops as the nurse moves through the stages of skill acquisition (Osterman & Schwartz-Barcott, 1996). If this is the case, then nurses at any stage are capable of being present to some degree. While an association between the capacity to be present with a patient and being an expert nurse is presumed as likely, a relationship has not been demonstrated. This is an important consideration for this study which explores the level of nursing expertise in regards to the

patient perception of nursing presence. However, a reliable and validated instrument for measuring nursing expertise has not been located. Commonly, nursing expertise is implied by indicators such as years of experience and educational level attained or by performance descriptions. Therefore, in this study, consideration has been given to the method of determining nursing expertise.

Benner's (1982) developmental model of nursing practice skill acquisition forms the basis for the descriptive definitions of levels of nursing expertise. She observed nursing students, new graduate nurses and experienced nurses working in various clinical settings as she explored the applicability of the Dreyfus model of skill acquisition to nursing practice. From this work she defined five levels of nursing practice in the Dreyfus model. The novice nurse performs tasks to attain objectives within a set of rules but is unable to discern the relevant value of tasks or when an exception to a rule is acceptable. The advanced beginner is able to see aspects of care that are contextually reoccurring because of some experience with situations. The competent nurse, with two to three years of experience, uses goal attainment to direct care but is able to prioritize based on relative values of aspects of care. Care planning is based on conscious, abstract, and analytic contemplations of a problem. Proficient nurses have an experience-based ability to prioritize care based on recognition of deviations from expected patterns and are able to modify care as a response. They are able to perceive situations as wholes and consider fewer options because they more accurately sense the most important aspects of a problem. Expert nurses use intuition stemming from extensive experience to see the broader context of the patient's care and attend to the most relevant needs. The two upper

levels are separated from the lower three in part, by being able to see possibilities in situations and in the thinking process used to solve problems. Proficient and expert nurses use intuition and experience to guide their practice rather than rules.

Years of nursing experience and attainment of certification status has been questioned as useful indicators of nursing expertise. Bobay (2004) reported findings from portions of her dissertation research study of a large sample (338) of emergency department nurses who had passed the Certification for Emergency Nursing examination within a calendar year. They were give a survey aimed at measuring nursing practice expertise considering the following five factors: experience, domain-specific knowledge, quest for knowledge (defined as professionalism, leadership, and accountability), reinvestment (continuous life-long learning) and progressive problem solving including decision making and creativity. Experience was measured as both years as a nurse and years in the specialty, in this case ED nursing. Results indicated that nurses in this study with more years of experience tended to demonstrate lower levels of problem solving, complex thinking and domain-specific knowledge than nurses with fewer years of experience. The author concluded that longevity of experience alone does not constitute expertise, but rather the transformation of the nurse's understanding due to experience leads to progressively more expertise. She strongly recommends that longevity of experience be discontinued as a measure of nursing expertise.

Roche, Morsi and Chandler (2009) reported the results of an exploratory predictive correlational design study to examine the relationship between work empowerment, work relationships and self-reported expertise in experienced nurses in

acute clinical care setting. Nurses were surveyed who had at least five years of experience and who worked at least sixteen hours per week. Three different instruments were used in the survey to gather demographic data, to self-measure clinical expertise and measure conditions of work effectiveness. 115 nurses were included in the study. Their average age in years was 43.8, their average years of nursing experience was 19.4, average years of experience on their unit was 11.7 and average years of experience in their specialty was 14.6. There were 32 nurses with diploma degrees, 27 with associate nursing degrees, 39 with bachelors in nursing degrees, 5 with master nursing degrees and the remainder held other bachelor or master's degrees. The results of the this study showed that only years of experience in the specialty related to nurse expertise. There was not a relationship between nursing expertise and educational level, years of nursing experience nor years of experience on the unit. Work empowerment, considered as opportunity for leadership, support, access to resources and information, was related to nursing expertise.

Jasper (1994) conducted a concept analysis of the term expert as it appears in reference to nursing. She found defining attributes of expert nursing to be the possession of a specialized body of knowledge or skill, extensive experience in that field of practice, a highly developed level of pattern recognition and acknowledgement by others. For the acknowledgement of others to be valid, she identified three requisite conditions. First, the possessed expert knowledge and skill is judged as relevant by others. Secondly, the person must be acknowledged as an expert by others. Finally, the recognition must be by people who are qualified to make that judgment. She also reported antecedents to the

development of an expert to include having confidence in oneself and one's decision making skills, working with colleagues, having exposure to a single environment within which skills and knowledge can develop, holding the appropriate base qualifications in the chosen area and having the opportunity to develop them. Consequences of becoming an expert are reported as accordance of high status within the profession, consultation by others and being used as a role model. These findings support the use of peer assessment of nursing expertise in this study.

Barriers to Nursing Presence

It is suggested that being with a patient is desirable for both the patient and nurse however barriers may exist which inhibit or prevent nurses from being present with their patients. Sandelowski (2002) discussed challenges to being present as evident in the rapidly advancing cyberspace of health care technologies which gather and assimilate body function data upon which bodily care is delivered. She describes the notion of the post human perspective, the view of the body as a disembodied informational structure with replaceable parts, unassociated with the self. She notes that this phenomenon of information technology is occurring simultaneously to the awareness of a mind / body connectedness. When nurses flocked to be the keepers of advancing bedside technology, they assumed responsibility for the hands-off-the-patient information gathering instruments and relinquished the hands-on care of the body, delegating it to lesser trained personnel. But in that, nurses lost the ways of knowing the patient and gathering information that occurs with touch and the attendance to the needs of the body. Nurses find themselves in-between the patient and the technology, needing information from

both devices and from being with the patient. Sandelowski describes a movement to revitalize nursing as caring for the body and thus gathering information unperceivable to even the most sophisticated device.

Watson's (1999) presents a similar concern in her theory of transpersonal caring-healing in which she elucidates the challenge to caring for contemporary nurses. She believes nursing has abandoned feminine caring/healing in the pursuit of masculine medicine/curing. Nursing, in her view, has been misled to value efficiency, technical prowess, and emotional distancing from those in need of care. The caring expressions of touch, of being with, of spiritual connectedness have been submerged under the need to be ever more "expert" servants to medicine. She is critical of educational reform which she believes "often results in people learning more, having more content and more factual, empirical knowledge, rather than being more, the necessary ingredient for a caring community (p. 69). Watson implores the profession of nursing to resurrect an ethical, caring and relational identity in a partnership-compliment to medicine.

McCabe (2004) explored patient's experiences of how nurses communicate with them using a qualitative, Heideggerian / Gadamerian hermeneutic phenomenological approach. The study was based in assumptions that health care organizational cultures do not support positive communication within the nurse-patient relationship and that nurses assume they know what care patients need and want. She interviewed eight adult patient participants chosen purposefully on the basis of their experience with inpatient nurse-patient relational communication and their ability to articulate opinions. The data revealed four main themes. First, there was a lack of communication, without sufficient

sharing of information particularly when the nurses were too busy attending to tasks. Next, patients valued feeling attended to. This was described as the nurse being accessible to give of his or her time and be there with the patient. Empathy in understanding the patient's feelings was another theme as was being friendly and approachable. The author concluded that nursing tasks are more valued by the organizational culture than is the nurse patient relationship. The tasks are more easily standardized, measureable and can be used for predictability of nurse performance. Nurses are capable of patient-center communication but avoid it in favor of task fulfillment or superficial communication.

Macdonald (2007) describes barriers to being present in a report of a study to explain the origins of difficulty in the nurse-patient encounter. She undertook a constructivist approach to grounded theory research generating data from 120 hours of clinical observations on a family medicine unit and interviews with twelve patient and 10 nurse informants. The data revealed that time limits were the most problematic issue as a barrier to nursing presence. Conflicts arose in the nurse patient relationships when nurses did not have sufficient time to get to know the patients. In turn, the patients were dissatisfied because they felt the lack of attention from the nurses. Contributing factors to limitation placed on the nurse's time included attending to patient's family's needs, the availability of supplies and equipment, who is working and time needed for care space changes (as in discharge planning). A negative consequence of time limitations was the response by nurses to increase their control over patient care by taking actions to speed up the patient care such as limiting choices or reducing visiting hours. In essence, when

the nurse does not have time to know the patient, presence cannot emerge within the nurse patient relationship.

Outcomes Associated with Nursing Presence

There is evidence to suggest that nursing presence, promoted by education and practice models, results in better patient satisfaction with care. Bournes and Ferguson-Pare' (2007) designed a professional development model in which staff nurses were provided 20% of their salaried time in focused mentorship and learning about patient-centered practice based on Parse's theory of human becoming. They conducted a longitudinal, repeated measures, descriptive-comparative design study using quantitative measures to ascertain patient satisfaction and nursing job satisfaction. They collected data from institutional records regarding staff turnover, sick time use, overtime hours, agency use, labor cost, patient length of stay, rates of falls and medication incidents. A pre-post descriptive qualitative design was used to ascertain changes that emerged among patients, staff and management before and after the implementation of the 80/20 human becoming patient-centered care professional development model (80/20 HBPCC model).

A number of positive outcomes resulted from the use of this care model. Patient satisfaction was highly rated, overtime use and staff turnover declined and staff satisfaction improved without an effect on the variable direct labor cost. Importantly, there was a reduced rate of patient falls on the study unit during the time of the intervention. The qualitative data analysis revealed a change in the nature of nurse-patient engagements, from being focused on tasks of care to being present, listening, getting to know the patients. The nurse participants related an increase in their understanding of the

patient as the subject of care and respecting patients as experts of their own health. Patients reported the nurses as being willing to listen, keeping them informed, getting to know them as people and include them in what was happening. Nurses were described as being attentive, knowledgeable, genuinely interested. This study supports the notion that nurses can be taught to be present with patients. And it demonstrates that there is value to both nurses and patients when nursing theories reflective of nursing presence are taught to nurses, and when they are supported by the institutional culture to apply the theory to their nursing practice.

Summary of Literature Review

Being present constitutes a letting go of power-based preconceived notions about how a particular health event will unfold for an individual patient. Being present is an acknowledgement of someone's being in the world as different than our own. When the nurse engages the patient with presence, in an I-You relationship, the nurse gains understanding of the patient's reality and conveys information to the patient. Thus the patient has more information to incorporate into his knowledge of his health condition, thus expanding his reality and increasing his power over his situation. Being present is an intentional act with positive consequences for the patient and the nurse.

Based on the literature reviewed a list of personal trait antecedents and attributes which contribute to a nurse's capacity to be present is shown in Table 1. This summary arranges the antecedents and attributes under three categories of the nurse's ability to be present: emotional, philosophical and professional. If able, the nurse must have willingness to engage the patient in a reciprocal and dialogical relationship in order to

take action and intervene with presence. It is not suggested that the nurse must possess all of the antecedents and attributes in each category to be capable of engaging a patient with nursing presence. It is the stance of this researcher that there is sufficient literature to support the notion of levels of engagement in nursing presence which will be associated with some of the items in the list.

Table 1

Nursing Presence Antecedents and Attributes

Nurse characteristics enabling the emergence of nursing presence	Personal trait antecedents to nursing presence	Nurse attributes of presence
Emotionally Able	• Authenticity • Compassion • Self-knowledge • Self-awareness • Self-confidence • Genuineness • Maturity	• Is emotionally available • Is with • Gives gift of whole self • Is comforting
Philosophically Able	• Humility (absence of domination) • Openness to others • Belief in perception as reality • Theoretical knowledge • Accepts unlimited view of reality • Sense of mission	• Is absent of presumptions • Believes in uniqueness of patient • Is absent of objectification • Views patient as subject of care • Co-participant in the health care process
Professionally Able	• Clinical knowledge • Clinical competence • Knowing the patient • Authenticity • Communication skills • Intuitive understanding • Subjective sensing • Sees inherent strengths • Presencing knowledge	• Sees relative importance of factors according to patient values • Is observant of patient's gestalt • Is encouraging • Is honest
Willingness	• Commitment to help (desire to help) • Intentionality to be with	• Chooses to be present • Prepares for patient encounter • Attention is complete toward patient • Responsive to patient requests (available)

Importance to the Advancement of Knowledge

The study reported here was undertaken to add to the understanding of nursing presence as it is evidenced in nursing practice by exploring the feasibility of measuring it's occurrence in the acute care setting. The wealth of conceptualizations and qualitative descriptive studies of nursing presence provides strong evidence of it's value to patients. However in order for nursing presence to be valued as a widely usable and important indicator of nursing care quality and patient satisfaction, it needs to be quantifiable. Thus the purpose of this study was to demonstrate the utility of measuring nursing presence as a quality of care indicator using the Presence of Nursing Scale. As a reliable and valid measure of nursing presence, it may have practical utility for further exploration of nursing presence related to the quality of nursing care and nursing care outcomes.

CHAPTER III

METHODS

Research Design

This chapter includes a description of data collection methods, the measurement instrument and surveys, sampling methods, data analysis procedures and considerations for human subjects protections. This was a two phase explanatory mixed method study to investigate nursing presence as perceived by adult patients hospitalized on an acute medical/surgical unit. This sequential data collection model was used as follow-up; qualitative data were collected to help explain the quantitative results (Creswell & Clark, 2007, p. 73). A quantitative approach was used to examine the relationships between the patients' perception of nursing presence and their general satisfaction with nursing care. The nurses' level of expertise and commonality of general demographic characteristics between the patients and nurses were explored. A qualitative approach was used to gain understanding of the perception of patient and nurses regarding the character of their relationship. This mixed method was used because the quantitative survey instrument has potential limitations which may be explained by follow-up qualitative data.

Specific Aims:

1. Test the reliability and validity of the Presence of Nursing Scale (PONS) developed by Kostovich (2002).
2. Identify the relationship between the PONS score and patient satisfaction with nursing care.
3. Explore the relationship between the PONS score and indicators of nursing expertise.
4. Explore the relationship between the PONS score and demographic characteristics of the participant nurses and patients.

Data Collection

Quantitative Data

The Presence of Nursing Scale (PONS) developed by Kostovich (2002) was used as the quantitative measure with the intention to further test the reliability and validity of the PONS and to address potential limitations to its widespread applicability. To begin, participants in the PONS development study were selected to complete the survey only if they stated they had encountered one or more registered nurses whose presence made a difference (either positively or negatively) to them during their hospitalization. Thus, the instrument was not used to measure the occurrence of nursing presence, but rather to measure its degree. If the PONS is ever to be widely employed as an implied measure of patient satisfaction and related to quality of care indicators, no such pre-screening would be feasible. In this study, a convenience sampling method was used without pre-screening

for perception of nursing presence in order to obtain a range of PONS scores which were further explained by the qualitative data from the survey participants.

Additionally, in the development study, the structure of the survey questions directed the patients to consider the nurses collectively in their survey responses. Such a collective evaluation of nursing care has been identified as problematic in that patients find it difficult to rate a group which contains some nurses who the patient was satisfied with and others who the patient was not satisfied with (O'Connell, Young, andTwigg, 1999). Thus, the PONS was used in this study with a change to its content to reflect the singular " registered nurse" rather than the plural "registered nurses". Patient participants were asked to consider one identified nurse who provided their care. This design facilitated the explanatory qualitative phase and the exploratory analysis of the nurse-patient dyads.

Finally, repeated studies using the PONS have not been published in the literature since it's development by Kostovich (2002). While the psychometric properties of the survey were sound in the initial study, the lack of repeated testing of the instrument by other researchers poses a limitation for wide applicability of results. In this study, psychometric analysis of the instrument was done and the qualitative data were used to further validate the PONS.

When completing the PONS, patient participants were asked to rate the frequency with which they perceived each of the 25 items of the survey considering the identified nurse. As in the original PONS, they were asked to rate each item using a five-point Likert scale as follows. The first 24 questions of the PONS (numbers 6 – 29 on the survey

form) were answered as never, rarely, occasionally, frequently or always. The last question (number 30 on the survey form) was answered as very negatively, negatively, no difference, positively or very positively (see Appendix A, Patient Participant Survey).

Question 31 on the survey form was used as an indicator of the patient's overall satisfaction with the nurse's care to correlate to the PONS score. Patients were asked to grade their overall satisfaction using a five-point Likert-type scale, labeled with a grade and corresponding % score, as if scoring a test in school. Existing instruments to measure patient satisfaction with nursing care were considered but discarded for a number of reasons. The 28-item La Monica-Oberst patient satisfaction scale, referred to as the LOPSS (La Monica, Oberst, Madea, & Wolf, 1986) has been widely used. However, its use to accurately measure characteristics of contemporary patient satisfaction with nursing care has been questioned (O'Connell, et al., 1999). Lynn, McMillen and Sidani (2007) also questioned the modern applicability of the LOPSS and responded by developing the Patient Assessment of Quality Scale – Acute Care Version (PAQS-ACV). This 44-item survey focuses on elements of individualized care, caring, nurse characteristics and responsiveness. While this measure appears to be sensitive to measure what patients value in nursing care and incorporates elements of nursing presence as measured in the PONS, it is long. It is the opinion of this researcher that the addition of another complete survey instrument to this study design would add a significant burden to the survey process for the participants and likely result in survey fatigue. Therefore, the single rating of patient satisfaction with nursing care was used.

In addition to the PONS, the survey asked patients to explain why they were

hospitalized, to provide demographic information (gender, age and ethnicity) and whether or not they had prior hospitalization experience on the study unit and if the nurse considered in answering the survey questions had given them care during a prior hospitalization. A final open ended question allowed participants to include comments. The quantitative data collected are summarized in Table 2.

Table 2

Dependent and Independent Variables

Dependent Variable	PONS	25 items Five-point Likert scale Composite score recorded
Independent Variables		
Patient Participants	Satisfaction with nursing care	1 item Five-point Likert scale
	6 month hospitalization history	Frequency on this unit Frequency with this nurse
	Demographics	Age, Gender, Race/ethnicity Clinical Diagnosis
Nurse participants	Indicators of nursing expertise	• Highest nursing degree • Highest degree in other discipline • Years of experience as RN • Years of experience on this unit • Years of experience in this specialty • Perceived expertise composite score • Employment status on this unit • Certification held • Leadership responibilities
	Demographics	Name, Age, Gender, Race/ethnicity

Nurse participants completed a survey to elicit general demographic information (gender, age and ethnicity), the extent of their nursing experience, their educational levels, role on the unit they work on and the opportunities they have had for leadership (see Appendix B, Nurse Participant Survey 1). To further explore individual nurse expertise, the participating nurses rated each other's nursing expertise based on Benner's stages of skill acquisition (Benner, 1982) (see Appendix C, Nurse Participant Survey 2 Impression of Nursing Expertise Aamongst Peers).

Qualitative Data

Selected patients and nurses participated in semi-structured interviews about the experiences of their nurse-patient relationship (see Appendix D, Patient Participant Interview Guide and Appendix E, Nurse Participant Interview Guide).

Sample

Permission to access to the study site at an academic medical center hospital was given from ranking institution administrators and stake holders. Initial contact was made with a PhD prepared nurse who serves as the institutional liaison for all nursing research conducted at the study site. She reviewed the study and identified a medical/surgical nursing unit as being likely to have sufficient patients to meet the study inclusion requirements. The researcher then met with nurse leaders and staff nurse council members from that unit to explain the study. They granted the researcher permission to conduct the study on their unit and to access the nursing staff and patients for possible participation. Subsequently, the researcher applied for and was granted approval to conduct the research from the institutional Human Research Protections Program Board.

Data Collection Procedures

Quantitative Phase

All direct care registered nurses working on the participating unit were recruited to the study in order to form patient-nurse dyads for data analysis. At the direction of the unit nurse leaders and the staff nurse practice council members, the following steps were taken to recruit nurse participants. First, a flyer announcing the study and explaining general information about the study was distributed in the staff nurse mailboxes. Over the course of the subsequent three weeks, the researcher was available on the unit at varying times to discuss the study and answer questions of interest staff nurses. If a nurse agreed to participate, informed consent according to human subject protection standards (Dunn and Chadwick, 2002) was obtained for the quantitative phase of the study. In the consent, the nurse provided a mailing address which the researcher could use to mail the second nurse participant survey. The nurse was given the Nurse Participant Survey 1 (see Appendix B) to complete and return to the researcher. A container was made available on the unit for the nurses to return the survey, however most of the nurses chose to complete the surveys at the time of signing the informed consent and hand the surveys back to the researcher. During this three week period, 20 nurses volunteered to participate in the study. The second nurse participant survey was constructed with the names of the nurse participants (see Appendix C, Impression of Nursing Expertise Amongst Peers). This survey was mailed to the address provided by the nurse participants. A detailed instruction for completion of the second survey, an explanation of the levels of Benner's nursing skill acquisition model, a copy of Benner's original article describing the model,

and a stamped return addressed envelope were included in the mailing. Approximately two weeks later a reminder to complete and return the survey was sent to the nurses who had not replied. As patient participants were being added to the study, it became apparent that four nurses who were interested in participating in the study had not been included. They had been on extended vacations or otherwise off the unit during the original recruitment period. The researcher informally surveyed the nurse participants and found no objections to completing an additional page of the Nursing Expertise Amongst Peers survey. Informed consent was obtained from the additional four nurses, they completed the Nurse Participant Survey 1 and were mailed the same packet of information as the original nurse participants, with the addition of their names to the survey. The original nurse participants were mailed the additional page of the survey with a stamped return addressed envelope.

A convenience sample of adult patients hospitalized on the study unit was recruited for inclusion in the study. A computerized power analysis using G*Power (versions 3.1.2) was done for a one tailed analysis with an alpha of .05, a power of .95 to minimize a type II error, and a moderate effect size to predict a sample size of 111 patient participants (Faul, Erdfelder, Lang and Buchner, 2007). Patients who were 18 years of age or older who had been hospitalized on the nursing unit for a minimum of 2 days (48 hours) and who were anticipated to be discharged from the hospital within 24 hours, who spoke English and were willing to talk to the researcher were identified by the unit charge nurses. During a daily telephone conversation, the researcher and the charge nurse determined if there were potential patient participants. If so, the researcher visited the

patient at a time to avoid any delay of or disruption in care which might occur as a result of a patient's participating in the study. This was generally late in the twelve hour day shift. The researcher introduced herself and confirmed the patient was interested in learning more about the study. If so, the researcher proceeded to provide informed consent according to human subject protection standards (Dunn and Chadwick, 2002), answer questions and pre-screen the patient according to inclusion criteria.

A semi-directed sampling method was initially used with the intent to form nurse-patient dyads and to randomly select nurses whom the patient would consider in answering the questions on the PONS. Two selection conditions were considered regarding the nurse who had provided care to the patient during that day shift: the patient affirmed he or she knew the nurse and the nurse was a study participant. If either condition was not met, the patient and researcher discussed nurses from the previous shifts in consecutive reverse order to determine if the selection conditions were met during a prior shift. However, some patients had difficulty discerning a study participant nurse who had provided their care and a number of patients did not have care given by a nurse participant. This limited the ability to have every PONS completed with random sampling of a nurse participant and it limited the rate of patient participation. Therefore, a decision was made to preserve the patient as a study participant and the PONS was answered regarding the nurse who provided care on that shift or the previous twelve hour night shift if the patient did not recall the day shift nurse. This preserved the primary study purpose to test the reliability and validity of the PONS regarding a random sample of nurses.

After two months of surveying patient participants, the actual enrollment rate of participants was markedly behind the anticipated enrollment rate. In conference with the charge nurses, it was determined that they were not always able to predict discharge dates and many patients who were potential participants were discharged without the researcher speaking with them. Therefore, the researcher began visiting the nursing unit on a near daily basis to be available to speak with potential patient participants. This approach resulted in an improved rate of patient participant enrollment to the study.

Qualitative Phase

After patient participants gave informed consent to participate in the study, the researcher asked if they would like to complete the survey on their own and have the researcher return to collect it, or if they would prefer for the researcher to read the survey to them. If they requested the researcher read the survey, they were invited to offer clarifying comments regarding their answers and they were told the researcher would take handwritten notes. The survey interviews were done at the patient's beside, with the researcher sitting in close proximity to the patient so the conversation could be conducted in low tones and privacy protected. At no time was a patient interview conducted within hearing range of any nursing staff members.

Six nurses were selected for follow-up interviews. They had been considered in the completion of multiple PONS surveys and agreed to be interviewed. A seventh nurse considered in multiple PONS surveys expressed reservation about being interviewed so she was not included in the qualitative phase of the study. Prior to the nurse participant interviews, the researcher explained the purpose of the interview to the participant and

described how the information would be recorded, i.e., the researcher would make some written notes and would use an audio recording device to record the interview. Informed consent was obtained for this audio-recorded interview. The researcher told the nurse participants when the audio recording device was on and interview guides were used to direct the interview to collect the data of interest for the study.

Data Analysis

Quantitative Data Analysis

A composite score of the PONS was calculated based on responses to the rating scale. Twenty-two of the 25 items received points according to the following rating: never receives 1 point, rarely receives 2 points, occasionally receives 3 points, frequently receives 4 points and always receives 5 points. This same system was used for question 26 which had Likert scale labeling that reflected the language of the question. Reverse scoring was used for 3 reverse worded questions designed to prevent response bias. PONS surveys with missing data were immediately reviewed with the patient participants for clarification to prevent data point omissions. The internal consistency reliability of the PONS was calculated using the Cronbach's alpha reliability coefficient and accepted as reliable with an alpha of greater than or equal to 0.7. Construct validity was examined using a Spearman's rho bivariate correlation technique to test the relationship between the PONS scores and the patient satisfaction with nursing care scores. Descriptive statistics of the patient demographic variables were examined and relationships to the PONS scores were analyzed using techniques applicable to the data scale.

The nurse participant data were examined separately and then compared to the

patients' PONS scores, with limitations, due to the frequency of the patient/nurse dyad data. A mean score was calculated for each nurse's level of skill acquisition based on numbers assigned as follows: novice =1; advanced beginner = 2; competent = 3; proficient = 4; expert = 5. Relationships between the mean score and the variables suggested as indicative of nurse expertise were tested using techniques applicable to the data scales. Correlated values were used to calculate a nurse expertise rating. The relationships between indicators of nurse expertise and PONS scores were explored. All quantitative data were analyzed using SPSS version 18 computer software.

Qualitative Data Analysis

Following patient participant survey data collection, interview field notes were transcribed. A general understanding of the expressed ideas was gained during the transcription. During the first detailed reading of the transcripts, segments of text were coded using a open coding and a pre-defined coding scheme based on the levels of presence described by numerous researchers. The groupings of codes into categories followed this initial reading. The nurse participant audio recordings were transcribed and a general understanding of the nurse's approach to connecting with patients was revealed. The patient interview codes were used and new codes added when an existing code did not represent the text. Categories of codes were identified and regrouped until there were apparent duplicates in code meaning. ATLASti (versions 5.2) software was used to facilitate analysis of the qualitative data.

Sequential Data Analysis

A follow-up explanations model was applied to the analysis of the qualitative data

to further explain the results of the PONS survey, the dependent variable, and relationships to the independent variables (Creswell & Clark, 2007).

Human Subjects

Permission to conduct the study was obtained from the university institutional review board and the Human Research Protections Program Board of the study site (see Appendices G and H, respectively). An institution employee was required to act as the principal investigator so a professional colleague of the researcher agreed to serve in that formal position. Written informed consent was obtained from all volunteers prior to their participation in the study in accordance with accepted standards to protect human research volunteers (Dunn and Chadwick, 2002). An additional informed consent was obtained from nurse participants immediately prior to the audio-recording of their interviews. During the informed consent process, potential participants were given information about the nature of the study, what would happen to them if they participated and the potential risks and benefits to them. They were told that there would be no compensation and participation was entirely voluntary. The imperative to protect the confidentiality and anonymity of the study participants was explained. The method of randomly coding all study surveys to remove personal identifying information was described. The nurse peer expertise rating surveys were mailed to an address provided by the participant and returned to the researcher by mail to maintain strict privacy of the information. The name of the nurse who was considered by the patient participants was coded on the survey form so only the patient and the researcher knew who the nurse subject was. Only the researcher had the code and conducted all surveys and interviews.

Risks and Benefits

There was a risk that patient participants might be uncomfortable completing the PONS while still hospitalized, especially if they were not satisfied with their nursing care. There was a risk that nurse participants would feel uncomfortable sharing personal details and rating the level of expertise of peers particularly if that information was to be shared with unit management personnel. And there was a risk they would feel uncomfortable expressing their approach to establishing a nurse patient relationship. In addition to explaining the method of data coding to prevent identification of the volunteer participants, they were informed that all data would be kept anonymous and confidential to the extent that results would not be reported in a way to expose the identification of any individual participant. And they were told that all collected data, including completed PONS surveys, nurse surveys, transcriptions of interviews, field notes and signed informed consents would be stored in a locked location, accessible only to the researcher and the principal investigator. In addition, participants were told that information they told the researcher as part of the study data collection would not be given to institution management personnel. Only the researcher and a transcriptionist have had access to the audio recordings with the nurse identification blinded to the transcriptionist. A statistician to assist in data analysis has only had access to the blinded data files.

Privacy during the consent and survey processes was of prime importance and maintained as follows. The patient informed consent and survey interviews were conducted in their hospital rooms. In semi-private rooms, when another patient was present, partitions separating the patients at the foot of the beds were kept in place and

bedside curtains were pulled as needed to enhance privacy. The researcher positioned herself to be seated close to the patient's head so the interview could be conducted in low vocal volumes. If a member of the staff entered the room, the survey session was paused until privacy could be restored. Most nurse participants returned the signed informed consent and the demographic survey to the researcher after the researcher presented the study to small groups of nurses. One nurse returned both items to the researcher by depositing them in the container provided by the researcher. The nurse interviews were conducted in a location at the hospital, chosen by the nurse as being sufficiently private.

Risk / Benefit Ratio

The risks to participation in this study were minimal and no direct benefit to the participants has been identified. The results of this research may provide information of use to the nursing profession about nursing presence in the acute care setting and whether or not nursing presence is a measurable construct using the PONS.

CHAPTER IV

RESULTS

Participant Profiles

Registered Nurses

This study began by conducting two surveys of the nurse participants. The first gathered information about their nursing education, experience and general demographics. The variables were selected because of their potential to characterize the level of nurse expertise. Twenty-four registered nurses completed the first survey; three were male (12.5 %), and 21 were female (87.5%). As shown in Table 3, more of the nurses held Bachelor of Science in Nursing degrees than held Associate Degrees. Ten of the nurses had earned a specialty certification. Of those, nine held orthopedic nurse certifications and one held a medical-surgical nurse certification. The majority were employed at the mid level of the clinical nurse ladder. Two were working at the entry level and eight were at the upper level. One participant was a travel nurse.

Table 3

Education, Specialty Certification and Employment Status of Nurse Participants

	Education		Certification		Employment Status, Clinical Nurse Ladder *		
	AD	BSN	Yes	No	CN I	CNII	CN III
N	7	17	10	14	2	13	8
%	29.2	70.8	41.7	58.3	8.3	54.2	33.3

* One Travel Nurse not represented in table.

The participants represented a wide range of ages and years as a nurse and a corresponding wide range of years of nursing on the study unit and nursing in the specialty area of orthopedics and neurosurgery (see Table 4).

Table 4

Age and Longevity of Working as a Nurse Among Nurse Participants

	Years of Age	Years as a RN	Years worked on unit	Years worked in specialty
Mean	39.9	10.8	5.8	8.6
Range	23.75- 57.58	0 – 36	1 - 30	1 - 30

Four unit leadership activities were listed on the survey: acting as a preceptor for new employees and students, being the shift charge nurse, serving on unit committees and teaching unit inservices. Of these, acting as a preceptor was the responsibility most often assumed; teaching unit inservices was the least (see Table 5). Four of the nurses assumed all of these leadership responsibilities on the study unit; six had three; five had two; one had one and eight of the nurses did not have any of these responsibilities.

Table 5

Leadership Responsibilities Among Nurse Participants

	Preceptor for New Staff, Students	Shift Charge Nurse	Serve on Unit Committee	Teach Unit Inservies
N	16	13	11	5
%	66.7	54.2	45.8	20.8

The ethnicity of the nurse participants compared to the population of California registered nurses is shown in Table 6. The study sample held more Asian or Hispanic nurses and fewer Caucasian nurses than the ethnic distribution of practicing nurses in California (Diversity in California's health professions: registered nursing, 2008).

Table 6

Ethnicity of Nurse Participants and California Registered Nurse Population

	N 24	Percent	
		Nurse Participants	CA Registered Nurse
Asian	11	45.8	21.5
Caucasian	9	37.5	64.3
Hispanic	3	12.5	5.7
Black	1	4.2	4.5

In the second survey, the nurses categorized each other and themselves based on Benner's (1982) skill acquisition model of novice to expert. Twenty of the 24 nurse participants (83%) returned the survey. Two of those did not rank themselves, despite the instruction to do so. Rankings were scored according to the five levels described in the

model: novice=1, advanced beginner = 2, competent = 3, proficient = 4, expert = 5. A mean ranking for each nurse was calculated from the survey responses. Comparisons were made between the nurses' self ranking and peer ranking mean. The correlation was large and statistically significant, $r(17) = .671$, $p<0.01$. The higher the nurse's self ranking, the higher the peer ranking. The overall mean ranking inclusive of peer and self rankings, of each nurse was determined to be a reasonable representation of the nurse's level of skill acquisition in nursing practice based on the novice to expert model. Thus, this ranking (NE mean) was used in further analysis of the data as representing the nurse's clinical practice expertise.

Frequencies and distributions of the NE mean were examined. The histogram looked to be negatively skewed and testing using the Kolmogov-Smirnov calculation confirmed this non-normal distribution as shown in Table 7. Thus, further testing was done using non-parametric methods. Comparisons were made between ranked variables so relationships were examined using the Spearman's rho Correlation Coefficient (Field, 2005, p. 129).

Table 7

Distribution of Novice to Expert Mean Ratings Among Nurse Participants

	N	Mean (SD)	Median	Mode	Skew	Kurtosis
NE mean	24	3.46 (.718)	3.56	3.56	-.777	1.305

Relationships were tested between the NE mean and other variables considered representative of nurse expertise and general demographic data. The resultant correlation matrix is shown in Table 8.

Table 8

NE Mean Compared to Indicators of Nurse Expertise.

Spearman's rho Correlation Coefficient: N=24							
	NE mean	Age	Yrs as RN	Yrs RN on Unit	Yrs RN in Specialty	Staff Nurse Level	Leadership
NE mean	1.000	.567**	.757**	.641**	.656**	.568**	.516**
Age		1.000	.596**	.463*	.552**	.300	.503**
Years as RN			1.000	.662**	.866**	.435*	.535**
Years RN on Unit				1.000	.746**	.421*	.600**
Years RN in Specialty					1.000	.465*	.504**
Staff Nurse Level						1.000	.384*
Leadership							1.000

**. Correlation is significant at the 0.01 level (1-tailed).

*. Correlation is significant at the 0.05 level (1-tailed).

The correlations between the NE mean and the nurse's age, years as a registered nurse, years as a nurse on the unit, years as a nurse in the specialty field, employment level on the clinical ladder and amount of leadership responsibility were all large and statistically significant, $p<0.01$. The nurse's age was correlated to his/her years as a registered nurse, years in the specialty, $p<0.01$, and to the years the nurse had worked on the unit, $p<0.05$. Age was not statistically related to the nurse's leadership responsibilities. The effect of specialty certification on the NE mean was examined using a Mann-Whitney independent t-test and found to be statistically significant, $p<0.05$. There was not a significant effect for the nurse's educational level comparing AD to BSN, $p=.193$.

In the second survey, the nurses categorized each other and themselves based on Benner's (1982) skill acquisition model of novice to expert. Twenty of the 24 nurse participants (83%) returned the survey. Two of those did not rank themselves, despite the instruction to do so. Rankings were scored according to the five levels described in the model: novice=1, advanced beginner = 2, competent = 3, proficient = 4, expert = 5. A mean ranking for each nurse was calculated from the survey responses. Comparisons were made between the nurses' self ranking and peer ranking mean. The correlation was large and statistically significant, $r(17) = .671$, $p<0.01$. The higher the nurse's self ranking, the higher the peer ranking. The overall mean ranking inclusive of peer and self rankings, of each nurse was determined to be a reasonable representation of the nurse's level of skill acquisition in nursing practice based on the novice to expert model. Thus, this ranking (NE mean) was used in further analysis of the data as representing the nurse's clinical practice expertise.

Frequencies and distributions of the NE mean were examined. The histogram looked to be negatively skewed and testing using the Kolmogov-Smirnov calculation confirmed this non-normal distribution as shown in Table 7. Thus, further testing was done using non-parametric methods. Comparisons were made between ranked variables so relationships were examined using the Spearman's rho Correlation Coefficient (Field, 2005, p. 129).

The NEL was calculated as follows. The NE mean served as the basis for calculation. A point was added for holding specialty certification. One point was added for each of the leadership activities for which the nurse had responsibility. And one to four points were added based on the nurse's longevity as a registered nurse. The longevity points were determined by separating the sample into quartiles based on the distribution of the

number of years of nursing. Nurses with ≤ 2 years of experience were in the lower quartile and given one point. Those with >2 and < 7 years experience received two points. Those with >7 and < 14 years received three points, and if the nurse had > 14 years of experience, four points were added. The sum of points resulted in the NEL, which was further explored.

The NEL distribution was examined for normalcy using a Kolmogorov-Smirnov test (*D*) and was found to be normal, $D(24) = .20$. The NEL mean was 8.29 and the median was 8.70. The four variables were summed in assorted combinations and compared to the NE mean to explore the NEL as a reasonable representation of nurse expertise. The statistically significant effect of certification on the NE mean has already been established. Likewise, an independent samples Mann-Whitney t-test was used to examine the effect of certification on leadership and on the years of nursing by quartiles. In both tests, there was a significant effect, $p<0.05$. The Spearmans's rho was used to examine the correlations of the assorted sums, as shown in Table 9. There was a moderate correlation, $r(23) = .443$, $p< 0.05$, between leadership and quartile ranked years of nursing. The correlation between the sum of certification and leadership scores was compared to the quartile ranked years of nursing, and this was also moderate and statistically significant, $r(23) = .431$, $p<0.05$. The correlation between NE mean and the sum of the other three variables was large and statistically significant, $r(23) = .711$, $p<0.01$.

Table 9

NE Mean Compared to NEL Factors:

	M	L	Y	C+Y+L	L+Y	C+Y	C+L
NE mean (M)	1.000	.516**	.684**	.711**	.678**	.767**	.587**
Leadership (L)		1.000	.443*			.555**	
Yrs RN Quartiles (Y)			1.000				.431*

** Correlation is significant at the 0.01 level (1-tailed).

* Correlation is significant at the 0.05 level (1-tailed).

These results indicate that the four selected indicators of nursing expertise are positively related. Therefore, the NEL was determined to be a reasonable representative of nursing practice expertise in the study sample of nurses.

Patient Participants

Over a four-month period, 75 patients completed a survey to gather information about their medical diagnosis, frequency of repeat hospitalizations and general demographic data. The survey included the PONS and an overall rating of satisfaction with nursing care. This represented a smaller sample size than was estimated in the power analysis due to time constraints for data collection.

Demographics of the patient participants are shown in Table 10. There was one more male than female participant, and their ages in years was normally distributed.

Table 10

Gender and Age of Patient Participants

	N (%)	Mean (Range)	Skewness	Kurtosis
All	75 (100)	49.1 (19.1 – 88.5)	.130	-.346
Male	37 (49.3)	43.7 (19.1 – 87.2)	.842	.687
Female	38 (50.7)	54.1 (23.5 – 88.5)	.786	.197

The majority of the patients in the sample were Caucasian, representing a higher proportion than in the reported population census in the two-county region served by the study site hospital (US Census, 2010). There were slightly fewer Hispanic or Latino and much fewer Asian patient participants than in the target adult population. There was one Middle Eastern patient and one who identified himself as Pacific Islander (Table 11).

Table 11

Ethnicity of Patient Participants Compared to Adult Population

	N 75	Patient Participants Percent	Adult Population Percent
Caucasian	45	60	51.1
Hispanic	22	29.3	30.3
Asian	3	4	10.6
Black	3	4	4.7

The reason for the participants' hospitalization was categorized by the researcher into groups generally based on the intensity of required nursing care. The majority of the participants (20%) had experienced a motor vehicle accident (MVA) and sustained multiple trauma including fractures, without a head injury. The second largest groups had either

sustained a hip fracture or had a spine-related injury (13.3% each). Twelve percent had undergone abdominal surgery and 9.3% had undergone knee arthroplasty. Lower extremity fractures or cancer diagnoses each accounted for 8% of the reasons for hospitalization, with other medical reasons and other types of surgery being 6.7% and 5.3%, respectively. Four percent of the participants were hospitalized for intravenous antibiotic treatment of infections.

Quantitative Data

Presence of Nursing Scale

The Presence of Nursing Scale (PONS) was used to measure patients' perception of nursing presence in their relationship with a randomly selected nurse who provided care to them during their inpatient hospitalization. All patient participants completed the survey, and there were no missing data points. Each of the twenty-five items on the scale was scored on a five-point Likert-type scale. Three of the items were reverse worded to reduce response bias. Those items were reverse scored for analysis. Twenty-four of the questions were answer and scored as follows: never = 1, rarely = 2, occasionally =3, frequently = 4, always =5. Responses to the final question were worded to correspond to the question as follows: very negatively = 1, negatively =2, no difference = 3, positively =4, very positively =5. The PONS score was the sum of the points with 125 being the highest possible score and 25 being the lowest possible score. The histogram of the PONS score data was examined and looked to represent a negatively skewed distribution. Data frequency calculations confirmed this non-normal distribution (Table 12).

Table 12

PONS Score Distribution

	N (%)	Mean (SD)	Skewness	Kurtosis
PONS Score	75 (100)	104.52 (17.26)	.-1.787	3.916

The first aim of the study was to test the reliability and validity of the PONS. The Cronbach's alpha was .937, demonstrating high internal consistency of the instrument. Therefore, criterion-related validity testing was done to determine if the PONS was related to patient satisfaction with nursing care. This type of validity testing compares the instrument to a variable that represents a similar construct to the one measured by the instrument (Huck,2004, p.90). It is reasonable to expect that a patient's perception of nursing presence would be positively related to that patient's reported satisfaction with care from the same nurse. In this study, concurrent validity was used, meaning the data were collected for both variables at the same time. The relationship was examined between the PONS score and a single item five-point Likert-type rating of the patient's overall satisfaction with the care given by that nurse, expressed as a letter grade, with an assigned point values as follows: A = 5, B = 4, C = 3, D = 2, F = 1. A scatter plot of the two variables was examined and a positive linear relationship between them was suggested. The Spearman's rho was used to test the relationship between the PONS score and the single item ranked grade. The correlation was found to be large and statistically significant, $r(73) = .708$, $p<0.01$. The more often the patient perceived the nurse's presence, the more satisfied the patient was with care from that nurse. This finding supported the study *Hypothesis 1*: there is a positive relationship between PONS scores

and patient satisfaction scores.

Because the PONS was found to be a reliable and valid instrument to measure nursing presence in this sample of patient participants, further exploration of the data was done to address the study aims and test hypotheses beginning with R*esearch Hypothesis 2*: there is a positive relationship between PONS scores and personal/demographic characteristics of the patient. A Mann-Whitney independent samples t-test was calculated to compare PONS scores between groups of patient participants. There was no difference in PONS scores between patient participants based on ethnicity of being Caucasian or non-Caucasian, $p = .709$. Likewise, no difference was found for the PONS score between male and female patient participants, $p = .567$. When patients were grouped into either a high pain or moderate/low pain category based on clinical knowledge and judgment of the researcher, no difference was found in the PONS score, $p = .889$. A scatter plot of PONS scores and patients' ages was examined and no relationship was illustrated. A calculated Spearman's rho confirmed that the two variables were not significantly related, $p = .482$. These findings reject the *Research Hypothesis 2.* There is no relationship between PONS scores and personal/demographic characteristics of the patient.

Next, attention was directed to *Research Hypothesis 3*: there is a positive relationship between PONS scores and personal/demographic characteristics of the nurse, and *Research Hypothesis 4*: there is positive relationship between PONS scores and commonality of personal/demographic characteristics between the patient and the nurse. Comparisons to test these hypotheses were limited by the sample size and the ability to identify nurse-patient dyads. Fifty-nine of the 75 patients considered nurse participants

when answering the PONS survey and among those, there was unequal distribution of the numbers of PONS scores per nurse. Three nurses were considered only once; three considered twice; two considered three times; two considered five times; three considered six times; one considered seven times and one considered nine times. This unequal frequency of representation of the nurse participants prevented significance testing of the PONS based on nurse characteristics or on commonality of nurse-patient characteristics.

Quantitative Analysis of Subset

An exploration of the PONS scores for seven nurse participants who were most often represented in a nurse/patient dyad was done to gain insight into possible trends. These nurses were considered in 44 of the cases: two in five cases, three in six cases, one in seven cases and one in nine cases. There was a non-normal negatively skewed distribution of PONS scores similar to the distribution seen for all the cases (Table 13).

Table 13

PONS Score Distribution: Nurse-Patient Dyads

	N (%)	Mean (SD)	Skewness	Kurtosis
PONS Score All	75 (100)	104.52 (17.26)	.-1.787	3.916
PONS Score Nurse – Patient dyads	44 (100%)	106.57 (12.90)	-1.268	3.027

A scatter plot was examined of PONS scores and patient satisfaction with nursing care ratings. There was a moderate positive relationship between the two variables. A Spearman's rho correlation coefficient was calculated and found to be large and statistically significant, $r(43) = .616$, $p<0.01$. Patients who perceived nursing presence

more often were more satisfied with the care they received from the nurse in this subset of the sample.

Finally, the relationship between the PONS score and the expertise of the nurse was explored considering the seven nurses in this subset to address *Research Hypothesis 5*: there is a positive relationship between PONS scores and the expertise of the nurse. Direct correlations could not be made between all the PONS scores and the nurse NEL because of unequal numbers of repeated PONS measures per nurse. Therefore, the mean PONS score was examined in comparison to the NEL. The scatter plot of these data points showed a negative trend. The higher the PONS score, the lower the NEL tended to be. The Spearman's rho correlation calculation was not statistically significant, $r(6) = -.604$, $p=.074$ (1-tailed). Thus *Research Hypothesis 5* could neither be supported nor denied. This very limited sample size shows a trend which must be cautiously interpreted. This quantitative data were explored further in the qualitative analysis.

Qualitative Data

A follow-up explanatory design model was used in this study to explain the quantitative study results. Using this model, some of the quantitative data is selected, based on a defining characteristic or result, which may be better understood with associated qualitative data (Creswell, 2007, p. 72). In this study, there were two approaches to the selection of quantitative data for qualitative explanation. The first approach was aimed at explaining the distribution of the PONS scores in an attempt to understand the meaning of the scores along the scale continuum. The second aim was to

explain the PONS scores of the seven nurses who were most often referenced in a nurse-patient dyad considering their levels of nursing expertise.

Case Selection for Qualitative Data Analysis

The researcher was interested in using the qualitative data gathered from the patients during the survey process, as previously described, to explain the PONS scores that fell at either end of the scale. To select individual cases for analysis, quartiles of the non-normal distribution of the PONS scores were examined to identify the PONS scores that represented the points of lower and upper quartile scores. Twenty cases with PONS scores $\leq$ 99 represented the lowest scoring 25% of the sample. Nineteen cases with a PONS score $\geq$ 116 represented the highest scoring 25% of the study cases. Next, it was determined which of these PONS surveys were completed with concurrent patient participant interviews. Nineteen of the 20 lower scored PONS surveys and 11 of the 19 higher scoring PONS surveys had been completed by patients who were also interviewed. These 30 interviews were read and analyzed to help explain the PONS scores.

The seven nurse participants who were previously described as being referred to most often by patients completing the PONS, were selected to be interviewed to gain understanding of their approach to connecting with their patients. One of the seven nurses expressed a reservation about being interviewed so was not included in the qualitative data analysis of nurse participant interviews. These seven nurses represented 44 of the PONS scores in a non-normal distribution, as previously described. As before, the cases with PONS scores representing the lowest and highest quartile scores along the scale

continuum were selected for further examination. The upper quartile PONS cutoff score for this subset of the data was $\geq$ 114. The lower quartile cutoff score was the same as for the entire data set, $\leq$ 99. Of the 44 cases representing the seven nurses, 11 were in the lower quartile and 12 were in the upper quartile of PONS scores. Of those, 10 of the lower and 10 of the higher quartile PONS scores were from surveys by patients who were interviewed.

Data Coding Scheme

Once the cases were selected for explanation of the PONS score with qualitative data, attention was turned to selecting a method of coding for data analysis. The purpose of coding was to identify pieces of textual data that represented a common idea. Like-coded data could be grouped to look for common themes in the patient and nurse comments which would help explain the variation in PONS scores along the score continuum. There is a large body of qualitative evidence related to the concept of presence and it was not an aim of this study to contribute to that body of knowledge per se. Therefore, a categorizing scheme was built on existing conceptual analyses of nursing presence, particularly on works that attempted to delineate varying levels of nursing presence (Easter, 2000; Fredriksson, 1999; Godkin, 2001; Hannemann, 1996; McKivergen, 1994; Osterman, 1996). Common descriptors of levels of presence were extrapolated from the existing models and use to being the coding process. Free coding was used when an existing code did not fit the textual data. The categories were viewed on an interactive computer graphic display where they could be examined for similarity,

grouped into common meanings and associated with levels of PONS scores. From this data analysis the following explanations of the quantitative were found.

Qualitative Data: Lowest 25% PONS Scores

The PONS scores that represented the lowest 25% of the total distribution and that also had patient participant interviews ranged in score from 38 to 96. At the lowest half of these scores a theme emerged of the patient being the object of the work of the nurse. Patients did not sense that the nurse related to them as a person in need to whom they should extend concern. Patients felt objectified in I-It (Buber 1970) nurse-patient encounters. One patient described her interactions with her nurse as devoid of any relationship.

> The nurse saw me crying because the pain was so bad, and she wanted me to walk. She wanted to do it the way she wanted, not what I needed. She made me feel alone. Some of the nurses gave me hugs and made me feel better, but not her. She was only committed to me because she had to be. It is her job. Most of the nurses they made me feel like family, like I am somebody. This nurse made me feel the other way. I thought maybe they were busy and that is why she was like that, but they said no.

Patients perceived their nurses as only doing the work that was necessary in response to the patient's call for help. They believed the nurses had time constraints to get the work done and did not have a commitment to the work. In addition, they felt the nurses avoided intrapersonal interactions with the work. This was evidenced when patients' spiritual needs were ignored. One patient who was facing a terminal diagnosis

explained, "I talked to the housekeeper about wanting a bible or a Christian book, but she couldn't find one. I believe in God and wanted to talk about it". Another patient who survived a near fatal motor vehicle crash and who was wearing communion beads around his neck, became tearful when recounting his ordeal and his faith that he would survive. His spiritual need was never assessed by the nurse.

The higher scores in this lower quartile of the PONS scores distribution represent a change in the perception of the patient toward the nurse. Patients perceived they were being attended to rather than the nurse's work. They did not report objectification in the nurse-patient relationship; instead, they saw a professional interaction. And they felt confident in the nurse's skill and knowledge. One patient stated, "I haven't developed a personal relationship with the nurse, but technically, the nurse has responded beautifully". The patients also expressed feeling supported and comforted by their nurses when the PONS scores reached the upper limit of this subgroup. There was movement away from feelings of being alone and the object of the work, toward a more caring relationship with a nurse who was there for them.

Qualitative Data: Highest 25% PONS Scores

In the upper 25% of the PONS distribution, scores of 116 to 125, a textual theme of relationship was evident. Patients perceived their nurses took measures to build a rapport with them, to be committed to them and to see them as individuals in an I-Thou (Buber, 1970) relationship. One patient said, "She asked about my family and that was good. She cared enough to find out about me. That is what a nurse should do. Show the patients they care". The relationship theme was supported by the display of availability

by the nurses. Nurses took actions to demonstrate their physical presence to their patients. One way they did this was to check on the patients without being called, as related by one patient who said, "She constantly stuck her head in the door". Another patient said, "She told me to call if I needed her in between [her visits]. It makes you feel good when you know your nurse is coming in to check on you". Availability was coupled with trust of nurses who told patients when they would be at the bedside and arrived as promised. Trust in the nurse to do what she said she would do influenced the perception of availability and contributed to relationship building as shown by a patient who said, "She told me when she was going to be here and she was".

Pain management was a significant clinical issue for most of the patient participants. High PONS scores were associated with the nurse's acceptance of the patient's report of pain without judgment and when patients sensed that the nurse was attentive to pain relief as shown in the following quotes from three patients.

> "The nurse was very kind. She comforted me when she gave me my pills and told me she would get me something for pain and she was glad when it helped".
>
> "She gave me my pain medication and that takes away my pain and that comforted me".
>
> "One time I was crying and it was so painful. She told me I wasn't ready to go home. How could I handle it? She told me not to push myself. I never had a nurse tell me something like that".

The patient's trust in the nurse to attend to pain relief contributed to establishing their relationship.

Qualitative Data: Seven Nurse Subset

The textual data related to the seven nurse subset were examined considering their nurse expertise levels. In initial analysis, no distinguishable themes emerged; however, there was a general sense that the less experienced nurses took more actions to establish a relationship with their patients who felt reassured that the nurse was available. In contrast, the more experienced nurses were perceived as answering a need expressed by the patient, which was not associated with a nurse-patient relationship. Across the group as a whole, the patients had a sense of being heard and feeling confident in the nurse's skill and knowledge.

The textual data from the nurse interviews were categorized and grouped based on self-described approaches to connecting with patients and personal nursing philosophy. Associations emerged between the nurses' and patients' perceptions of nursing care and nurse-patient relationships. For instance, patients who perceived professional interactions with their nurses were also encouraged. These patients had health care goals to get better and go home, and they were encouraged by nurses who helped them move toward that goal. These same nurses focused on physical care outcomes, took satisfaction in the patient's success and related advocating for patients in matters related to achieving outcomes. Patients and nurses shared a common goal. The professional interactions were perceived as helpful. As described earlier, this level of relationship became evident as PONS scores entered the mid 90's.

Nurses described various means to build rapport with their patients. Some mentioned how they introduced themselves and checked pain levels at the start of the

shift; others related how they made regular rounds; and others described identifying the patient as similar to a friend or family members which made their approach to nursing care more personally meaningful.

> "One patient was about the age of my son. I kept thinking about my own son. I guess I just got more personal with him. Trying to get him to warm up to me, to know I was there for him and to not be afraid".

Building rapport was associated with the patient's trust of the nurse. These two categories held textual data that expressed similar ideas but were kept distinct in the category scheme because establishing rapport was not always seen as an antecedent to establishing trust. Four patients reported having trust of their nurses but did not relate particular events that built a rapport. Those who felt bonding with their nurses reported high PONS scores (114, 117, 117, 125, 125) as did those who felt trust (95. 114, 118, 125). When patients felt both rapport and trust, they reported PONS scores of 117, 117, 125 and 125.

A category of I-Thou was used to characterize an expressed view of the patient as the subject rather than the object of care. It included accounts of patients who felt understood and respected as individual people. For example, one patient said, "There was a sister here from my church and this nurse let us be alone. She respected my need for this privacy". I-thou was also used when nurses expressed elements of patient-centered care. One nurse described a tenet of her philosophy of nursing practice:

> "You have to find out what makes the patient feel better and what they need because everyone is different. So you have to find out what their needs are and

how you can meet their needs and make them feel unafraid and trusting and cared for while they're in here."

More experienced nurses viewed the end result of care as important and incorporated a wide range of nursing care actions into achieving the goal. They related the importance of meeting the medical model goals of curing and healing and the nursing model goals of caring and comforting. The least experienced nurse was least represented in the categories related to achieving outcomes and more in categories related to comforting and serving.

CHAPTER V

DISCUSSION

Evaluation of the Presence of Nursing Scale

Reliability

The primary aim of this study was to determine if it is possible to reliably measure the concept of nursing presence using an existing instrument designed for that purpose. In this group of 75 patients, it was determined that the requirement of internal reliability of the Presence of Nursing Scale, developed by Kostovich (2001), was met. However, the validity of the tool to measure nursing presence, the meaning of the PONS scores along the continuum of the scale, and the utility of the instrument as an aid in nursing practice improvement efforts are not established. These are important topics for consideration and will be discussed in this chapter.

Meaning of the PONS Score

Validity

The PONS was determined to be a valid measure compared to the measure of a similar construct, in this case, patient satisfaction with the care of the nurse. The PONS captured patient's perspectives of nursing care, rated along a continuum in a non-normal distribution that is to be expected in surveys intended to capture patient opinions of care.

As discussed by Press (2002), patient satisfaction surveys tend to be bias toward the upper end of a scale. He states that on "surveys with a 5-point answer scale, 90 percent of patients rate hospital care at 4 or 5" (p. 80).This bias is heightened by extending the time of the survey away from the care event and a perceived negative consequence if the survey is completed while the patient is still under the care of the people who are the subject of the survey. In this study, two measures were taken to minimize upper level scoring bias. First, the patients were surveyed as close as possible to their hospital discharge. In some instances this was within the hour before they left; in others, it was the day before. In addition, the surveys were most often directed to the nurse who provided care to the patient within the 24 hours before the survey. Frequently, the PONS was completed late on the day shift, considering the nurse who provided care that shift. These measures helped to ensure the patient was recalling a very recent relationship with a particular nurse. Secondly, the assurance of confidentiality of the results, particularly the protection of the data from being seen by the nurse or a supervisor, was expressed as important to patients. This assurance may have mitigated fears of negative consequences related to giving a low score and produced less response bias than otherwise might have been expected.

Rank Order of PONS Scores

The meanings of the scores along the continuum are important to try to understand. The quantification of a concept is only useful if markers are established at points on the scale that signify a rank value. If 125 was a perfect score, how did that differ from a score of 121? What does a score of 114 mean besides being less than 125?

The qualitative data from this study were used to suggest general rank order meanings of the PONS scores. At the lower end of scale, patients did not feel they were treated as unique individuals, nor did they feel respectfully attended to. Their need for reassurance that someone was there to take care of them went unmet. And they did not perceive they were partners with the nurses to achieve their defined health care goals. As scores increased, perceptions emerged of professional nurse-patient relationships that resulted in the achievement of the patient's health care goals. Toward the upper end of the scale, patients felt more rapport with their nurse, more trust and more security.

Specific nursing practice behaviors that contributed to identifying these general rank order descriptions are more difficult to extract from the available data. The exploration of the small subset of nurses suggests some possible trends. First, the most expert nurses did not have the highest PONS scores, and there was wide variation in both the PONS scores and the textual data about the patient's perceptions of these nurses. Conversely, the highest PONS scores tended to be related to lesser experienced nurses. One explanation of this finding is that the less experienced nurses built rapport and a trusting relationship with their patients by frequent rounding. At the lower end of the PONS scores, patients did not perceive the nurse was checking on them. When they did not see the nurse making rounds, they felt forgotten about and unimportant. Thus, one must question what the upper level PONS scores are indicating. Perhaps the PONS favors items that measure feelings of being more closely attended to. Patient might not have felt as connected to the more expert nurses who, by their own descriptions, focused their attention and took pride in helping patients achieve their care outcome goals. These

nurses told of being proud of their successes of patient advocacy and seeing the recovery of patients with devastating injuries. Newer nurses are less likely to have experienced great satisfaction in the outcomes of their nursing practice, especially in the context of difficult patient care events. Nor is it likely that newer nurses have the clinical experience or confidence to act as a strong patient advocate to intervene in a challenging clinical situation. The expert nurse may use prior clinical experience to guide decision making regarding time allotment and delegation of tasks to be able to focus attention on patients whose needs demand the skill and knowledge of the registered nurse. A lesser experienced nurse might not have the depth and breadth of experience to make this distinction and be less skilled at delegation of tasks to non-licensed personnel. Instead, the newer nurse may focus on building rapport with all patients. This could raise the PONS score in favor of the less experienced nurse if the instrument is more sensitive to measures of connectedness.

Rank Labeling of PONS Scores

If rank order markers can be established to aid in understanding the PONS, then labeling the ranks demands careful consideration, least the labels of good and bad be applied by default. In the experience of this researcher, the PONS was perceived by some patients as measuring good verses bad nursing care. If the PONS is measuring levels of presence, then it is reasonable to use levels of presence labels described in the literature as rank labels. Unfortunately, the available conceptual models contain similar terminology but differ in the numbers of levels (ranks) of presence and in conceptual foci (see Appendix G, Conceptual Foundation for Coding). For example, Fredriksson (1999)

defines two major headings: being there and being with. These are defined in part as having contact or connection, respectively. She focuses differentiation of the levels on three indicators: hearing verses listening, task-oriented verse connective touch and the patient's choice to deny or receive nursing presence. Terms are used to characterize the nature of the nurse's approach to the patient and the patient outcomes in each of the levels. For example, a nurse who is "being there" answers an expressed need of a patient, is available and thereby facilitates coping. A nurse who is "being with" offers the gift of self in response to an invitation to enter the patient's world and the result is the alleviation of suffering.

McKivergin (1994) labeled three progressive levels of presence: bedside presence, clinical presence and healing presence. The levels were distinguished by the type of contact between the nurse and the patient and the nursing skill needed to engage in each level. Godkin (2001) used McKivergin's (1994) three levels as part of a "hierarchy of healing presence model". In this model, the three levels of presence are aligned with six features of nursing presence described by Doona, et al. (1999). Godkin (2001) arranges the features as progressive building blocks in requisite order as follows: uniqueness, connecting with the patient's experience, sensing, going beyond the scientific data, knowing what will work and when to act and being present. The alignment of the features to progressive levels of nursing presence represents a departure from the explanation of them by the original authors who claim, "the experience of nursing presence either exists as a whole or it does not exist" and the features are "logical distinctions rather than exclusive parts that make up a whole" (Doona, et al., 1999).

Godkin (2001) includes progressive models of nursing expertise, most notably Benner's (1982) skill acquisition model, to the hierarchy array, thereby relating higher levels of nursing presence to more expert nurses.

Osterman's (1996) model of four ways of being present may contain the descriptors of levels of nursing presence that best fit the PONS scores in this study. She labels the four as presence, partial presence, full presence and transcendent presence. The levels are differentiated by the focus of the nurse's energy, the character of the nurse-patient encounter, the physical or psychological presence of the nurse and the outcome for the patient. At the level of presence, the nurse is physically present, but there is not an interpersonal encounter and the nurse's energy is self-absorbed. The patient is reassured that the nurse is physically there and may experience stress reduction. At the other end of the model, in transcendent presence, the nurse, if both physically and psychologically present, experiences energy convergence with the patient in a role-free relationship which results in an expansion of consciousness with spiritual peace, hope and meaning for both nurse and patient. The highest PONS scores in this study did not represent transcendent presence as defined by Osterman (1996), but the first three levels of the model capture the meaning of the PONS scores as described by the patients.

Application of the PONS to Nursing Practice Quality Improvement

The data collection method employed in this study that randomly selected individual nurses for patient consideration when completing the survey, has merit to gather important information about nursing care practices at the unit level. It is noteworthy that many patients commented they would not answer the survey the same for

every nurse. This was affirming for the purpose of this study design, but raises the issue that results may be different if participants are asked to answer the survey considering all the nurses who provided their care. While mass distributed patient satisfaction surveys provide general trends, they are not meant, nor can they be used, to guide specific quality improvement efforts (Press, 2002; Spooner, 2003). This researcher believes the use of the PONS as a widely distributed aggregate measurement would not contribute information that could be used to design quality improvement strategies at the level of bedside care. However, as it was used in the study, the PONS served as both a measure of presence and as an interview tool to elicit details of the patients' perceptions of nursing care practices which they considered important. The resultant data were specific enough to identify gaps in nursing practice that could be improved with targeted education and training.

There is sufficient evidence in the literature to demonstrate that nursing practice behaviors which result in being present can be taught. McKivergin (1994) describes a two-day course, *The Essence of Therapeutic Presence,* which was taught to caregivers to help them have a "deeper appreciation of the whole of the patient's experience as well as of personal and intrapersonal dynamics of presence with self, patients and other nurses". Pederson (1993) describes observable presencing behaviors that are of value in providing care to hospitalized children, such as using carefully chosen words and tones of voice along with touch and eye contact to establish rapport with the patients. Bournes & Ferguson-Pare' (2007) demonstrated that teaching presencing theory to staff nurses and promoting associated behaviors in nursing practice resulted in increased patient satisfaction with care and increased nurse job satisfaction. In the reported study, there

was evidence to suggest that patients perceived higher levels of presence when nurses made rounds. This notion is supported by Meade, et al. (2006) who demonstrated the value of hourly nursing rounds in the improvement of indicators of patient satisfaction with care. Thus, understanding of presencing, if not already possessed by a nurse, can be taught and learned. This knowledge can be applied to nursing practice behaviors which are likely to improve the patient's perception of nursing presence and satisfaction with care.

The Expert Nurse

Determinates of Expertise

The lack of a reliable quantitative instrument to identify nursing expertise posed a problem in this study, which attempted to relate high PONS scores to expert nurses. The researcher attempted to categorize nurses based on an aggregate score using four factors associated with the label of expert nurse. A mean Novice to Expert score was calculated for each nurse from peer surveys on which they categorized each other and themselves into one of five skill acquisition levels (Benner, 1982). This served as the basis for calculating the Nursing Expert Level. Three other indicators suggestive of nursing expertise were quantified and incorporated into the NEL score. Those three, specialty certification, years of practice and leadership experience, were easily identifiable and quantifiable. The NEL was deemed to be a reasonable representation of the nurses' practice expertise

It is worth noting that three of the 24 nurse participants did not return the peer surveys despite repeat mailings and reminder notes. Two of the nurses who returned the

survey did not rate themselves, even though the instruction to "rate yourself" was on the instruction sheet in larger bolded font. There was not face-to-face follow up with these nurses to determine why they did not respond, however, one must consider the inherent challenges of peer review. The Benner (1982) model does not judge the value of the nurse, but the survey may have been viewed as an evaluation rather than a categorization. The researcher has learned that the staff of the nursing unit where the study was conducted has only recently begun to experience peer review, thus the survey may have been perceived as threatening. To that point, many of the nurses needed reassurance that the data would not be seen by the other nurses nor the supervisor and that reporting would be in a manner to protect their identity.

There is a need for a reliable determinate of a nurses' level of expertise. Too often, the term "expert nurse" is used without sufficient explanation as to how that determination was made or what it means when applied to a particular nurse. The quantified measure employed in this small sample of nurses represents an exploration of using an indexed model of expertise that incorporates generally accepted indicators of expert practice. The calculation can easily be made, particularly since the novice to expert mean score was not significantly different than the nurses' self categorization. The other three factors are easily accessible objective data and can be added to the nurse's self evaluation of level of skill acquisition. It is possible that this quantified combination of indicators may provide a more reliable measure of expertise than any one of the factors alone.

Relating Levels of Presence to Nurse Expertise

Levels of nursing presence have been described as having a positive, linear relationship to levels of nursing expertise (Godkin, 1999; McKivergin, 1994); however, this correlation has not been statistically demonstrated. Interpretation of nursing presence compared to nursing expertise is challenged by the inconsistent taxonomies used to describe the concepts. Models of nursing presence do not agree on the number of levels nor the descriptive terms to label those levels. Benner's (1982) descriptive model of skill acquisition is often referenced as the measure of nursing expertise but not employed as such. The lack of a measure to quantify nursing expertise and the lack of a common taxonomy to interpret levels of measured nursing presence makes comparisons between the two constructs difficult to analyze.

Limitations of this Study

It was the intention of this study to collect sufficient PONS scores per nurse to test relationships between the scores and characteristics of the nurses. Two methodological errors were made that prevented sufficient data to make the comparison. First, there were too few day shift nurses participating in the study. The timing of patient data collection resulted in the day shift nurse being the one most often considered in the PONS. However, all of the day shift nurses did not participate in the study. This limited the opportunity to collect repeated measures for many nurses. Also, during the patient data collection time frame, additional nurses were added to the staff but were not added to the study. It was problematic to add nurses after the second survey was collected because it required sending an additional page of the second survey to the original sample

group. Four nurses were added midway through the patient data collection, but it added an element of respondent fatigue. It was decided that repeating that process again was not appropriate. The second survey, which elicited the peer appraisals of novice to expert rankings, could have been sent at the end of patient data collection period. This would have allowed the addition of nurses to the sample as they joined the staff over the time frame of the patient data collection period. Finally, accrual of patient participants was slow and inconsistent during the first weeks of data collection. The researcher altered the method of communication with the charge nurses from telephone calls to in-person conversations, and this significantly improved the recruitment process. However, time constraints prevented the addition of more samples beyond a four month period.

Summary

Nursing presence, characterized as spiritual communion between a nurse and patient, during which time both are changed with an expansion of consciousness, was not evident in this sample of patients even though nursing presence was highly rated on the PONS. The claim by Doona, et al. (1999) that presence either exists or it does not, references the highest existential manifestation of the concept which may be rarely experienced and beyond the limit of the relationship most nurses can experience in their every-day care of patients. The findings in this study support the notion that presence is felt in varying levels. And most importantly, nursing presence is highly felt by patients when specific, observable nursing practice patterns are evident. Presence may not be an observable phenomenon, as claimed Paterson & Zderad, (1976) but the nursing behaviors

that result in the perception of nursing presence by the patient can be seen, quantified and taught.

Future research

As previously discussed, there is an identified need for a reliable and valid instrument to quantify the concept of the expert nurse. Future research could be undertaken to develop the NEL as a measure of nursing expertise by conducting a study with a larger sample size to test the reliability and validity of the model. Should that be established, the NEL could be evaluated for its efficacy as a measurement tool for research and management purposes.

The results of this study raise many questions about the use of the PONS in future research. While it demonstrated reliability and validity compared to patient satisfaction, the meaning of the scores along the continuum needs further explanation. Further testing of the PONS needs to be done to determine if is reliable and valid when applied to measure presence for a group rather than for one nurse. If so, there is potential for its use to measure the results of changes to nursing practice such as instituting hourly rounds that may influence patient perceptions of nursing presence. Finally, it would be interesting to determine the relationship between PONS scores and nurses' perceptions of complexity of patient need. Do nurses attend more fully to patients whose needs are most demanding of the nurse's expertise? While the PONS did not capture presence as defined in terms of existential connectedness between nurses and their patients, it did appear to measure the operational levels of presence, applicable to the everyday work of bedside nurses.

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Appendix A
Patient Participant Survey

Please provide the following information about yourself:

1. Reason why your are in the hospital: _____

   _____

2. Age: _____Years and _____Months

3. What is your gender? ☐ Female ☐ Male

4. What is your race/ethnicity?

   ☐ Caucasian ☐ Hispanic ☐ Black ☐ Asian
   ☐ Pacific Islander ☐ American Indian / Alaskan Native

Directions: Please answer the following questions thinking about the registered nurse who has been your nurse most often during this hospital stay. If there is not one nurse who took care of you more than any other nurse, please think about the registered nurse who provided your care yesterday.

5. *The FIRST NAME of the REGISTERED NURSE who I am thinking about when I am* answering these questions is _____

Please answer the following questions by circling your response:

6. This Registered Nurse was open to my concerns.

   Never Rarely Occasionally Frequently Always

7. This Registered Nurse taught me what I needed to know.

   Never Rarely Occasionally Frequently Always

8. This Registered Nurse "checked" on me.

   Never Rarely Occasionally Frequently Always

9. This Registered Nurse met my spiritual needs.

   Never Rarely Occasionally Frequently Always

10. This Registered Nurse made me lonely.

Never Rarely Occasionally Frequently Always

11. This Registered Nurse physically comforted me.

Never Rarely Occasionally Frequently Always

12. This Registered Nurse emotionally comforted me.

Never Rarely Occasionally Frequently Always

13. This Registered Nurse understood my feelings.

Never Rarely Occasionally Frequently Always

14. This Registered Nurse earned my trust.

Never Rarely Occasionally Frequently Always

15. This Registered Nurse was skilled in nursing.

Never Rarely Occasionally Frequently Always

16. This Registered Nurse was there if I needed him / her.

Never Rarely Occasionally Frequently Always

17. This Registered Nurse helped my day run smoothly.

Never Rarely Occasionally Frequently Always

18. This Registered Nurse created a sense of healing around me.

Never Rarely Occasionally Frequently Always

19. This Registered Nurse listened and responded to my needs.

Never Rarely Occasionally Frequently Always

20. This Registered Nurse caused me to be afraid.

Never Rarely Occasionally Frequently Always

21. This Registered Nurse was concerned about me.

Never Rarely Occasionally Frequently Always

22. This Registered Nurse was committed to care for me.

Never Rarely Occasionally Frequently Always

23. This Registered Nurse made me feel safe.

Never Rarely Occasionally Frequently Always

24. This Registered Nurse made me feel peaceful.

Never Rarely Occasionally Frequently Always

25. This Registered Nurse took care of me as a person, not as a disease.

Never Rarely Occasionally Frequently Always

26. This Registered Nurse made me feel helpless.

Never Rarely Occasionally Frequently Always

27. This Registered Nurse made the quality of my life better.

Never Rarely Occasionally Frequently Always

28. I had confidence in this Registered Nurse.

Never Rarely Occasionally Frequently Always

29. I felt a connection between this Registered Nurse and myself.

Never Rarely Occasionally Frequently Always

30. The presence of this Registered Nurse made a difference to me.

Very Negatively Negatively No difference Positively Very Positively

31. If you were assigning an overall grade to this REGISTERED NURSE considering your OVERALL SATISFACTION with the care this nurse has given you during this hospitalization, what grade would you give? Please check the box to the left.

	Percent Score	Letter Grade
☐	100 - 90 %	A
☐	90 – 80 %	B
☐	80 – 70 %	C
☐	70 – 60%	D
☐	Less than 60%	F

32. How many times have you been hospitalized on this nursing unit in the last 6 months?
Please check the box to the left.

- ☐ Only this time
- ☐ Twice including this time
- ☐ Three times including this time
- ☐ Four times including this time
- ☐ More than five times including this time

33. If you were hospitalized on this unit more than this one time in the last 6 months, did the Registered Nurse you thought about when you answered these questions take care of you during any of those previous hospitalizations?

No Yes

If so, how many total times has this nurse taken care of you?

- ☐ Twice including this time
- ☐ Three times including this time
- ☐ Four times including this time
- ☐ More than five times including this time

34. Is there anything this REGISTERED NURSE could have done differently to improve your satisfaction with nursing care? (You may use the back of this paper if you need more space to write your answer).

Appendix B

Nurse Participant Survey 1

Please answer the following questions by checking the appropriate corresponding box or filling in the blank.

1. What is the highest **nursing** degree you hold?
   - □ PhD or DNS □ MSN □ BSN
   - □ Diploma □ AD
2. If you have a degree(s) in another discipline, please list:
3. What year did you become a Registered Nurse? _____
4. How many years have you worked as a Registered Nurse **on this unit**? _____ (please do not include time working in another role)
5. How many **years** have you worked **in this specialty area** as a Registered Nurse including time worked at other hospitals _____
6. Please list any specialty certification you have earned. (Please do not include such things as Advance Cardiac Life Support; only include those certifications which required course work and testing, such as Certified Medical Surgical Nurse)
7. What is your employment status on this unit?
   - □ Staff Nurse: CN I, CNII, CN III, CN IV (Please circle your level)
   - □ Per Diem
   - □ Travel Nurse
   - □ Registry Nurse
8. What, if any, opportunities have you had for leadership on your unit (check all that apply)?
   - □ Shift Charge Nurse
   - □ Preceptor for new employees or student nurses
   - □ Participation on committee
   - □ Teach inservices
9. What year were you born? _____
10. What is your first name? _____ (This will be coded for confidentiality. Only the investigator will have access to the code)
11. What is you gender? □ Female □ Male
12. What is your race/ethnicity?
    - □ Caucasian □ Hispanic □ Black □ Asian
    - □Pacific Islander □ American Indian / Alaskan Native

Appendix C

Nurse Participant Survey 2

Impression of Nursing Expertise Among Peers

It is important to understand the expertise of nurses participating in this study. Fellow nurses have been shown to be reliable in identifying the expertise of their peers. For this reason, you are being asked to state your perception of the expertise of the nurses who are participating in this study. If you believe you do not know the nurse well enough to have an opinion, please indicated that in the space provided.

Be assured that this information is kept completely confidential and that the identity of the nurses will be removed and replace by coding Only the researcher will have the code key. This information will not be shared with any of the individual nurses nor any administrative staff. In addition, the results of this study will be presented in aggregate, so no individual nurse's identity will be revealed.

The stages of expertise used in this survey were defined by Patricia Benner in her research of nurse's skill acquisition. She defines 5 stages, described below. Please make a mark in the box which corresponds to your perception of the stage of expertise for each nurse listed on this survey.

Please consider these description when making a selection for each nurse participating in the survey.
Novice: performances tasks to attain objectives within a set of rules. Unable to discern the relevant value of tasks or when an exception to a rule is acceptable.
Advanced Beginner: Able to see aspects of care that are contextually reoccurring because of some experience with situations.
Competent: Generally have 2-3 years of experience. Patient goal attainment directs care. Able to prioritize based on relative value of aspects of care. Plan of care is based on conscious, abstract, analytic contemplation of a problem
Proficient: experienced-based ability guides priority setting, recognition of deviations from expected patterns and ability to modify care in response. Perceives situations as wholes. Able to consider fewer options because more accurately focuses on the most important aspects of a problem.
Expert: Uses intuition stemming from extensive experience. Able to see broad context and zero in on relevant needs.

< Nurse Name>		☐ I do not know this nurse well enough to have an opinion.		
☐Novice	☐Advanced Beginner	☐Competent	☐Proficient	☐Expert

<The table will repeat, depending on the number of nurse participants>

Appendix D

Patient Participant Interview Guide

When you answered the questions in the survey, you were thinking about a particular nurse.
In this interview, please think about that same nurse.

1. How would you describe your relationship with this nurse?

2. What can you tell me about the way the nurse went about his or her work?

3. How would you describe the nurse' level of expertise?

4. Thinking about how satisfied or dissatisfied you were with the care you received from this nurse, what happened, or didn't happen that caused you to form this opinion?

Appendix E

Nurse Participant Interview Guide

1. What do you do to connect with your patients?
2. Have you even had a patient you felt particularly close to? If so, tell me about that.
3. What do you do if you feel you are not connecting with a particular patient?

Appendix F

Conceptual Foundation for Coding

Fredriksson, L. (1999). Modes of relating in a caring conversation: a research synthesis on presence, touch and listening. *Journal of Advanced Nursing, 30*(5), 1167-1176.

Being There	**Being With**
Encompasses communication and understanding Question and answer Answering an expressed need Being available Contact Hearing, Task-oriented touch Patient wants contact	Gift and invitation Opens vulnerability ---- Offer comfort Enter the other's world -- Offers gift of self Reciprocal giving and receiving Connection Listening, Caring and connective touch Patient wants connection

Easter, A. (2000). Construct analysis of four modes of being present. *Journal of Holistic Nursing, 18*(4), 362-377.

Physical Presence	**Therapeutic Presence**	**Holistic Presence**	**Spiritual Presence**
Physical proximity Commitment to help Support, comfort, hope, reassurance	RN self-aware, relates, empathize, accepts, expert knowledge & skill, Active listening	Holistic care of whole being in context, patterns. Nurse experiences increased meaning in life, optimism	Spiritual beliefs, Kything, prayer, meditation, communion
Body to Body communication	Mind to mind communication	Mind, Body and Spirit	Inquiry into being
Pt has a health deficit Pt senses being heard, encouraged	Pt feels support, hope, comfort, increased ability to cope	Pt has decreased anxiety, decreased pain	Pt has courage, self-affirmation, self-forgiveness
NPR: seeing, examining, touching, doing, hearing Constrained by time	NPR: trust Not constrained by time	NPR: reciprocal relationship	NPR: spiritual reciprocal relationship

Osterman, P., & Schwartz-Barcott, D. (1996). Presence: four ways of being there. *Nursing Forum, 31*(2), 23-30.

Presence	**Partial Presence**	**Full Presence**	**Transcendent Presence**
Physically present		Physically attending behaviors	Physically & Psychologically present
Energy is Self absorbed	Energy to tasks	Energy directed to the other.	Energy convergence - oneness
No intrapersonal encounter	Partial encounter with other	Interactive	Role free relationship
Reassurance that someone is there Stress reduction	Solve a mechanical problem Stress reduction	Solve a human problem Stress relief	Expansion of consciousness, Spiritual peace, hope, meaning

Doona, M. E., Chase, S. K., & Haggerty, L. A. (1999). Nursing presence: as real as a Milky Way bar. *Journal of Holistic Nursing, 17*(1), 54-70.

Uniqueness	Connecting with pt experience	Sensing	Going Beyond Scientific data	Knowing what will work & when to act	Being present

McKivergin, M. J., & Daubenmire, M. J. (1994). The healing process of presence. *Journal of Holistic Nursing, 12*(1), 65-81.

Bedside presence	**Clinical Presence**	**Healing presence**
Establish Rapport – anyone with good communication skills	Requires clinical skill and professional domain of interaction	Mind to mind Relate closely and attend
Lean understanding		Rich understanding

Benner, P. (1982). From novice to expert... the Dreyfus Model of Skill Acquisition. *American Journal of Nursing, 82*, 402-407.

Novice	**Advanced Beginner**	**Competent**	**Proficient**	**Expert**

Hanneman, S. K. (1996). Advancing nursing practice with a unit-based clinical expert. *Image: Journal of Nursing Scholarship, 28*(4), 331-337.

Non-Expert	**Expert**
Variable or absent presence Task oriented Lacks outcome vision of care	Gestaltic nursing process (Presence with & Focused assessment) Practice independence, Decisive action, strong outcome orientation. Presence is a requisite for expert practice and requires social, physical and emotional work

Appendix H

100989

UNIVERSITY OF CALIFORNIA, SAN DIEGO
HUMAN RESEARCH PROTECTIONS PROGRAM

TO: Mary Hackim Mailcode: 8929

RE: Project #100989
Examining Nursing Presence In The Acute Care Setting As An Indicator Of Patient Satisfaction With Nursing Care

Dear Dr. Hackim:

The above-referenced project was reviewed and approved by one of this institution's Institutional Review Boards in accordance with the requirements of the Code of Federal Regulations on the Protection of Human Subjects (45 CFR 46 and 21 CFR 50 and 56), including its relevant Subparts. This approval, based on the degree of risk, is for 365 days from the date of **IRB review and approval** unless otherwise stated in this letter. The regulations require that continuing review be conducted on or before the 1-year anniversary date of the IRB approval, even though the research activity may not begin until some time after the IRB has given approval.

Date of IRB review and approval: **6/24/2010**

On behalf of the Institutional Review Board,

/jd
Michael Caligiuri, Ph.D.
Director, Human Research Protections Program
(858) 455-5050

Note: All Human Subject research conducted at the VA facility and/or utilizing VA/VMRF funds MUST BE APPROVED by the VA Research and Development Committee prior to commencing any research. In addition, please ensure that the clinical trial agreement or other funding is appropriately in place prior to conducting any research activities.

IRB approval does not constitute funding **or other institutional required approvals.** Should your studies involve other review committees such as Conflict of Interest (COI), Protocol Review Monitoring Committee (PRMC), and committees under Environmental Health & Safety (EH&S) such as Institutional Biosafety Committee (IBC), Human Exposure Committee (HERC), and RSSC (Radiation Safety and Surveillance Committee), it is the researchers responsibility to ensure that all approvals are in place prior to conducting research involving human subjects or their related specimens.

Approval release date: 8/30/2010

100989

UNIVERSITY OF CALIFORNIA, SAN DIEGO
HUMAN RESEARCH PROTECTIONS PROGRAM

Date: December 16, 2010

To: Mary Hackim Mailcode: 8929

Re: Project #100989
Examining Nursing Presence In The Acute Care Setting As An Indicator Of Patient Satisfaction With Nursing Care

Dear Dr. Hackim:

Your request dated July 7, 2010 to amend project 100989 has been reviewed and approved. This amendment included the following:

1. Heather Warlan, RN, MSN. has been added to this study as a research assistant. She will assist in patient participant data collection.

Submitted for review were the following documents reflecting this change: cover letter and revised Research Plans (clean and tracked versions).

Please note that the amendment approval date does not alter the study expiration date. A modification is given approval only to the expiration date that was received at the most recent initial or continuing review. Also, please check your most recent initial or continuing review approval letter and ensure that continuing review materials are submitted approximately 45 days prior to that expiration.

Thank you for keeping us informed.

On behalf of the UCSD Institutional Review Board,

/mb
Michael Caligiuri, Ph.D.
Director, Human Research Protections Program
Mailcode: 0052 Phone: 858-455-5050

Appendix I

From: Kostovich, Carol
To: wendy hansbrough
Sent: Wednesday, February 06, 2008 6:56 PM
Subject: RE: Nursing Presence instrument

Hello Wendy,
Thank you for your interest in my instrument! You have my permission to use it. I would just ask that you send me a copy of your results when you complete your research.
Although several graduate students have contacted me requesting permission to use the instrument, I am not aware that any of them have published their findings.
Best of luck as you pursue your doctoral degree! Let me know if I can be of further help.
Sincerely,
Carol Kostovich

From: wendy hansbrough [mailto:whansbrough@msn.com]
Sent: Wed 2/6/2008 12:08 PM
To: Kostovich, Carol
Subject: Nursing Presence instrument

Dear Dr. Kostovich,

I am a doctoral nursing student at the University of San Diego and am interested in nursing presence as an intervention.
In my literature search, I found your dissertation! Thus far, yours is the only instrument I have found which attempts to measure nursing presence. I would very much like to use it in my dissertation. As yet, I am not sure of the patient population I will study, but have some options I am considering.
In any case, I am requesting your permission to use your Presence of Nursing Scale.
In addition, I have not been able to find other published studies using the scale. Are you aware of any?
Thank you very much for your time.

Respectfully,

Wendy Hansbrough