State Of The Science Of Nursing Presence Revisited: Knowledge For Preserving Nursing Presence Capability

By: **Rebecca L. Turpin, RN, MSN, NEA-BC, PhD(c)**

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Abstract

Nursing presence has been a central focus for theorists, researchers, educators, and practicing professional nurses for over a half a century. Knowledge development and measurement of this experience is crucial at a time when human communication is becoming more impersonal, and nursing presence capability is potentially declining. A literature search was conducted using Cumulative Index to Nursing and Allied Health Literature and other discipline-specific databases. Extensive manual review of all relevant journals, reference lists, and additional publications were explored and synthesized. This article provides an updated state of the science report on nursing presence in regard to cross-discipline conceptual comparison, nursing theoretic model development, and instrument development.

Keywords: nursing presence, presencing, theory, model, framework, research, instrument

Introduction

Nursing presence capability is the competency of a nurse in enacting an inter-relational experience with a patient that produces positive patient outcomes. This capability is often equated to an individual's ability to demonstrate art in nursing practice. Nursing presence occurs when both the nurse and patient are mutually open to one another, and the nurse spends himself or herself on behalf of the patient in such a way to meet patient needs. This behavioral concept has been explored and analyzed using several methods over half a century, yet even with this effort, nursing presence continues to retain a quality of sacredness and an internally experienced nature that many believe to be too internal to fully describe, understand, or enumerate. For many reasons, the concept of presence remains heavily bound to its origins of mysticism and existentialism, thus making measurement of the phenomenon elusive. A review of the concept's origins helps identify reasons for this dilemma.

Nursing presence was probably first defined by Florence Nightingale as a rare healing presence as denoted by Dossey (2000). Smith (2001) chronologically outlined the nursing literature from the 1960s forward and provided a convincing rationale for the connections between nursing presence and spiritual presence in Judaism, Islamism, and Christianity. Writings of the existentialist philosophers Marcel, Heidegger, and Buber helped identify clear origins for nursing presence. Heidegger's (1962) *Dasein* (being there) described the concept as an intentional action of making oneself available to be with and understand another person. Marcel (1951) defined presence as capability of being with someone in need with the whole of himself. Marcel's writings also supported the belief that presence is mystical and metaphysical, and therefore cannot be objectified or explained, rather only felt (Smith, 2001). In the 1970 translation of Buber's "I and Thou" (Buber, 1970), full presence involved a relational encounter and relationships were described as exclusive and unique. These early writings provide insight to the origins of nursing presence and its elusive nature. Reflection on nursing professional history and traditions provides contextual support for its perceived mystical quality.

Hospitals historically served as the site for nurse training and care provision. Hospitals were often established by religious organizations, promoting the belief that healing was dependent on spiritual connection and intervention. Mandated white nursing attire symbolized purity of spirit, thus adding to the spiritual nature of caregiving. Even today, nurses are equated to angels. This symbolism and historic context have likely reinforced notions on the spiritual nature of the interpersonal connection between nurse and patient. Nursing practice seeks to promote healing and nursing presence equates to a healing presence. This background forms the basis for why defining nursing presence has generally been accepted as primarily qualitative and spiritual in nature, thus obscure to strict definition or measurement.

In spite of this long-held belief that nursing presence is elusive, early nurse theorists sought to define what made nursing unique as a professional discipline and distinct from the medical profession. Thus, the ability to connect with patients in a uniquely healing presence was considered a key concept of grand nursing theory and as a result, interpersonal relationships and nursing presence are a central focus in many early nursing theories (Benner, 1984; Ferlic, 1968; Leininger, 1991; Newman, 1986; Orlando, 1961; Parse, 1981; Paterson & Zderad, 1976; Peplau, 1952; Rogers, 1970; Swanson, 1991; Travelbee, 1966; Vaillot, 1962, 1966; Watson, 1985).

Nursing presence is likely an underlying assumption in many other interpersonal models while not specifically identified by name. Additionally, several texts have been written that attempt to describe the phenomenon of presence further from different disciplinary standpoints in an effort to formalize its effect, usage, and importance in practice, and particularly in nursing (Koerner, 2007; Newman, 2008). The concept of presence is also identified in other non-nursing, professional interactions such as those found in education, psychiatry and counseling, and leadership, yet there is lack of understanding of how these disciplines' concept of presence compares with nursing's concept of presence. For this reason, it is important to clarify and compare the term presence across disciplines to better understand what may make it unique to the nursing profession. Clear and accurate knowledge regarding facilitation of presence unique to nursing is becoming increasingly more important for several reasons.

Preserving Nursing Presence Capability

Nursing presence is a behavioral concept that is considered essential in order for the nurse-patient relationship to be effective and is tied to positive patient outcomes. The capability of nurses to create caring and effective moments and environments is currently of central concern in all healthcare settings, but its importance has dramatically increased in the acute care hospital setting. Rutherford (2012) made this concern very clear in her proposed nursing value structure model. Key antecedents and attributes of nursing presence such as nursing intuition, nursing trust, nursing care, and nursing knowledge are linked with positive patient outcomes, and these concepts together define the amount of health value profitability.

It is argued that nursing care is now the driver of healthcare profitability based on the ability to achieve outcomes in a cost-effective and efficient manner. Andrus (2013) also described its significance. A direct relationship between nursing's ability to create caring presence and the current metrics used by the Centers for Medicare and Medicaid Services (CMS) to evaluate patient satisfaction is explained. As part of the Affordable Care Act, patient satisfaction metrics, otherwise known as Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS), are used by CMS to determine value-based purchasing reimbursements or penalties for hospitals based on patient perception (Department of Health and Human Services, 2012). Holistic nursing practice with enacting caring presence is suggested as the best practice for ensuring optimal financial viability within the hospital setting. Therefore, a hospital's potential economic survival may depend on the capability of nurses' collective

abilities to routinely create nursing presence. This comes at a time when many trends in generational and workforce factors are impeding or diminishing this capability.

Healthcare reimbursements are being decreased, and as a result hospitals are constrained from hiring experienced, more costly workers due to economic pressures. Less experienced and younger nurses just entering the workforce may be less capable at using nursing presence and yet more valued to fill positions with due to lower salary levels. Along with these challenges, the newest generation entering the nursing workforce has a markedly different communication style than prior generations, preferring to communicate via text, email, etc., versus face-to-face communication (Metcalf & Putnam, 2013). Additionally, nursing care is currently being provided using ever increasing technology with use of electronic healthcare records, telehealth, and personal data assistants, all of which may erode the "in-person," interpersonal interchange that traditionally took place at the bedside. It is unknown whether these low-touch environments may decrease holistic care or provide access to care that would not have been available otherwise. These changes in the healthcare delivery system have resulting effects in the nursing education system.

To meet the increasing need for nursing personnel, nursing schools maintain a primary focus on content-driven education to ensure successful passing of National Council License Examination (NCLEX-RN®) to bolster the nursing workforce. A knowledge worker that can quickly and effectively assume patient care with the least orientation possible is the desired candidate for employment in hospital settings. The content-laden educational burden minimizes the provision of high quality education focused on communication skills and personal interrelationships with patients. Content and practice for expertise in interpersonal skills are at best minimally interwoven into courses throughout the curriculum. These skills may have become significantly deemphasized due to the overburdened focus on curricula that are content saturated (Giddens & Brady, 2007). Nursing school admission and selection criteria are most often based on grade point average, nursing grade point average, pre-testing success, and success in science courses. There is limited research that supports use of interview or essay (to evaluate interpersonal skills) as selection criteria for predicting nursing school success (Schmidt & MacWilliams, 2011).

Nursing is one of the most stable career paths in the current U.S. economy. As a result, applications to nursing school are increasing. Many applicants are not entering the discipline based on a higher calling to give of self. Typical personality and emotional traits that assisted nursing students to be successful in providing holistic care may be missing from the applicant pool. The skill set or personal characteristics necessary to become proficient in nursing presence is no longer a prerequisite for entry, and typically there is sole reliance on a high grade point average to make as selection criteria. The nursing educational system thus is becoming more and more the factory of knowledge workers.

Problem Statement

Nursing presence capability is at risk for decline. This capability that sets the nursing profession apart must be preserved. This problem is of significance importance in inpatient settings where 59% of U.S. nurses are employed (Feldstein, 2005), and where economic detractors, as previously discussed, will have the largest negative impact. It is essential that nurses fully understand how nursing presence capability can be optimized. Nursing presence must be unveiled and demystified. Nursing presence capability can only be fostered when there is a full understanding of: 1) what makes nurse presencing unique; 2) what the current state of knowledge regarding nursing presence in inpatient settings is; and 3) what reliable and valid instruments are available to determine patients' perception of nursing presence. Evaluating disciplinary boundaries, current research on nursing presence in hospitals, and measures of nursing presence may help safeguard a future in which care environments are proactively designed to meet interpersonal needs of patients while ensuring that the art of nursing not only is sustained, but flourishes through optimal education of new professional nurses.

Aim

The aim of this article is to explore the current state of the science on nursing presence with a focus to describe interdisciplinary boundaries, knowledge gleaned from inpatient research on nursing presence, and the status of nursing presence instrumentation (theoretic models or instruments) which may further guide future research and provide insight for nurse educators in teaching nursing presence capability. If the essence of nursing is to be preserved and not diminished, the components of nursing presence must be defined, refined, and measured. This knowledge will enable nursing faculty and other nursing leaders to ensure that the essence of effecting nursing presence can be taught and role modeled effectively. This knowledge may assist organizations in researching to evaluate their environments of care for best practices in designing healthcare settings for optimal delivery of this much needed interaction. As nurse presencing leads to improved patient outcomes and additional improved professional satisfaction for individual nurses, it is of vital importance to all healthcare settings. Through this type of synthesis, useful knowledge and instruments can be developed so that the nursing profession is optimally prepared to educate new nurses for care provision in futuristic nursing care environments.

The purpose of this study is to synthesize the literature on the phenomenon of nursing presence, as it relates to disciplinary boundaries, inpatient nursing presence research, and nursing presence metrics. To accomplish this, a systematic review of research, review literature, theoretical models, and instruments was conducted. This study aimed to answer three distinct research questions:

1. How does nursing presence compare to presence within other helping disciplines?
2. What knowledge has been discovered in nursing presence research as it relates to inpatients?
3. What nursing presence theoretical models and instruments exist that include measurable nurse characteristics inherent in the nurse-patient interaction? Which models have been tested and what is their reliability and validity of identified instruments? In order to evaluate the existing literature sequentially, a strategic method for systematic review was undertaken.

Method

This systematic review was conceptualized with the methodology provided by Cooper (1998) using five stages of research synthesis. The five stages are as follows: 1) problem formulation, 2) literature search, 3) data evaluation, 4) data analysis and interpretation, and 5) presentation of the results. Stage one includes problem formulation, development of the research question, identification of concepts and relationships, delimiting the review, and outline of a coding mechanism in advance. For purposes of coding, theoretical literature was evaluated using Kirkevold's (1997) 4-point coding. Theoretical literature with a score of 3 to 4 was included for review and analysis, but the literature had to include information value. For coding research literature, Whittemore's (2005) 11-point quality criteria were used, and research with scores of 7 to 11 were required for inclusion.

The literature search included a variety of databases including CINAHL, PsycINFO, ERIC, Business Source Complete, and Web of Science. The literature search was initially done in a broad manner using each database searching only for the concept of presence within the title. CINAHL was the most likely to render literature from nursing and allied health, therefore it was initiated first. Literature in all databases was

limited to English language items. As prefixes within disciplines were discovered, further targeted searching was conducted within each database. For example, in CINAHL, the word presence had multiple meanings not reflective of only human connection, for example (presence of parents during resuscitation), therefore the search was limited to the search term of "nurse" or "nursing" or "caring" plus "presence" done under the category of all text to ensure that the focus of the literature was specific to the appropriate prefix. From this extensive review, documents that were pertinent to human relational use of the term presence were retrieved. Publication dates were limited from January 1988 to October 2013. In psychology and counseling, key prefixes included "therapist presence" or "therapeutic presence" to narrow the search within these fields, and then an additional search using these prefixes was conducted in PsycINFO. In like manner, the education literature was conducted in both CINAHL and ERIC databases using identified prefixes of "teaching" or "teacher" presence which was essential in narrowing down the educational literature. Finally, management literature was searched first for presence, and then narrowed down with the prefixes of "leader" or "leadership" to extract data from the management literature. As literature on presence within these prefix categories was extensively reviewed, all reference lists were evaluated for further pertinent literature and sources.

From this point, the nursing literature was categorized into one of three categories: 1) concept analyses/synthesis, 2) research, or 3) models/frameworks/instruments. In several cases, research articles may additionally have contained models or metrics of interest as well. To ensure that potential literature was not overlooked, additional search terms were used in CINAHL to identify "presence" plus "model," "theory," or "framework" and to identify "presence" plus "instrument," "scale," "questionnaire," or "tool."

Results

Presence literature resulting from other disciplines included sources from education, psychology/counseling, and management. Teaching or teacher presence was primarily found in literature and research involving online learning and 10 sources were included (Bangert, 2008; Fengfeng, 2010; Garrison, Cleveland-Inez, & Fung, 2010; Kornelson, 2006; Meijer, Korthagen, & Vasalos, 2009; Rodgers & Raider-Roth, 2006; Sharda et al., 2004; Shea & Bidjerano, 2009, 2010; Shea & Vickers, 2010). The psychiatric/counseling search rendered 10 articles (Crane-Okada, 2012; Dunn, Callahan, Swift, & Ivanovic, 2013; Fraelich, 1989; Geller, 2001; Geller & Greenberg, 2002; Geller, Greenberg, & Watson, 2010; Granick, 2011, McCollum & Gehart, 2010; Robbins, 1998; Tannen & Daniels, 2010). Seven sources were included from management literature (Baldoni, 2010; Fairhurst, 2009; Halpern & Lubar, 2004; Rosengren, Athlin, & Segesten, 2007; Scouller, 2011; Senge, Scharmer, Jaworski & Flower, 2004; Su & Wilkins, 2013). The nursing literature was next explored.

Within nursing literature, the results were significantly larger. Non-research literature consisted of 15 review articles with a primary focus on nursing presence; seven primary concept analyses; several syntheses of nursing presence independently or comparatively between nursing presence and other concepts. Two nursing texts were identified specific to nursing presence (Koerner, 2007; Newman, 2008). In regard to nursing research studies, 32 studies were evaluated to determine their fit and were delimited to inpatient settings. The resultant subset included 22 sources included in the study. This review indicates a proliferation of nursing presence literature since Smith's (2001) analysis. In all, nine of 15 review articles, five of seven primary concept analyses, four of six syntheses/comparable analyses, two books and 25 of 32 research studies have been completed post-2001. This indicates only a moderate increase in available nursing-specific literature and data to analyze for content over a 12-year span.

Data Analysis

Consecutive integrative reviews were conducted to evaluate the three research questions. The literature was compared for congruent themes between disciplines, within nursing research findings and models. An iterative review process was undertaken over several months to compare the data related to each research question.

Research Question 1

To evaluate interdisciplinary boundaries of the concept presence, extracted data were compiled into categories and then subcategories, resulting in a few common themes across disciplines. Common themes were identified by reading all resultant literature, reflecting on content and making continual notes throughout the review procedure. Additionally, references cited within literature when appropriate were also read and evaluated for inclusion. Definitions of presence were identified within each discipline.

Definitions of Presence

Teaching presence is defined as "a state of alert awareness, receptivity, and connectedness to the mental, emotional, and physical workings of both the individual and the group in the context of their learning environments, and the ability to respond with a considered and compassionate best next step" (Rodgers & Raider-Roth, 2006, p. 266). Therapeutic presence is defined as bringing one's whole self into the encounter with clients, by being completely in the moment on multiple levels: physically, emotionally, cognitively, and spiritually (Geller & Greenberg, 2002). Leader presence was defined as "authenticity" and "projection of the individual that brings people to follow him or her for a common purpose" (Baldoni, 2010, p.2).

Definition of Nursing Presence

Nursing presence is not seen as mere physical attendance of the nurse's body beside the patient as the dictionary definition of presence could provide. Instead nurse presence has been generally understood as an actual "connection" within the nurse-patient relationship that is felt during interactions by both patient and nurse. This type of behavioral concept is of primary interest to nurse researchers (Morse, 2000) and best analyzed and/or appraised using a method that is congruent with its contextual nature. By contrast, several authors have analyzed the concept of nurse presence using other methods which are more congruent with positivist paradigms (Hessel, 2009; Hines, 1992; Tavernier, 2006) or just conducted concept analysis without a stated methodology or just as a literature review (Melnechenko, 2003; Zyblock, 2010). Significant analysis has been done with the concept of presence using metasyntheses either solely (Finfgeld-Connett, 2006; Minicucci, 1998), or to compare presence with other related concepts (Finfgeld-Connett, 2008a; Finfgeld-Connett, 2008b; Fredriksson, 1999), or in collaboration with qualitative studies (Fuller, 1991). Although several definitions of nursing presence were identified, for the purposes of this research, nursing presence is defined as:

> …an intersubjective encounter between a nurse and a patient (based on patient invitation) in which the nurse encounters the patient as a unique human being in a unique situation and chooses to spend him/herself on the patient's behalf. (Doona, Haggert, & Chase, 1997)

Definitions of presence among disciplines are quite different. Teaching presence has some similarities to nursing presence in that there is focus on the inward perception and connectedness, however, education's definition additionally focuses on the broader dimension of social presence which is absent from the nursing definition. Therapist presence is more closely aligned with the nursing definition in that the focus is on the sole inward interaction and is viewed based on levels. Leadership presence is outwardly focused on projection of image to achieve connections and followership, instead of the interpersonal connection itself.

Although Morse (2004) advised that "clutter" in the literature by the proliferation of the same or similar concepts with different names inhibits deep concept development and use from a theoretical, research, or practice standpoint, nursing is a discipline that traditionally has borrowed theory and knowledge from other disciplines. McEwen (2007) supports this idea of conceptual knowledge in nursing originating from both nursing and other disciplines. While not the central focus of this analysis, failure to incorporate conceptual data from other disciplines may lead to lack of awareness of key conceptual linkages. Only one reference was located that demonstrated cross-discipline exploration on presence between psychology and nursing (Tannen & Daniels, 2010). Therefore, there is further need to evaluate these similarities based on conceptual analysis categorization inclusive of pre-conditions, attributes, and post-conditions of the phenomenon. Findings of this integrative review indicated similarities exist between nursing presence and other disciplines' understanding and use of the term. Table 1 provides an overview of these similarities in terms of antecedents, attributes, and outcomes.

Themes identified with the integrative review indicate that presence is generally identified as "being with" another person resulting in positive

Table 1.
Antecedents, Attributes, and Outcomes of Presence by Disciplines

Pre-conditions of Presence by Disciplines	
Nursing	**Education**
Patient conditions (has a need, invites the relationship, openness, vulnerability) Nurse conditions (willingness, personal and professional maturity, competence, in touch with self, willing to be involved, vulnerability) Environmental conditions (conducive work environment, time management, or quality management)	Student conditions (openness, readiness, awareness of online systems) Teacher conditions (openness, ability for self-disclosure, vulnerability) Environmental conditions (trusting environment, knowledge of systems, systems that respond readily that create social presence among students)
Psychology, Sociology, Counseling	**Management**
Patient conditions (request for help, openness) Therapist conditions (pre-session preparation, mindfulness of own reactions, bias) Environmental conditions (privacy)	Employee conditions (pre-conceived perceptions, ability to identify with leader) Leader conditions (pre-planning, rehearsal as in acting) Environmental conditions (open, supportive to change)
Attributes of Presence by Disciplines	
Nursing	**Education**
Relationship features (trusting, intimacy, interpersonal reciprocity (working together), knowing the patient or nurse (being familiar) Nurse features (expert nursing, demonstrating sensitivity, holism, and spirituality, ability to give of self, availability, listening & hearing, advocacy (being for), facilitation, monitoring progress, responsiveness to patient cues, full attention/attentiveness, maintenance of psychological presence, ability to adapt to unique situations, advocacy (being for), instills hope, monitoring progress, and teaching) Intentionality versus Instinctual Four behavioral levels: (physical, therapeutic, holistic, spiritual) Depth levels: (being there, partial presence, to full presence based on patient cues)	Teacher design of education Facilitation Monitoring progress Teaching Interactivity Assessment (ongoing) Three levels: lurking, supporting, and leading
Psychology, Sociology, Counseling	**Management**
Therapist features (openness to all client experience, openness to own experiences, ability to be with the client, capacity to respond, attention to the moment, authenticity, intentionality)	Leader features (reaching out, expressiveness, self-knowing, empathy, deep listening, authenticity, attentive in the moment, openness to self and others, narration)
Outcomes of Presence by Disciplines	
Nursing	**Education**
For patient: decreased stress, isolation, distress, and vulnerability; improved coping, problem-solving, physical conditions, maternal bonding, self-esteem, adaptive behavior and ability to change, safety, mental and physical well-being; self-care; connectedness; and personal growth. For nurse: improved mental well-being, professional satisfaction, calm environment	For student: improved cognitive presence (or recognition of gaining knowledge) and improved sense of social presence within the online learning environment
Psychology, Sociology, Counseling	**Management**
For patient: improved mental status and ability to function in normal activities, improved decision-making and self-concept	Employee enthusiasm, improved human relations, collaboration & positive work environment, establishment of trust between leader and employees

outcomes, and/or helping, mentoring, or teaching focus in the relationships between nurse and patient(s), teacher and student(s), therapist and patient/client(s), or leader and employee(s). In teaching, presence in the social realm (student to student presence) as well as within the teacher realm (presence of teacher with student), or absence thereof, are key uses of the term. Teacher presence is a helping relationship akin to the nursing presence relationship. Teacher presence is extensively evaluated qualitatively and quantitatively for determination of its key attributes along with its significance as a key concept within the community of inquiry theory. Antecedents of teacher presence include self-disclosure, connection, openness, vulnerability, inviting presence, and development of a trusting environment. Common attributes of teacher presence include facilitation, monitoring of progress, teaching, interactivity, and assessment. Outcomes of teacher presence include increases in social presence and cognitive presence as well as self-efficacy.

Psychology and counseling literature focus on therapeutic alliance more than therapeutic presence. Partnership attributes are more emphasized than the therapist's ability to enact presence. Antecedents to therapist or therapeutic presence include pre-session, preparation, and mindfulness as a strategy for teaching awareness prior to engaging in presence. Attributes of therapist presence include being available, openness to all client's experience, openness to own experience in being with the client, capacity to respond, attention to the moment, authenticity, and intention. The primary outcomes for therapeutic presence are improved mental or social functioning for the patient.

Management literature reveals minimal literature on concept development of presence and seems superficial by comparison to the other disciplines of nursing, education or psychology and counseling. Several books offer good theoretical background on leadership presence or its use, although most sources offer guidance on personal presence attainment (i.e., image) more than with expertise in relationship presence. Attributes of leadership presence include reaching out, expressiveness, self-knowing, being in the moment, empathy, listening, authenticity, deep listening, and openness. Outcomes of leader presence are described as enthusiasm, improved human relations, collaboration, and an improved work environment.

In the area of antecedents, several commonalities are noted. In nursing, antecedents of acceptance of self or being in touch with self compare to mindfulness in the counseling literature and self-knowing in the management literature. Likewise, self-disclosure in teaching antecedents would not be possible without self-knowing. Openness is common in either antecedents (nursing and teaching) or in attributes (counseling and management). Vulnerability is necessary for both nurse and patient, yet the literature shows the teacher alone needing to show vulnerability to his or her students to help facilitate a connection. Other primary common attributes of all disciplines mentioned are: 1) being attentive in the moment, 2) authenticity, 3) trusting relationships, 4) availability, and 5) interaction in terms of listening and monitoring of progress. Teaching is a key attribute in both nursing and education. Outcomes common to nursing and education include increased self-care/self-efficacy and increased cognitive presence/understanding. Outcomes common to nursing (for nurses) and to management include collaboration and improved work environments. The idea that presence is achieved in levels is common to nursing, teaching, and therapy. Within nursing, presence is described based on levels. Presence is described by: 1) intensity/depth: presence, partial presence, full presence, and transcending presence (Osterman & Schwartz-Barcott, 1996), 2) bedside, clinical, and healing presence (Godkin, 2001), 3) therapeutic levels: physical, psychological, and therapeutic (spiritual) (McKivergin & Daubenmire, 1994), and 4) modes of presence: physical, therapeutic, holistic, spiritual (Easter, 2000). Teaching presence contains three levels: lurking, supporting, or leading. Therapeutic presence is experienced in behavioral levels: physically, emotionally, cognitively, and spiritually. Thus there is congruence between disciplines in quantifying presence based on depth, linear progression, or behavioral categories to better understand the phenomenon. Although several cross-discipline similarities exist, in general, the concept of nursing presence is more fully developed than that of presence within other disciplines. This is also evident in the quantity and quality of nursing publications and research completed since the last state of the science report.

Research Question 2

The findings for inpatient nursing presence research are provided in Table 2. Over two-thirds of nursing presence research has been conducted using qualitative approaches, which is consistent with a behavioral concept in early development. Qualitative study designs include exploratory & descriptive (Brown, 1986; Duis-Nittsche, 2002; Hanson, 2004; Jackson, 2004; Mohnkern, 1992; Osterman et al., 2010), grounded theory (Edvardsson, Sandman, & Rasmussen, 2011; Hain, Logan, Cragg, & Van den Berg, 2007), phenomenology (Cohen, Hausner, & Johnson, 1994; Davis, 2005; Pettigrew, 1988), interpretive (Reis, Rempel, Scott, Brady-Fryer, & Aerde, 2010), and hermeneutics (Cantrell & Matula, 2009; Doona, Chase, & Haggerty, 1999; MacKimmon, McIntyre, & Quance, 2005; Turner & Stokes, 2006). The remaining six studies utilized quantitative methods: comparative (Busch et al., 2012; Papastavrou et al., 2011) and instrument development (Foust, 1998; Hansbrough, 2011; Hines, 1991; Kostovich, 2011). Based on this trajectory of studies, it can be concluded that quantitative research on nursing presence is in its infancy with only limited instrumentation. Review of instrumentation research will be discussed in a separate section. Key results from all research studies are outlined in Table 2, but are summarized as follows.

Most notably, nursing presence and reassuring presence are supported as critical elements in defining the most important quality in the hospitalized patients' experience of care (Brown, 1986, Davis, 2005). In addition, the depth in mode of delivery of staff presence even with demented patients influenced patient well-being (Edvardsson et al., 2011). This finding supports the assertions of Rutherford (2012) and Andrus (2013) regarding the importance patients place on nursing relational care. Several studies provide more qualification related to attributes of nursing presence from a patient perspective (Cantrell & Matula, 2009; MacKinnon et al., 2005), a nurse perspective (Doona et al., 1999; Hain et al., 2007; Hanson, 2004; Jackson, 2004; Mohnkern, 1992; Turner & Stokes, 2006), or both (Cohen et al., 1994; Duis-Nittsche, 2002; Osterman et al., 2010). Two studies evaluated family member perspectives on nursing presence (Pettigrew, 1988; Reis et al., 2010). Some findings support intentionality of nursing presence (Hain et al., 2007; Pettigrew, 1988; Reis et al., 2010) while another supports the intuitive nature of nursing presence (Osterman et al., 2010). Although small, one study (Busch et al., 2012), found no statistically significant differences between burn patients' pain medication usage when provided therapeutic touch versus nursing presence without touch, which is opposite of traditional thought that touch was an important feature during presencing. Interestingly, one large European study (Papastavrou et al., 2011) with surgical inpatients (n = 1537), identified a significant difference between patient and nurse views on assurance of human presence, with nurses (n = 1148) rating their performance of nursing presence higher than that perceived by patients ($p < 0.001$). This clearly indicates a gap in what nurses believe they provide versus what patients expect to be provided. While this study may not be generalized necessarily to the United States as there are international differences in how hospital settings are designed, it is a large enough study to be considered crucial findings that need to be explored through future replicated research. In

Table 2.
Nursing Presence Inpatient Research

Author/Title	Study Design	Sample Type & Size	Data Sources	Setting	Research Questions/ Hypothesis	Instruments	Results/Comments
Brown (1986)	Qualitative, descriptive	Convenience, adult hospitalized patients (*n* = 50)	Taped & transcribed accounts of caring nurse experiences	Medical-surgical area of hospital, Northeast US	To describe the patient's experience of caring by a nurse	NONE	*Reassuring presence* by the nurse was most important quality in the experience of "care."
Busch et al. (2012)	Quantitative, comparative two group	Randomized block, hospitalized patients receiving either therapeutic touch (TT) (*n* = 8) or nurse presence (NP) (*n* = 11)	Instruments, saliva cortisol, pain medication administra-tion records	20-bed burn ward in Rotterdam, Netherlands	Will TT or NP have different effects of reducing anxiety, pain, cortisol level, and pain medication in burn patients?	Burn Specific Pain Anxiety Scale (BSPAS) for pre-procedure pain/ anxiety,& Visual Analog Thermoment (VAT) for actual pain	Anxiety: no statistically significant differences found between interventions except by day 10 with post-procedure anxiety 19.0 (TT) vs. 38.7 (NP), $p \leq 0.05$). Pain: no statistically significant differences between groups. Cortisol: On day 2 of tx, the TT group showed a statistically higher cortisol level compared with the NP group before dressing change (12.2 vs. 5.8, $p = 0.014$). Pain medication: NP patients received more morphine than TT patients on day 1 ($p = 0.037$) & day 2 ($p = 0.015$). When taking all pain medications together in a sum score, no significant differences were noted between groups.
Cantrell & Matula (2009)	Hermeneutic	Purposive, childhood cancer survivors, (*n* = 11) 3 male, 8 female	Focus group & individual interviews	Oncology center in North East US	Describe experiences in being cared for by pediatric oncology nurses	NONE	Participants knew when nurses were *authentic* and made effort *to be present emotionally for them*. Expert care seen as incomplete without compassion.
Cohen et al. (1994)	Phenomen-ological	Convenience, nurses on a surgical unit (*n* = 24) who identified adult surgical patients, interviewed post-discharge at home (*n* = 24)	Open-ended interviews	Surgical unit US	Describe patient experiences as compared to nurse accounts	NONE	*Attentive presence* is described by patients when an attentive attitude is coupled with understanding and helpfulness/responsiveness.
Davis (2005)	Phenomen-ological	Purposive, & conceptually driven sequential, adult patients (*n* = 11), 7 female, 4 male	Interview	South central US	How do patients describe good nursing care?	NONE	*Nursing presence seen as defining characteristic of good nursing care:* most common theme was nursing presence (being there & being with). In descriptions of bad nursing care, presence was conspicuously absent.
Doona et al. (1999)	Hermeneutic	30 nursing j udgment narratives from 3 previous studies	Transcripts from each data set (*n* = 10 per set)	Critical care, perinatal & psychiatric care settings, Northeast US	1. What are the common features of the context of nursing judgment? 2. What are the features of the nurses' connection with the patient that contribute to nursing judgment?	NONE	*Six features of nursing presence were identified:* uniqueness, connecting with the patient's experience, sensing, going beyond the scientific date, knowing (what will work & when to act), and being with the patient.

Table 2. (continued)

Author/Title	Study Design	Sample Type & Size	Data Sources	Setting	Research Questions/ Hypothesis	Instruments	Results/Comments
Duis-Nittsche (2002)	Qualitative, descriptive	Seven nurse-patient dyads	Semistructured interviews	South central US	Describe the nature, experience and impact of nursing presence within the nurse/patient relationship	Nurse & Researcher developed interview tool	*Nurse themes of nursing presence:* knowing the patient, responding to needs, attitudes/ beliefs, bonding with the patient, influencing others, & relationships. *Patient themes:* knowing me, accessibility, bonding, supporting & encouraging me/others, healing.
Edvardsson et al. (2011)	Grounded theory	Patients with moderate to severe dementia	Participant observation (36 hours)	24-bed, psycho-geriatric ward in university hospital in Sweden	Explore the psychosocial climate and its influence on the well-being of people with dementia in a hospital psycho-geriatric unit	NONE	Different modes of *staff presence* or absence influenced patient well-being. Modes: *sharing place & moment* (presence), sharing place but not moment (task orientation), sharing neither place nor moment (absence). Sharing place & moment associated with less observations of anxious behavior and more signs of well-being (smiles, laughter)
Foust (1998)	Quantitative	Random, registered nurses (n = 210)	Survey instruments	South central US	Examine relationship of presence, self-esteem, and demographic characteristics of registered nurses and conduct instrument development	Measurement of Presence Scale (Hines, 1991), MOP Visual Analog Scale (MOPVAS), & Rosenberg Self-Esteem Scale (RSES)	Presence level and self-esteem level was high with respective means of 231, SD = 16.52 and 34, SD = 4.46. The mean of the MOPVAS was 85, SD = 1.73. Reliability MOPS = alpha of .9106, for Rosenburg's Self-Esteem Scale alpha = 0.8571. Internal consistency for MOPS 0.8512. Validity supported with low correlations of MOPS and MOPVAS r = 0.263 (p = 0.01) and MOPVAS and RSES r = .329. (p = .01). MOPS factor analysis subscale factors was different than for Hines, 1991, but similar. *Results supportive of instrument measurement of presence.*
Hain et al. (2007)	Qualitative, grounded theory	Convenience, expert nurse participants (n = 9)	Interviews	Ottawa, Ontario, Canada	Examine how critical care nurses practice nurse presence with their patients	NONE	*Presence as a practice emerged as a three-phased process:* 1) commitment, (initial sensing & engagement), 2) presencing strategies, & 3) connection. Ways of being: empathetic, authentic. Ways of doing: advocacy, reassurance, support.
Hansbrough (2011)	Quantitative, instrument development	Convenience, hospitalized patients (n = 75), & nurses (n = 24)	Survey instruments	Western US	What is the reliability & validity of the PONS as tested against a single-item measure of patient satisfaction? What is the relationship between PONS score and levels of nursing expertise (NEL)?	Presence of Nursing Scale (PONS), a single-item measure of patient satisfaction, & Nurse Expertise Level (NEL)	PONS reliable with Cronbach's alpha = 0.937, Correlation between PONS & patient satisfaction large as determined by Spearmen's *rho* (p < 0.01). Nursing expertise level categorized for all nurse participants. Correlations between NEL & PONS were inconclusive.

Table 2. (continued)

Author/Title	Study Design	Sample Type & Size	Data Sources	Setting	Research Questions/ Hypothesis	Instruments	Results/Comments
Hanson (2004)	Qualitative, descriptive	Random, regionalized mailing to critical care nurses (*n* = 84)	Mailed survey	Southwest US	Identify categories or patterns related to caring based on personal experiences of critical care nurses & determine whether findings validate Swanson's caring theory	Survey with 13 demographic items & 2 open-ended questions	*Being there* included themes of taking time to listen, asking questions and allowing time to talk, and doing little things. This theme seemed to validate Swanson's "Being With" component of theory.
Hines (1991)	Quantitative, exploratory	Convenience, registered nurses (*n* = 324)	Survey instrument	Hospitals, clinics & locations for nurses meeting in the Midwest, West, & South US	To test and explore the Measurement of Presence Scale (MOPS) to conduct scholarly inquiry about the phenomenon of presence. Reliability will be > .70 for the tool and > .60 for subscales	Measurement of Presence Scale (MOPS)	MOPS reliability with Cronbach's alpha = 0.9324. Subscale alpha correlation coefficients > .060. Nine subscales were interpreted: 1) valuing/attending to self/ others, 2) connecting, 3) transacting, 4) enduring memory from past, 5) engaging for growth, 6) encountering, 7) availability, 8) person or even sustaining memory, and 9) disclosing & enclosing. Correlation between total MOPS and subscales was significant at the 0.01 level.
Jackson (2004)	Qualitative	Homogenous, criterion & network, medical-surgical nurses (*n* = 11)	Semistructured depth interviews	University-affiliated, community hospitals in large metropolitan area (US)	What factors contribute to nurses' self-image as a healer or self-image of not being a healer?	NONE	Emergent themes: Healing is about caring connections/ relationships, & involves *nursing presence (listening, being with)*.
Kostovich (2011)	Quantitative, field testing of instrument	Convenience, acutely ill, hospitalized adult patients	Instrument	Medical-surgical units of hospital Midwest, US	Develop and conduct psychometric testing on first patient-perceived measurement scale for nursing presence	Presence of Nursing Scale, new instrument	Instrument addressed 25 items identified by prior nursing presence concept analysis and based on Paterson & Zderad's (1976) theoretical framework. Construct validity was established by comparing the total instrument score with a single-item measure of patient satisfaction with a very high positive correlation (*rpb* = .801). Reliability (Cronbach's alpha) was 0.95 and test-retest reliability of 0.729.
MacKinnon et al. (2005)	Hermeneutic	Purposive, post-partum women within 6 months of delivery (*n* = 6)	Audiotaped & transcribed interviews	Urban center in Canada	What meanings do women in labor attribute to the intrapartum nurse's presence during their childbirth experience?	NONE	*Nurse presence* was the way in which a nurse was "there for them" described as: to be available, be emotionally involved, help create special moments, hear/respond to concerns, share responsibility for keeping them safe, & to be a go between with them & family. Other key concepts included nurse competence, being known & understood & getting to know the nurses. *Nursing presence* involved being there (physical presence), being with (emotional presence) & being for (advocacy).

Table 2. (continued)

Author/Title	Study Design	Sample Type & Size	Data Sources	Setting	Research Questions/ Hypothesis	Instruments	Results/Comments
Mohnkern, S. (1992)	Qualitative	Nurses (*n* = 15)	Interviews	Southwest US	Describe antecedents, defining attributes & consequences of presence	NONE	*Antecedents:* Patient in need who trusts the nurse, Nurse with mission & desire to help patient (altruism), has an affinity for patient, demonstrates instinct, insight, intuition, maturity/self-confidence. *Defining attributes*: initial physical closeness, metaphysical connection/ exchange. *Consequences:* positive patient progress, improved patient functioning or death, patient desire for more nurse contact, nurse availability continues, nurse personal & professional development promoted.
Osterman et al. (2010)	Qualitative, descriptive	Convenience, nurses (*n* = 5), hospital inpatients (*n* = 10)	Participant-observation, with informal & formal interviews	30-35 bed oncology unit in a 275-bed community hospital in New England, US	Identify & describe various forms of presence that occurred with any one nurse while providing daily care on an oncology unit. Determine if similarities existed in the use of presence between nurses	NONE	*Nursing presence* was not a deliberate nursing strategy. Presence was embedded in individual nurses' manner & approach & easily identified by patients. Cues from the patients were the stimulus for guiding the level of presence provided by the nurse (partial or full). Openness & spontaneity to respond & alter levels of presence was based on the interplay between the patient's needs and behaviors, the current context of the unit & the nurse's past experience.
Papastavrou et al. (2011)	Quantitative, descriptive comparative	Convenience sample from 34 hospitals. Surgical inpatients (*n* = 1537) & their nurses for that shift (*n* = 1148)	Participant-completed questionnaires	Inpatient surgical wards in six European countries: Cyprus, the Czech Republic, Finland, Greece, Hungary, & Italy	Compare patients' & nurses' perceptions of caring behaviors	Caring-Behaviors Inventory - 24	Significant differences found between patient and nurse views on the sub-scale of *assurance of human presence* with nurses rating themselves higher than the patients ($p < 0.001$), while the sub-scale of positive connectedness was not significantly different. Factors for assurance of presence included: visiting the patient, communicating, encouraging calling, & responding to patient calls.
Pettigrew (1988)	Phenomen-ological	Purposive, family members of cancer patients (*n* = 6)	Unstructured interviews	After death of terminal patient, Western US	What are the essential elements of the lived-experience of the nurse's presence as experienced by family members or friends of a terminally-ill cancer patient?	NONE	Nurse's presence evolved around time of crisis. Presence recognized by: deliberate behavior, verbal affirmation, good listening & non-verbal skills, clinical competency, spiritual care, action beyond ordinary, unrestricted availability, compassion, valuing personhood & staying power, nurse vulnerability/ investment. Occurs upon invitation from the suffering.

Table 2. (continued)

Author/Title	Study Design	Sample Type & Size	Data Sources	Setting	Research Questions/ Hypothesis	Instruments	Results/Comments
Reis et al. (2010)	Qualitative, interpretive	Purposive, parents of NICU patients (*n* = 10)	Semistructured interviews	Tertiary-level care 69-bed NICU in Alberta, Canada	Explore parental perceptions of the nurse's contribution to the parents' NICU experience & their satisfaction with the care of the infants	NONE	Perceptive engagement, cautious guidance, and *subtle presence* were seen as antecedents in development of their relationship with the bedside nurse. Ideal nurses seen as teacher, guardian, and facilitator. *Presence is described as being available & accessible to parents to support them, offering constructive correction, and providing parents with positive affirmation.* A model of negotiated partnership is provided.
Turner-Stokes (2006)	Hermeneutic	Convenience, registered nurses (*n* = 14)	Individual interviews	Acute care hospital & long-term care facility in Melbourne, Australia	Understand the hope-facilitation strategies used while caring for patients	NONE	Two emergent themes: *connecting* with the inner being & *journeying with them, building trust over time* are aligned with presencing. Type of facility and potentially length of time together impacted the depth of hope facilitation.

summary, inpatient research has focused evenly on nurse and patient perceptions of nursing presence. Studies for the most part utilized convenience or purposive samples and the majority of studies were conducted in the United States and Canada. The largest multi-center, quantitative survey was conducted in six European counties and investigated caring behaviors as its primary goal, but results had significant implications regarding the difference between nurse and patient perceptions of presence. The results of this systematic review indicate that inpatient research on this traditionally elusive concept has increased but is slow with only 15 studies being published in the 12 years since the last state of the science report. Few of the research studies (both inpatient and outpatient) specifically identified their theoretical foundations, thus additional subsequent literature searches were conducted to identify all applicable nursing models or metrics.

Research Question 3

Nursing presence models. As stated earlier, nursing presence has been cited as a major component in several nursing theories (Benner, 1984; Leininger, 1991; Parse, 1981; Paterson & Zderad, 1976; Swanson, 1991; Watson, 1985). A theoretical foundation for nursing presence theory is found in Kim's (2000) nursing theory which outlines four different domains within nursing (client domain, nurse-client domain, domain of practice, and the environment domain). Nursing presence resides within the nurse-client domain. After conducting an extensive search, 10 additional models/ frameworks were identified and are described in Table 3. These models are best explained in terms of level of specificity.

The broadest, macro view is provided by the relational self-organization in workforce redevelopment model (Ray & Turkel, 2012). Nursing ethical decision points for whether to provide caring and presencing behaviors are shown to have a direct relationship on organizational success. The closely related theory of the relational work of nurses provides details on organizational factors that may inhibit or facilitate relational work of nurses (DeFrino, 2009). This theory provides more insight to why nurses disappear from practice in environments where relational work is not fostered and has implications for design of nurse workloads. The hierarchy of healing presence (Godkin, 2001 and Godkin & Godkin, 2004) and Halldorsdottir's theory of caring (Halldorsdottir, 2012) are models that provide linear explanations of how caring and presence are achieved. Presencing takes place in the Halldorsdottir biogenic and bioactive phases. These two models may offer a structure for measurement of depth of nurses' interpersonal experience with patients. Two models concentrate primarily on nurse attributes or actions the client receives from the nurse. The Mayo nursing care model (Harms, Eversman, Matt-Hensrud, Ruen, & Schroeder, 2010) identifies seven principle caring roles of the nurse, while the paradigm for nursing interventions (which is specific to suffering and chronic sorrow) identifies components of nurse inputs (Melvin & Heater, 2004). This model also describes the client trajectory and outcomes. At the most intricate level, a hybrid model of Orlando's deliberative nursing process and the Crick and Dodge model of social information processing, shows many direct linear communication processes within the nurse-patient relationship (Sheldon & Ellington, 2008). This model might serve as a good framework for direct observational studies between nurses and patients due to its intricacy of detail regarding patient cues, encoding of communication and response. Finally two models, transformative nursing presence (Iseminger, Levitt, & Kirk, 2009) and the mid-range theory of nursing presence (McMahon & Christopher, 2011) offer the most general and comprehensive views of nursing presence.

The transformative nursing presence model outlines forces that serve as barriers to nursing presence along with transcendent practices that facilitate nursing presence. The experiential components of nursing presence and the outcomes are also included at the patient, nurse, organization, and community levels. This theory provides key precursors required for nursing

Table 3.
Key Theoretical Models/Frameworks of Nursing Presence

Model/Framework	Theorist/Author(s)	Description
Halldorsdottir's theory of caring AND nurse's compassionate competence	Bailey (2011) Halldorsdottir (1991) Halldorsdottir & Karlsdottir (1996) Halldorsdottir (2012)	Caring to Uncaring Continuum - Five Basic Modes of Being with Another: Life-Giving – biogenic, Life-Sustaining – bioactive, Life-Neutral – biopassive, Life-Restraining – biostatic, Life-Destroying – biocidic. Nursing presence likely occurs during biogenic and bioactive modes. Potential guide for employing nurse presence and/or measuring it. Compassionate competence includes wisdom, clinical competence, communication/connection, attentiveness, self-knowing/development and caring.
Hierarch of healing presence	Godkin (2001) Godkin & Godkin (2004)	Nursing presence is described in a linear ascending fashion beginning with bedside presence (uniqueness, & connecting with the patient experience) extending to clinical presence (sensing & going beyond scientific data), then extending to healing presence (know what & when to act, being present). As nurse task maturity grows, the nurse presence capability is optimized. Nursing presence indicators are outlined in the 2004 article.
Mayo nursing care model	Harms et al. (2010)	The nurse-patient & family relationship is lived through seven principle caring roles: caring healer, problem solver, navigator, teacher, pivotal communicator, vigilant guardian, and transformational leaders.
Mid-range theory of nursing presence	McMahon & Christopher (2011)	Very comprehensive model represents nurse characteristics, client characteristics, and compatibility factors within the nurse-client dyad (relationship). Key components of nursing presence and variables influencing its successful application are outlined. Nurse determines level of intentionality, and select dose & delivery mode of presence. Desired client outcomes are listed.
Orlando's theory of deliberative nursing process and Crick & Dodge model of social information processing	Sheldon & Ellington (2008)	A hybrid model is proposed. The nurse encodes and interprets patient cues using thought and feeling, producing arousal regulation, response access, and response decision. Nurse performs activity that is deliberate and reciprocal based on additional data intake from ongoing patient cues and responses.
Paradigm for nursing interventions Suffering and chronic sorrow	Melvin & Heater (2004)	Through enacting of nursing presence, the client receives expert communication skills, compassion, human touch, trust, and honesty. These inputs move the client to experience self transcendence, autonomy, feeling of truly being heard, with decreases in isolation, abandonment, and despair. Outcomes include the client finding meaning and peace.
Relational self-organization in workforce redevelopment	Ray & Turkel (2012)	Nurse ethical decision points (to provide care in manner consistent with caring & presencing) have a direct impact (positively or negatively) on organizational success.
Theory of the relational work of nurses	DeFrino (2009)	Derived from parent theory of relational work of women (Fletcher et al., 2000), this model presents how nurses use relational work to preserve work, self-achieve, create team, and mutually empower. Factors causing relational practices of nurses to disappear are presented (likely important in the design of workload to facilitate improved relational practice and retention in practice).
Transformative nursing presence model	Iseminger et al. (2009)	Actual and perceived barriers to nursing presence identified. Transcendent practices are employed that lead to enhanced nursing presence, and then lead to patient/family and nurse outcomes/benefits. Transcendent practices include awareness, empathic appreciation, appreciative abandonment, respectful listening, skilled communication, selective focusing, availability, awe, openness, flexibility, supportive milieu, embrace another's situation, alignment with organization.

presence capability but does not clearly outline what happens within the process. It therefore provides several domains for instrument development about nursing practices, but is less useful for training nursing students. The mid-range theory of nursing presence, on the other hand, is better suited for nurse student education on the process of nursing presence.

The mid-range theory of nursing presence was postulated as a specific theoretical framework within the last two years (McMahon & Christopher, 2011). The mid-range theory of nursing presence depicts the micro vision of the nurse-managed intervention. It provides key information regarding nurse capability requirements including knowledge and maturities (professional, moral, relational, and personal) which lead to the nurses' ability to recognize need when they are open to the patient. The use of presence is a deliberate intention which is delivered by a dose which is chosen by the nurse along with delivery mode. The patient's individual needs determine his or her openness to enter into presence. Desired patient outcomes are also outlined. This theory depicts the most comprehensive model, while portraying an understandable process for nursing students and entry level nurses to reflect upon during practice situations. Because of the comprehensive nature, it is a good overall template for metric development to measure student or nurse interactions with patients. In summary, many of these models could be effectively used as foundations for further instrument development, dependent on the desired level of specificity for measurement. Finally, the systematic review was continued to evaluate existence of already developed metrics.

Nursing presence metrics. To date, only a few initial attempts have been made at quantitative measurement of nursing presence. Only three metrics with overall purpose of measuring nursing presence were identified. Two measure nursing presence from the nurse perspective. The Measurement of Presence Scale (MOPS) was developed by Hines (1991) as part of dissertation work and further studied in subsequent dissertation (Foust, 1998). The MOPS is a 60-item scale developed by systematic theory analysis, and content was validated from a panel of experts. It was initially tested with a sample of 324 nurses to measure nurse perception of nursing presence. Internal consistency reliability (Cronbach's alpha) was 0.9324. Subscale alpha correlation coefficients were all greater than 0.60. Factor analysis led to nine mutually exclusive subscales. Correlation between subscales and total MOPS were significant ($p = 0.01$), leading the researcher to assert that the tool was supported.

In 1998, Foust retested the instrument with a random sample of 210 registered nurses. A Measurement of Presence Visual Analog Scale (MOPVAS) was developed by Foust and tested along with the original tool (MOPS) as well as the Rosenberg Self-Esteem Scale (RSES). Presence (via original MOPS) and self-esteem levels were high with respective means of 231, ($SD = 16.52$) and 34, ($SD = 4.46$). The MOPVAS mean was 85, ($SD = 1.73$). Reliability for MOPS (Cronbach's alpha) was 0.9106, for the self-esteem scale, 0.8571; and for the MOPVAS, 0.8512. Construct validity was supported with low correlations of MOPS and MOPVAS ($r = 0.263$, $p = 0.01$) and MOPS and RSES ($r = 0.329$, $p = 0.01$). Factor analysis on second study data produced similar but not exactly the same subscale factors likely indicating the need for further instrument testing. While these studies showed support for the Measurement of Presence Scale, no other studies were located in which instrument development were tested. This is indicative of minimal instrument development in measuring nursing presence from the nurse perspective. Similar results were found in review of nursing presence instrument development which measured nursing presence from the patient's perspective.

The final tool identified by this review evaluated nursing presence from the patient's perspective and has been used by two researchers (Kostovich, 2002; Hansbrough, 2011), both of which were part of dissertations. Kostovich (2002) developed the Presence of Nursing Scale (PONS). This 25-item scale was tested on a sample of 330 acutely ill, medical-surgical patients in four units of a mid-western hospital (Kostovich (2011). Content validity was established by four expert reviewers. In the initial study, construct validity was established by comparing the total instrument score with a single-item measure of patient satisfaction with a very high positive correlation ($rpb = .801$). Reliability (Cronbach's alpha) was 0.95 and test-retest reliability was 0.729. Exploratory factor analysis was not conducted; therefore, potential patterns of relationships between the tool subscales were not evaluated. This tool has been subsequently tested in the Veteran's Administration system in acute care and long-term care with a sample of 102 patients by the original developer (unpublished at present) and in a West Coast hospital (Hansbrough, 2011).

Hansbrough retested the PONS with a convenience sample of 75 hospitalized patients. Again the PONS was tested against a single-item measure of patient satisfaction. PONS was again reliable with Cronbach's alpha of 0.937 and correlation with a patient satisfaction measure was strong and statistically significant ($p > 0.01$). Again, no factor analysis was reported for this study.

In addition to instruments specific to nursing presence measurement, there are potentially other instruments in use that measure the patient's perspective of the nurse/patient inter-relational experience. These tools could offer insight to the further development of the Presence of Nursing Scale, and/or if used in concert, serve to potentially demonstrate convergent construct validity. Additional instruments for consideration are found in Table 4.

Limitations

This review was conducted by a single researcher as part of the requirements for doctor of philosophy study in nursing. Time limitations prevented more in-depth analysis of all potential instruments designed to measure additional components of the nurse-patient interaction. Due to these limits, the review contains only tools that had immediate pertinence to nursing presence. Additionally, analysis of potential presence models or metrics from other disciplines was not undertaken.

Recommendations

This analysis found that there are similarities between presence in nursing and presence in other therapeutic professional relationships, however there is a large gap in the literature for interdisciplinary research or research designed to carve out the uniqueness of nursing presence. Nurse educators are uniquely situated to study similarities between nursing presence and teacher presence. More interprofessional concept development studies are needed to clarify similarities or differences. Non-nursing disciplines also need more in-depth attention to concept analysis and concept development endeavors to form the distinct components of their concepts of presence.

While inpatient research is likely crucial given the potential concern over imminent loss of nursing presence capability, the progress on this knowledge development has been slow. There is a great need for additional research that further identifies inpatient perception of nursing presence given the healthcare climate. Further studies are indicated that use measurement scales and instruments to determine if presence in nursing is being measured adequately across different patient populations. For existing instruments, it is essential that exploratory and confirmatory factor analysis be conducted to further develop and evaluate their ability to measure this phenomenon. New instruments need to be developed based on the improved definition and conceptual development of nursing presence over the last decade. Further qualitative studies need to be initiated to explore the nuance of presence in nontraditional healthcare settings, including telehealth environments. Nursing care environments might

Table 4.
Instruments Relevant to Measurement of Nursing Presence

Instrument	Author	Description	Reliability and Validity Data
Caring Behaviors Inventory – 24	Wolf et al. (1994) Papastavrou et al. (2010)	Revised from the original 43-item tool to 24 items. Based on Watson's transpersonal caring theory. Contains a sub-scale of "assurance of human presence" and thus could be a potential construct validity measure.	Internal consistency (Cronbach's alpha) = 0.94 (nurses); 0.96 (patients).
Caring nurse-patient interaction scale (CNPI-short scale)	Cosette et al. (2006)	Revised from an original 70-item questionnaire, the tool contains 23 items reflecting four caring domains: humanistic care, relational care, clinical care, and comforting care.	All items relate to their theoretical domain alone (factor loading > or = 0.40). Alpha coefficients for the four domains = 0.63 - 0.74, 0.90 - 0.92, 0.80 - 0.94, & 0.61 - 0.76 respectively.
Nurse caring patient scale	Della-Monica (2008)	Developed from a metasynthesis of patient descriptors within a "mid-range theory of Nurse Caring." Contains three attributes: 1) Presence, concern for the other; 2) Knowledgeable, competent care; and 3) Respect for the person.	Factor analysis resulted in parsimonious three factor solution that accounted for 50.49% of the total variance. The final NCPS contained 23 items with an alpha of 0.91. The presence item contains 11 items with an alpha of 0.89.
Patient evaluation of emotional care during hospitalisation	Williams et al. (2011)	Tool to evaluate quality of interpersonal interactions of staff that had been experienced during hospitalization. Originally containing 3 sub-scales of Level of Security, Level of Knowing, and Level of Personal Knowing.	Confirmatory factor analysis substantiated the four sub-scales. Cronbach's alpha coefficients ranged from 0.73 - 0.86, however, the subscale for Level of Connection, was lower at 0.59. This may be due to its being a new sub-scale.
Technological competency as caring in nursing instrument	Parcells & Locsin (2011)	Expresses five core assumptions of the theory with 5 items each. This is a modification from the original 30-item tool (Locsin, 1999). This revision was done by having 13 experts rate item validity. Several items are representative of nursing presence attributes or conditions.	Item validity rating range from .38 - 1.00. Items .70 and below were deleted and items rated .70 - .95 were modified based on expert recommendations.
Watson caritas patient score	Watson, Brew, & D'Alfonso (2010)	Contains five critical caring questions, with a 7-point Likert scale to assess frequency of authentic human caring practices. The items are derived from the 10 Caritas Processes™ of Watson's human caring theory. The scale has different versions and has been translated into Italian, Hebrew, and Arabic.	Is currently being evaluated in extensive multi-site clinical research in systems who have implemented the human caring model.

benefit from institutional-based studies to evaluate how time management of presence is accomplished. These same environments need to be studied to determine best practices to promote healthy work environments that support the ability and time to demonstrate nursing presence.

As with all concepts, historical context is likely to have an impact or change understandings and use of concepts. With the emergence of technological advances, Finfgeld-Connett (2006) urged researchers interested in studying nursing presence to establish ways to preserve nursing presence when deploying telehealth technology. Sandelowski (2002) warned about the potential implications that technology will have on our ability to enact a true nursing presence in the future. In response to contextual change for nursing presence, few authors have conducted studies in relation to this new virtual nursing presence (Finfgeld-Connett, 2005; Savenstedt, Zingmark, & Sandman, 2004; Schlachta-Fairchild, Varghese, Deickman, & Castelli, 2010). The resulting derived concept of telepresence was defined as "the subjective experience of being together with a person in one place when one is geographically situated in another" (Savenstedt et al., 2004, p. 1047). To date, there have been no instruments tested to evaluate patient perception of nurse virtual presence and whether it differs from physical nursing presence. Further review, analysis, and refinement are indicated.

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