NURSING PRESENCE IN THE PERIOPERATIVE AREA

A dissertation submitted to the Caspersen School of Graduate Studies

Drew University in partial fulfillment of

The requirements for the degree,

Doctor of Medical Humanities

Rebecca Dufner-Mantore

Drew University

Madison, New Jersey

May 2017

ABSTRACT

Nursing Presence in the Perioperative Area

Doctor of Medical Humanities by

Rebecca Dufner-Mantore

The Caspersen School of Graduate Studies
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The basic nursing intervention expected of Operating Room nurses is the ability to skillfully guide and protect their patients through the surgical experience to wellness. To accomplish this effectively Operating Room nurses must be there with and be there for their patients. That is, Operating Room nurses must be present. Nursing presence is here defined as, mindfulness by the Operating Room nurse in the context of the surgical patient.

Perioperative nurses, constantly pressed to work harder and faster, find taking the time to be present with their patients virtually impossible and virtually unsupported by Operating Room directors and hospital administrators alike. The demand to perform increasingly complex nursing tasks and technological skills in decreasingly less time has left perioperative nurses emotionally exhausted, depersonalized, and demoralized—all predictors of professional burnout, all predictors of declining patient care.

The unique training of Operating Room nurses means nurses from other disciplines cannot easily replace them. Hospitals cannot afford to lose perioperative nurses at a time when a nursing shortage threatens the care of an aging population that requires increasingly higher incidents of surgical intervention.

Surgery is serious business and patients deserve surgical nurses who are present and in the moment for quality nursing care. Presence by perioperative nurses in the context of their patients is a safety measure. It is possible to prevent a number of errors through nursing presence before surgery when nurses provide a moment or two of distraction-free time with their patients. It is during the application of presence when patients are able to think and communicate clearly to Operating Room nurses that errors may be avoided.

Surgical patients benefit from nursing presence in countless ways. Perioperative nurses are the single group of professionals in the department of surgery responsible for nursing the whole patient; that is considering each patient as having a unique blend of medical, social, and psychological concerns. The holistic approach to patient care is a hallmark of Operating Room nurses' practice as surgery requires one-of-a-kind care regardless of how routine the surgery is. Pre-surgical presencing by perioperative nurses does much to over ride the stress-pain-stress-more-pain cycle. Surgical nurses who are present are best at offering this valuable intervention. Surgical nurses who are present provide emotional support and comfort for each patient exclusively. Finally, surgical nurses who are present ultimately bear witness to the event of surgery.

This dissertation discusses the need for presence by nurses generally and perioperative nurses specifically. The dissertation also expands coverage of nursing presence to include outward signs of presence as seen by patients and inward signs of presence as felt by nurses as well as barriers to presence and the financial cost of nursing presence.

DEDICATION

To my wonderful husband, Bob Mantore, for his love and tireless support year after year.

To my remarkable sister, Gretchen Warrington, who was always the voice of reason and common sense.

To my precious stepdaughter, Marlena Mantore, and my long time friend, Andrea Hennessey, for cheering me on.

To my colleagues in the Operating Room, both nurses and technicians, who taught me what it is to be giving, noble, tireless, and brave.

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ACKNOWLEDGEMENTS

I would like to gratefully acknowledge the guidance, support, and encouragement of Dr. Phyllis DeJesse, Dr. Phil Scibilia, and Dr. Jeanne Kerwin. Their assistance helped enormously in directing my progress and I am forever grateful.

INTRODUCTION

> Presence, a state of being where one is fully attending to the task at hand without an agenda.
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> —Ozum Ucok, *Transparency, Communication and Mindfulness*

Patients undergoing surgery need nursing support. The unique qualifications of Operating Room nurses support surgical patients by way of nursing presence defined as *mindfulness by the perioperative nurse in the context of the surgical patient*.[1] Stated another way, presence is the conscious effort by perioperative nurses "being-with and being-there" for their surgical patients.[2] However, attempts by hospital management to utilize the Operating Room (OR) efficiently constantly press these valuable nurses to reduce the time spent interacting preoperatively with their patients. As far back as 1997, Mark Mitchell's study of surgical patients highlighted that "medical and pharmacological advances" had "out-paced current pre-operative psychological preparation."[3] Nurse driven studies show more nursing presence equals better satisfaction scores for patients and more nursing presence equals better job satisfaction scores for nurses.[4]

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1 The definition of nursing presence developed by the author is offered here as a straightforward explanation of the concept of presence. It is important to remember a concept definition must avoid the concept name (such as presence) in its description. That is, explaining presence as being present is useless: therefore the use of the term mindful, although not identical to presence is used. Repeatedly in my research, I labored through convoluted definitions of presence as if written by a lawyer or legislator. Any definition that is to be usable to Operating Room nurses has to be elegantly clean and organically simple. The simplicity of my definition of presence allows its application to all nursing and has remained relevant and clear throughout my research of presence in the perioperative area.

2 Holly Covington, "Caring Presence."*Journal of Holistic Nursing* 21, no. 3 (2003): 301.

3 Mark Mitchell, "Patients' Perceptions of Pre-Operative Preparation for Day of Surgery." *Journal of Advanced Nursing*, 1997: 356.

4 Sue Penque and Gina Kearney, "The Effects of Nursing Presence on Patient Satisfaction." *Nursing Management* 46, no 4 (2015): 39.

Most Operating Room nurses, also referred to as perioperative or surgical nurses, realize connecting with their patients in these final, few moments before surgery as critical for the safety and satisfaction of patients and registered nurses alike.

This dissertation seeks to examine the subject of nursing presence in the perioperative area; that is, mindfulness by the perioperative nurse in the context of the surgical patient. I will argue that nursing presence in perioperative nursing is essential for a safe high quality surgical experience. Extensive literature review and theory synthesis provide support for this thesis statement as well as results of the survey I conducted of perioperative nurses; the majority of whom ranked nursing presence as extremely important or very important. My research of nursing presence includes presence in all nursing disciplines as well as a concentrated focus on nursing presence in the Operating Room.

The underlying hypothesis for this dissertation is as follows. There is a *direct* relationship between the amount of time spent with surgical patients preoperatively by nurses who offer presence and improved patient satisfaction. Namely, more nursing presence equals better patient satisfaction scores. There is an *inverse* relationship between the amount of time spent with surgical patients preoperatively by nurses who offer presence and patient anxiety. Namely, more nursing presence equals less patient anxiety.

Background

Registered professional Operating Room nurses generally greet their patients in a preoperative area. By this time patients have changed into a gown, completed all necessary paper and blood work, and are awaiting the arrival of their surgeon. Historically, patients who come to the hospital have little or no preoperative

psychological preparation for surgery.[5] Efforts by Operating Room directors and hospital administrators seek to reduce or eliminate the period of time patients have to wait in this anxious, worry filled period just prior to surgery. Nevertheless, this brief interlude to surgery and the positive interaction with nurses who are taking responsibility for their patients while in surgery are pivotal for a good surgical experience.

Patients undergoing surgery need care delivered by qualified registered professional nurses.[6] Operating Room nurses, even in the best of circumstances, have little time to determine the wellbeing of their patients much less intervene to allay the effects of fear or anxiety.[7] Sadly, it is during the immediate preoperative period that oftentimes the least skilled employees, such as transporters, give patients unskilled care.[8] It is common for patients to ask medical advice of orderlies in the OR simply because orderlies have spent more time with these patients than their nurses. Surgical nurses realize they must carefully defend the use of this time for presencing before surgery if their patients are to receive high quality nursing care. This care is too important for appropriation by unlicensed assistive personnel (UAP). Constant pressure to reduce the time they spend interacting with their patients before the induction of anesthesia has compromised the excellent care perioperative nurses want to give their patients.[9]

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[5] Mitchell, 363.

[6] Muriel Shewchuk, "Why a Registered Nurse (RN) in the OR?" *Canadian Operating Room Nursing Journal* 25, no. 4 (2007): 38.

[7] Michael Prichard, "Identifying and Assessing Anxiety in Pre-Operative Patients." *Nursing Standard* 23, no. 51 (2009): 35.

[8] Helen Caunt, "Preoperative Nursing Intervention to Relieve Stress." *British Journal of Nursing*, 1992:174.

[9] Mereana Hunt, "Practice." *Kai Tiaki Nursing New Zealand*, 2006: 20.

Doctors, managers, and technicians all compete for control of this time just before surgery; [10] however, it is registered nurses who have the commission to advocate for their patients in this exclusive holistic way. Therefore, it is critical that this precious portion of time just before surgery remain in the control of perioperative nurses.[11]

The exceptional training and unique positioning of perioperative nurses affords them the opportunity to key into patient anxiety or uncertainty both of which negatively affect the surgical experience.[12] Operating Room nurses, with the rare combination of surgical knowledge and nursing skill, have the training to assess surgical patients physically and emotionally before surgery. This effort to connect and be present for one's patients is historically associated with nursing's roots and continues to be a highly regarded professional trait. Nurses in the perioperative area practice a unique integration of the art of caring and the "pragmatic application of scientific knowledge."[13]

Operating Room nurses commit to jealously guarding these pre-surgical minutes, however brief, from others who would trivialize them. The moments just before surgical incision should be under the direction of perioperative nurses and not hijacked by technical personnel or eliminated by detached administrators.

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[10] Robin Riley and Elizabeth Manias. "Governing Time in Operating Rooms." *Journal of Clinical Nursing* 15, no. 5 (2006): 546.

[11] Marja Silen-Lipponen, Kerttu Tossavainen, Hannele Turunen, and Ann Smith, "Potential Errors and their Prevention in Operating Room Teamwork as Experienced by Finnish, British and American Nurses." *International Journal of Nursing Practice* 1, no. 11 (2005): 21.

[12] Hunt, 20.

[13] Bernard Yam, "From Vocation to Profession: The Quest for Professionalization of Nursing." *British Journal of Nursing* 13, no. 16 (2004): 982.

Registered nurses in the perioperative area must have the freedom to give needed help to each patient as they see fit.[14] This care includes the authentic presence of nurses whose responsibility it is to advocate for their patients when patients cannot advocate for themselves. It is my hope that my research will illuminate the uniqueness of nursing presence in the OR and encourage Operating Room nurses to further quantify nursing presence. This quantification will showcase the inestimable value of presence ultimately preserving nurses' ability to offer presence to surgical patients in the future.

There is a demand for continued studies measuring patient perception of nursing presence given the healthcare climate and significance of patient satisfaction scores to hospital reimbursement rates. There is also a call for the development of new instruments measuring the effects of presence based on an improved conceptual definition and its benefit to both nurses and patients.[15] Although much information exists about the commitment to safe nursing practice in the OR, little information exists about the limited time to identify a problem or correct it before surgery. Nursing presence is the first step in patient safety.

Methodology

As an Operating Room nurse for over 20 years, I saw on a daily basis the value of being present for surgical patients. It was so evident to me that just a few minutes of authentic connection with my patients prior to surgery made all the difference in the world to them. Virtually every surgery was a life-event to my patients; did I not owe

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[14] Prichard, 36.

[15] Rebecca Turpin, "State of the Science of Nursing Presence Revisited: Knowledge for Preserving Nursing Presence Capability." *International Journal for Human Caring* 18, no. 4 (2014): 29.

them, at the very least, a brief unscripted conversation? I was entering into an unspoken agreement with them to watch over them when they were unable to watch out for themselves. Did they not deserve to see my face and hear from my mouth that I was taking this responsibility seriously and willingly?

The answer is "yes." If "yes" then why was I constantly being forced by surgeons and managers to justify using this brief time to offer presence? This research project is an effort to define in finite minutes the period in question as well as highlight nursing presence in surgical nursing as the valuable intervention it is.

Time in the OR is expensive and its use must be constantly justified as a legitimate cost/benefit ratio. My study investigates how much time the surveyed OR nurses actually spend with their surgical patients. Determining the actual time in minutes nurses in the perioperative area spend at this critical point is an important first step toward determining just how much time is needed to offer presence as well as safely assess the patient before surgery. The goal of this research is to measure the actual time surgical nurses spend with their patients just prior to surgery. The study will also establish how much time surgical nurses require to offer their presence. My investigation of nursing presence will explore outward signs of presence—those patients see, as well as inner signs of presence—those nurses feel.

Given that little or no research has addressed this particular preoperative period with the qualifiers of presence and time, this research question classifies as a Level one study. Level one studies include topics or populations with little or no literature available. The purpose of a Level one study is to describe a phenomenon "as it exists naturally."[16]

[16] Margaret Wood and Janet Ross-Kerr, Basic *Steps in Planning Nursing Research.* 6th. Boston: Jones and Bartlett, 2006, 11.

Quantitative Survey

The method of studying Operating Room nurses was by the use of Survey Monkey, an online surveying service by which I studied a convenience sample of forty-nine Operating Room nurses in 2011. Data collection centered on these nurses' professional opinion of the importance of nursing presence to their patients and the nurses themselves. Participants were also asked how often outward signs of nursing presence are offered as well as the inward effects of presence on nurses' internal feelings. Questions included the actual time nurses had for presencing and the time they felt they needed to offer nursing presence plus some demographic information.

Advantages to this type of study design are that I was able to reach more surgical nurses than face-to-face focus groups. The online format took less time for participants than in-person interviews besides affording participants the convenience of responding any time of day. Survey Monkey has an anonymous response function I employed to encourage participation as well as honesty and accuracy in responding. I was able to ask additional questions regarding offering presence and provided free text options for participants who wanted to write additional reflections on their view of nursing presence. The data collected proved to be tamper proof and the response design was self-categorizing. Because of the use of an online format, I avoided any untoward bias nurses may have felt completing the study on a hospital campus. The web-based method of research also bypassed others, say managers or administrators, who may not want the limited time for nursing presence verified as an actual value.

Disadvantages of an online survey are that various nurses may define the term "time" in different ways. Limitations include that participants were self-selecting as those who

value nursing presence. As in any study, survey questions control research direction as opposed to the free flow of ideas regarding nursing presence in interviews and focus groups conducted on campus. In addition, rich data evident to an on-site researcher are hidden and/or eliminated using the online method of surveying.

Significance to Nursing

Registered nurses in the OR want to perform high quality nursing by engaging surgical patients in therapeutic communication with the goal of supporting them in the minutes before surgery. Determination of the actual time, in minutes, perioperative nurses spend with surgical patients will provide a base line from which other studies may begin.

Continued research questions could investigate the quality of this presurgical time, the significance of the preoperative interview to patients as a moment to reflect, or asking that last important question before surgery. Nursing research subjects may include tension-relieving exercises as part of surgical nurse's preoperative interventions.[17]

There is an additional call for studies that measure patients' perception of nursing presence given the healthcare climate and significance of patients' satisfaction scores to reimbursement rates. In addition, nursing has an obligation to develop new instruments based on the improved conceptual definition of presence and its benefits to both nurses and patients.[18]

Ultimately, additional studies should answer:

- Does presence offered by registered nurses in the Operating Room make a difference to surgical patients?

[17] Kristing Kwekkeboom and Elfa Gretarsdottir, "Systematic Review of Relaxation Interventions for Pain." *Journal of Nursing Scholarship* 31, no. 5 (2006): 277.

[18] Turpin, 14.

- Does presence offered by registered nurses in the Operating Room make a difference to perioperative nurses?

The focus of my research targets the perioperative community, OR registered nurses specifically, as a call to action to guard their unique positioning in providing nursing presence to surgical patients. I am hopeful that my exploration of nursing presence will also prove to be an affirmation of the central and irreplaceable role OR nurses play in patients' surgical experience.

Chapter One

In chapter one I discuss the literature on nursing presence in general as well as its relevance to Operating Room nursing specifically. Precious few journal articles were available on the subject of nursing presence in the perioperative area; however, careful selection of articles from other nursing disciplines ensured the transferability of data to perioperative nursing. To this end, if Operating Room nurses are to continue providing care that includes presence for their surgical patients, they will need to present solid data in defense of this intervention. Nursing presence is of incalculable value to surgical patients and perioperative nurses alike. It is my hope that research such as this dissertation will contribute to the body of knowledge perioperative nurses can access in defense of nursing presence.

Chapter one also includes a detailed description of my research pathways and to what extent I used search engines such as CINAHL, EBSCOhost, Encyclopedia of Management, JSTOR, MEDLINE, Proquest Nursing & Allied Health Source, PubMed, PychINFO, and ScienceDirect. The only non-medical database accessed was BusinessSource Elite that provided financial data for chapter four. As my research on

nursing presence advanced, categories and sub-headings broadened or compressed as needed for a clear picture of nursing presence in the perioperative area.

The research on the concept of presence in nursing began in the late 1960s and has continued to the present. In chapter one, I trace this research as well as consider some of the various definitions of presence. My research led to the synthesis of a clean definition of nursing presence for use in the Operating Room: discussion and explanation of this definition is in chapter one. Also included in this chapter is a concept map, developed by me that illustrates nursing presence and is a product of my research. Initial work by Osterman and Schwartz-Barcott provided the basis for my map and was the first journal article I found explaining nursing presence clearly and succinctly.[19]

Chapter Two

Chapter two is a discussion of how nursing presence affects the surgical patient. I include accounts of patient experiences I witnessed firsthand during my twenty years as an Operating Room nurse. Patients presenting for surgery have had little or no preparation for their surgical experience and consistently rely upon their perioperative nurse for guidance and support. Nurses who are present for their patients are best at giving this support.

To ensure the most pragmatic view of nursing presence, and how presence affects surgical patients, I chose an ethnographic model. That is, the anthropological description of people living within a culture. This method provides a descriptive and contextual account of surgical patients as a population and frames the surgical experience within patients' entire medical care.

[19] Paulette Osterman and Donna Schwartz-Barcott, "Presence: Four Ways of Being There." *Nursing Forum* 31, no. 2 (1996): 23.

Because my search for journal articles on nursing presence in surgery yielded few articles, pieces written for other nursing disciplines became part of the information used. Namely, if data from studies conducted in other hospital departments were significant and if they were transferrable and relevant to surgical nursing, I included them in my research.

I discuss how surgical patients experience unbelievable stress on the day of surgery and cannot be expected to be themselves. Nursing presence helps ground patients emotionally as well as provides a psychological safe-haven before surgical incision. Patients who sense OR nurses' authentic interest in the moments before surgery avoid the conveyor belt mentality that leads to surgical errors.

Incorporated in this chapter are degrees of nursing presence as a real life explanation of presence and what this phenomenon looks like in the clinical setting. The chapter concludes with the concept mapping of nursing presence that developed because of my research on this subject. I include a discussion of the outward signs of nursing presence that are indicators to patients their surgical nurses are in the moment and there for them.

Chapter Three

Perioperative nursing is unique among all nursing disciplines and the Operating Room is a closed unit, hidden from the public at large. I introduce an explanation of perioperative nursing because most individuals would have no idea the time restrictions surgical nurses work under unless there was some clarification. This chapter outlines the benefits of nursing presence enjoyed by perioperative nurses. These nurse benefits are such things as improved job satisfaction and professional self-worth as well as protection

against burnout. Chapter three also outlines qualities required of nurses before they can successfully offer their presence: qualities such as professional maturity, moral maturity, personal maturity, and relational skill maturity.

Chapter three covers barriers to offering presence by surgical nurses, as well. The aforementioned closed nature of the OR keeps barriers to nursing presence hidden from most patients. This chapter reveals the constant sense of time urgency experienced by perioperative nurses that hinders any amount of presencing. Other obstacles to presence are such things as technology, increased workload and responsibility for RNs, plus limited experience in the use of presence.

Included in chapter three are results of my 2011 study of Operating Room nurses. There is a discussion of the study's design and rationale for the design as well as survey results and analysis. The study proved to be an example to my nursing colleagues of real research done by a real nurse in the real world.

Chapter Four

Chapter four is a discussion of nursing presence in the Operating Room and its effect on the OR's economy. Efficiency in the surgical unit has important implications on hospital finances as well as surgeon, patient, and staff satisfaction. The discussion of business and presence begins with a global view of the healthcare financial philosophy as it affects hospitals. Then because of the Operating Room's unique economy, there is a discussion of the OR's close ties to current medical products and cost.

I examine the influence of global and local business on the practice of Operating Room nurses and their use of time. Finally, there is the discussion of the cost of time in the OR and the complicated formula used to calculate that time. Presence began as a

concept in liturgy but adopted by nursing as a way to explain and clarify their caring intentions.[20]

Chapter four, The Business of Presence, was one I actually did not intend to write when I began my research. Information on the business of healthcare, hospital management or Operating Room finances seemed unrelated to nursing presence at the outset of my project. To be sure, many of my views promoting nursing presence also vilified managers and administrators as mercenaries who looked down on nursing in general and perioperative nursing specifically. Nevertheless, if my research were going to be truly thorough, I needed to explore the financial impact of nursing presence. It would be frivolous to advocate for nursing presence if it meant unlimited, leisurely, unstructured conversations with patients prior to surgery. Without a chapter on real-world economics, my thesis statement appeared unrealistic and starry-eyed.

In all honesty, when my research on the fiscal aspects of surgery began, I wondered if making a financially sound case for nursing presence in the perioperative area was possible. To my surprise, offering nursing presence makes perfect economic sense.

I knew Operating Room time to be expensive and any modality that took up that time had to be justified in a cost/benefit ratio. The complicated formula for determining the cost per minute of Operating Room time interweaves with an ever-changing cost index, hospital costing policy, and federal reimbursement rates. A study of Operating Room time forces one to realize that the greatest potential for profit in the hospital exists

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20 Paulette Osterman, Donna Schwatz-Barcott, and Marilyn Asselin, "An Exploratory Study of Nurses' Presence in Daily Care on an Oncology Unit." Nursing Forum 45, no. 2 (2010): 197.

in the OR. Hospitals are in the business of surgery. Operating Room nurses want their hospitals to be strong financially, but they also realize that taking the time to offer nursing presence is worth the cost.

The next chapter will discuss how the concept of presence in nursing has been developed and modified for use in clinical practice. However, it is my hope that this dissertation will highlight the unique opportunity of surgical nurses to offer their presence at a pivotal time in patient care. Perioperative nurses have the commission to care for their patients holistically and as such need time to deliver the intervention of presence.

CHAPTER ONE

HISTORY OF RESEARCH AND CONCEPT DEVELOPMENT

> Being present is real work.
> —Laura Van Dernoot Lipsky *Trauma Stewardship: An Everyday Guide to Caring for Self While Caring for Others*

Countless times when my sons were teenagers, I could tell when they tuned me out as I talked. I could just see their minds had drifted into outer space. Then I would put on my annoying mom-voice and say something like, "Earth to Jason, earth to Konrad." Reluctantly, they would drag their attention back to earth, back to my mom-lecture, back to the present.

This is a simple example of presence versus absence to which most people—and all parents—can relate. Questions of note are as follows. Since no one had left the room, how did I know they were absent—not present? How did I know when they were present again? Moreover, most importantly, why did it matter? This dissertation answers these same questions on presence as they apply, not to parenting but to nursing in general and Operating Room nursing in particular. Being present is necessary for the exchange of important information between stakeholders, it is a basic human courtesy and an absolute essential if you are a teenager who wants to borrow the car.

There are similarities between presence in nursing and presence in other meaningful relationships such as family matters, social dealings, or business affairs. If the relationship is crucial, attendance is mandatory. If parties are present, it is confirmation they feel the exchange is important enough to be engaged and aware. However, being present is not an all-or-nothing proposition: this dissertation will clarify the degrees of presence as well as reveal that presence is a choice. Individuals may choose to interact

with others through their presence or not, as well as choose to what extent. Being present is also good business.

Regarding business presence, Fiona Powell, in the October 2014 issue of *New Zealand Management* points out that deepening the power of presence expands one's mental capacity beyond the habitual point of view; that is, presence gives the individual "internal spaciousness" to free the mind and be in the moment.[21] The permission to let go of habitual thought leads to clarity and increased resilience.[22] The *Journal of Management Development* suggests the practice of presence is time saving:

> If we could actually be present to listen to each other in the workplace with close attention we might minimize much misunderstanding and confusion, and maybe reduce the amount of time and energy we spend in repairing what we might have missed or misunderstood because we were not really paying attention.[23]

Moreover, in 2013, *Total Quality Management Journal* proposed that mental presence allows employees to practice contemplative observation and non-judgment that results in better work time wellbeing.[24] In other words, presence allows one to think about the moment without background criticism freeing up one's mind to concentrate on the here and now.[25]

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[21] Fiona Powell, "Mindfulness for Managers and Leaders." *New Zealand Management* 61, no. 3 (2014): 24.

[22] Powell, 24.

[23] Ozum Ucok, "Transparency, Communication and Mindfulness." *Journal of Management Development* 25, no. 10 (2006): 1024.

[24] Claudio Baccarani, Vittorio Mascherpa, and Marco Minozzo, "Zen and Well-Being at the Workplace." *The Total Quality Management Journal* 25, no. 6 (2013): 609.

[25] Lisette Hilton, "As Exhaustion Jumps, Satisfaction Slumps." *Urology Times* 44, no. 1 (2016): 19.

Certainly, presence in the relationships mentioned earlier is important; however, the significance of presence in nursing is amplified because it is the health and safety of patients and nurses alike that is at stake. [26] To be sure, Janice Zeller and Pamela Levin, both nurses, describe nursing as work that requires sophisticated technical skill and superior judgment performed under intense pressure.[27] Workplace stress, for nurses, leads to burnout, compassion fatigue, inattention, treatment errors and needle sticks. *Journal of Nursing Scholarship* reports that 32% of nurses in one international study report "high emotional exhaustion" as contributing to burnout.[28] Nursing presence is an antidote to workplace stress.[29] Programs designed to increase present moment awareness, result in nurses who respond to stressful situations in healthier and more adaptive ways. [30]

Interestingly, exercises designed to increase one's ability to be present and in the moment were associated with decreases in amygdaloid gray matter density. [31] The more participants' stress levels decreased, the greater the decrease of gray matter density in the

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[26] Britta Holzel, James Carmody, Karleyton Evans, Elizabeth Hoge, Jeffery Duesk, Lucas Morgan, Roger Pitman, and Sara Lazar, "Stress Reduction Correlates with Structural Changes in the Amygdala." *SCAN* 5, (2010): 11.

[27]Janice Zeller and Pamela Levin, "Mindfulness Interventions to Reduce Stress among Nursing Personnel." *Workplace Health and Safety* 61, no. 2 (2013): 85-89.

[28] Apiradee Nantsupwat, Raymoul Nantsupwat, Wipada Kunavikikul, Sue Turale, and Lusine Poghosyan, "Nurse Burnout, Nurse-Reported Quality of Care, and Patient Outcomes in Thai Hospitals." *Journal of Nursing Scholarship* 48, no. 1 (2016): 83.

[29] Suzy Bashford, "Staying Calm: It's the Thought That Counts." *Occupational Health* 64, no. 6 (2012): 22.

[30] Zeller, 87.

[31] Holzel, 13.

right amygdala.[32] Namely, active learning or re-learning of emotional response to the stress, of say nursing, can lead to beneficial changes in brain structure and wellbeing even if there is no change in the stressful environment.[33]

Due, in part to the popularity of Mindfulness Based Stress Reduction programs for nurses and others that incorporate awareness of the present moment, the concept of presence has emerged as timely for nurses.[34] Efforts to advance the concept of presence, or any concept in nursing, starts with qualitative research that first develops theory: forming well-researched and qualitatively constructed theory remains difficult at best.[35] Concept development is no different from theory development as it entails the synthesis and explanation of a concept's hard-to-define qualities. For example, presence explained by the word presence is ineffective; rather clarification of the concept of presence has to be by other words. Concept analysis and concept development remain the main methods of advancing theory.[36] Interestingly, nurse-scholars often do not seem to think of their

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[32] The 2010 study by Holzel, et al. was of 26 individuals who reported high stress levels pre-intervention. Participants were given an 8-week mindfulness stress reduction course: following the intervention participants reported significantly reduced perceived stress. Reductions in stress correlated positively with decreases in amygdala gray matter density seen through MRI imaging. The amygdala is a structure of the brain that plays a crucial role during stress responses such as detection of threatening stimuli and initiating adaptive coping responses. Exaggerated activation of the amygdala results in such conditions as anxiety, post-traumatic stress disorder, depression, and impulsive aggression.

[33] Holzel, 15.

[34] Joanne Cohen-Katz, Susan Wiley, Terry Capuano, Debra Baker, and Shauna Shapiro, "The Effects of Mindfulness-Based Stress Reduction on Nurse Stress and Burnout." *Holistic Nursing Practice* 18, no. 4 (2004): 302.

[35] Deborah Finfgeld-Connett, "Qualitative Convergence of Three Nursing Concepts: Art of Nursing, Presence and Caring." *Journal of Advanced Nursing* 63, no. 5 (2008): 528.

[36] Daniela Lillekroken, "Slow Nursing - The Concept Inventing Process." *International Journal for Human Caring* 18, no. 4 (2014): 40.

work in concept development as research. Clinical phenomena and observations nurses make in their daily routine can be a path to the discovery of new themes in nursing and may be the basis of conceptualizing these experiences.[37] To be sure, the 2010 Institute of Medicine report recognizes it is nurses' responsibility to "identify problems, find improvements, and implement changes."[38]

Despite the difficulty in forming accurate descriptions of elusive phenomena, nursing scholars must pursue these efforts if nursing is going to advance as a scholarly discipline.[39] In the field of nursing, constructing theoretical frameworks and systematic examination of concepts leads to an enhanced understanding of the discipline. That was my goal as I began my exploration of the concept of nursing presence in the Operating Room: that is, to expand the meaning of nursing presence in the precious few minutes before surgical incision.

Concepts are the basic building blocks of theory. A concept such as nursing presence is a succinct description of a phenomenon—a mental image of an experience with all its details and facets. The definition of presence as an evolving concept remains elusive despite the general expectation that high quality nursing care must incorporate it. It is my hope that advancing the concept of presence within the perioperative area will lead to greater conceptualization of the role of nurses who use presence in their perioperative practice.

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[37] Beth Rodgers and Kathleen Knafl, *Concept Devlopment in Nursing: Foundations, Techniques, and Applications.* Second. Philadelphia: Saunders, 2000: 324.

[38] Renae Battie', "The IOM Report on the Future of Nursing: What Perioperative Nurses Need to Know." *AORN Journal* 98, no. 3 (2013): 229.

[39] Lillekroken, 40.

A systematic review of literature included several databases including BusinessSource Elite, CINAHL, EBSCOhost, Encyclopedia of Management, JSTOR, MEDLINE, Proquest Nursing & Allied Health Source, PubMed, PychINFO, and ScienceDirect. Researching the topic of presence in nursing began as a broad search of the term and concept. Only one article from the perioperative organization AORN contained the concept of presence and was a simple patient account: it failed to draw any conclusions about the concept of presence in the Operating Room. The article added little information to the body of knowledge on presence. Search history was at the onset done with an extensive approach using each database except for BusinessSource Elite's fiscal articles regarding Operating Room finances and hospital economics as they relate to theory.

This general search began with the word presence within the title. The only articles considered were those written in English or translated into English. Publication dates were limited to April 1996 to August 2016. The starting place was articles related to nursing so my search began with Proquest Nursing & Allied Health Source and CINAHL. When conducting searches in ScienceDirect and PsychINFO additional terms such as "therapeutic" and "therapy" were used in addition to "presence." Searching business literature for presence began broadly in BusinessSource Elite then narrowed down with the modifiers "management" and "fiscal."

If the abstract of an article appeared to meet the criteria of being applicable to nursing presence and transferrable to nursing presence in the perioperative area, a copy of the article was included for review. Reading of each article was for identification of key points regarding study design, study results, unique terminology, and the author's

definition of presence. Notes made included the study's attributes, antecedents, and consequences of the application of presence. My remarks incorporated the author's viewpoint of presence as well as how presence factored in other nursing disciplines. The cumulative effect of the literature search was sharpening the borders of the concept of presence and developing an understanding of the theoretical aspects of presence.

Concept Development

Presence within various disciplines revealed the word reflected meanings other than mindfulness; for example, many articles appeared on nurses' view of family presence during resuscitation. Presence in nursing yielded articles on nurse leaders, like Florence Nightingale, who were said to have a certain presence as they walked through the wards. It also became evident nursing presence meant something akin to occupation: such as, nursing presence in Afghanistan or nursing presence at the bargaining table. Therefore, the inquiry was limited to the search term of "nursing" or "nurse" plus presence done under the category of all text to make sure articles focused on presence offered specifically by nurses. On occasion, modifiers such as "true" or "authentic" were added to "nursing" or "nurse" as a way to expand the inquiry. From this comprehensive search, articles that pertained to nursing relational skills and presence were gathered.

As my literature search continued, it was evident that the subject of presence often contained modifying words such as caring presence, authentic presence, and true presence. In fact, one article argued against *any* modifying words as if presence was not already authentic, true, and caring.[40] This argument shows the complexity of concept

[40] Deborah Finfgeld-Connett, "Qualitative Comparison and Synthesis of Nursing Presence and Caring." *International Journal of Nursing Terminologies and Classifications* 19, no. 3 (2008): 111.

development and the merge of differing views. To be sure, theory building and concept development in nursing are valuable endeavors as the work uncovers theoretical parallels by comparing and contrasting various concepts. My research on the subject of presence has revealed similarities among such concepts as caring, presence, and mindfulness in nursing. Indeed some studies of mindfulness became supporting data for presence because mindfulness incorporates many of the attributes of presence.

As research of presence continued, groupings of ideas and meanings expanded, collapsed, or phased out altogether as needed. Along with developing an understanding of nursing presence, I was able to develop a concept map as well as illustration of the degrees of nursing presence and a succinct definition of presence that has withstood application in the perioperative area. (Figure 1)

The use of a constant comparison method of data analysis assured validity of research. Throughout the data analysis process, I acknowledged any preconceived ideas about the concept of presence that I held prior to my research. I remained acutely aware of the disproportionate amount of data that were available for presence and nursing vs. presence in the Operating Room.

Osterman, Schwartz-Barcott, and Asselin credit liturgy as the origin of the concept of presence.[41] Dr. Covington traces presence' first appearance as a concept in nursing to the late 1960s when nurse leaders identified presence as a means to deliver authentic nursing care.[42] By the 1970s through 1980s nursing's paradigm shifted from empirical-analytical to transformative which highlighted the value of nurse-patient

[41] Osterman, Schwartz-Barcott, and Asselin, 197.

[42] Covington, 301.

interconnectedness.[43] Presence is a concept that has its place in psychology as well as motivational techniques of the work place.

Fredriksson defines the concept of presence theoretically in 1999 as, "a gift of self that is conveyed through being available and at the disposal of the other person," and "an inter-subjective encounter between a nurse and a patient." [44]

Nurse Fredriksson illustrates one of many operational definitions of presence; that is, presence appears in real life as "a flow of feelings between two persons in a shared situation …, being there in the midst of a helpless situation … [despite] not knowing, not curing and not healing." Presence is explained as "being with" the patient together at the moment as opposed to "being there" which implies simply showing up at the same time and place.[45] As Fredriksson points out, being-with the patient requires nurses to give of themselves as well as make room for the other person in the nurses' care.

Nine years later Finfgeld-Connett's theoretical definition is virtually the same; that is, "an intentional therapeutic process that involves expert nursing practice and intimate interpersonal sensitivity."[46] Operationally, Finfgeld-Connett defines presence as "a rhythmic give-and-take pattern that develops between the nurse and recipient."[47] Presence by nurses is evidenced by eye contact, touching and vigilant surveillance which

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[43] Covington, 317.

[44] Lennart Fredriksson, "Modes of Relating in a Caring Conversation: A Research Synthesis on Presence, Touch, and Listening." *Journal of Advanced Nursing* 30, no. 5 (1999): 1168.

[45] Fredriksson, 1168.

[46] Finfgeld-Connett, 111.

[47] Finfgeld-Connett, 112.

leads to holistic interventions that avoid or ease patient discomfort. Others define presence as an invitation for nurses into their patients' lives and journeys as they share the experience.[48]

It is noteworthy that both Fredriksson and Finfgeld-Connett combine the study of presence with other qualities. Fredriksson's research unites listening and touch as part of caring and places them as antecedents to presence.[49] Finfgeld-Connett as well, joins presence with caring as synonymous terms despite efforts to find discrepancies in their use.[50] Both researchers describe presence in much the same way with terms such as "interpersonal," "inter-subjective," "being-with" and "caring." These researchers, however, do not agree on every aspect of presence. Presence, as examined by Fredriksson, was viewed as a stand-alone concept; whereas, Finfgeld-Connett combined presence and caring as virtually the same concept. Interestingly, Finfgeld-Connett believes that it is because the use of terms such as presence and caring are separate and/or interchangeable that these concepts are largely misunderstood. Although widely used in nursing, poor understanding of terms such as presence and caring result in redundancy and confusion in nursing communication.[51]

Fredricksson identifies areas of further research as the inter-connection between presence, listening and touch as well as how the nurse can judge the degree of closeness that is appropriate for each patient. Finfgeld-Connett points to future studies and

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[48] Karen Melnechenko, "To Make a Difference: Nursing Presence." *Nursing Forum* 38, no. 2 (2003): 20.

[49] Fredriksson, 1168.

[50] Finfgeld-Connett, 111.

[51] Finfgeld-Connett, 112.

standardization of nursing terms as a prerequisite for expert research and theory development.

Concept Mapping

The published work by Beth Rodgers and Kathleen Knafl, *Concept Development in Nursing: Foundations, Techniques, and Applications,* was instrumental in development of my concept map of the degrees of presence.[52] A model representing a concept gives meaning to data by highlighting the relationship of various aspects of the concept to each other. When nurses are able to grasp a concept, they are able to think, converse and categorize phenomena into a mental package. Without the possession of this conceptual knowledge, nurses are unable to accomplish this mental work or even able to discuss the concept with any understanding.[53] Concepts in nursing are the word-symbols for clinical events and are the way empirical science connects to the real world. Concepts, when defined, become the building blocks of nursing theory: theory that is separate and distinct from that of medicine. To be sure, nursing functions independently from medicine in that nursing has professional traits that include the humanistic, holistic approach to patient care. Nurses Donna Nickitas and Kevelle Frederickson, writing in *Nursing Economic$*, note that nursing's unique theoretical foundation must continue to be expanded in discipline-specific areas if nurses are going to maintain their position as a credible resource to healthcare.

> For nursing care to be valuable in today's value-based environment, nursing theory must be fully realized. It requires the rich and continued development of the discipline where there is a body of knowledge that is uniquely recognized as nursing. This means going beyond evidence-based

[52] Rodgers, 194.

[53] Rodgers, 25.

> practice guidelines and protocols to theory-driven capability and reliability where nursing knowledge development drives and determines nursing practice.[54]

True, models are not the real thing but a model may illustrate for the viewer the pathway of events a concept travels when seen in clinical practice. For example, the map of presence at the end of this chapter begins with the category of *Absent* to emphasize there is a possibility no nurses are present in any capacity to support patients. A model reveals relationships among various categories or attributes of a category such as the map of nursing presence that shows the category of *Partial Presence* has having a technical/mechanical focus. A model will also reveal patterns such as every category, except *Absent,* in the aforementioned map has physical presence as a defining quality, indicating that being physically present is a requirement for any degree of nursing presence. Interestingly, the more abstract the concept, the harder it is to map.[55]

To be sure, modeling and sharpening the boundaries of nursing concepts are germane to the knowledge base of nursing and form the solid foundation from which effective nursing interventions can be derived. [56] Clear concepts have the power to generate nursing knowledge and form the basis of more effective care for patients. Ultimately, concept mapping and clarification have as a target the prediction and control of phenomena in nursing practice.

Concept clarification has the goal of arriving at an operational definition for nurses. Namely, how will nurses know when the concept is before them: how will nurses

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[54] Donna Nickitas and Keville Fredrerickson, "Nursing Knowledge and Theory: Where is the Economic Value." *Nursing Economic$* 33, no. 4 (2015): 190.

[55] Rodgers, 199.

[56] Rodgers, 193.

know when it is in operation? An operational definition of a concept may also measure degrees or quantify the concept: all of which provide the basis for future research and development. As stated previously, my operational definition of presence in nursing is mindfulness by the perioperative nurse in the context of the surgical patient. I developed this sleek definition of nursing presence after reading countless complicated descriptions of presence that proved to be unwieldy and impractical for actual use in nursing.

It is my hope that this dissertation will clarify the concept of nursing presence in the Operating Room and will contribute to the holistic body of nursing knowledge. That is, this research will expand and illuminate knowledge of nursing presence in the OR in the context of patient care, nursing interventions, and surgery. Chapter two will explore the need for and power of nursing presence to surgical patients.

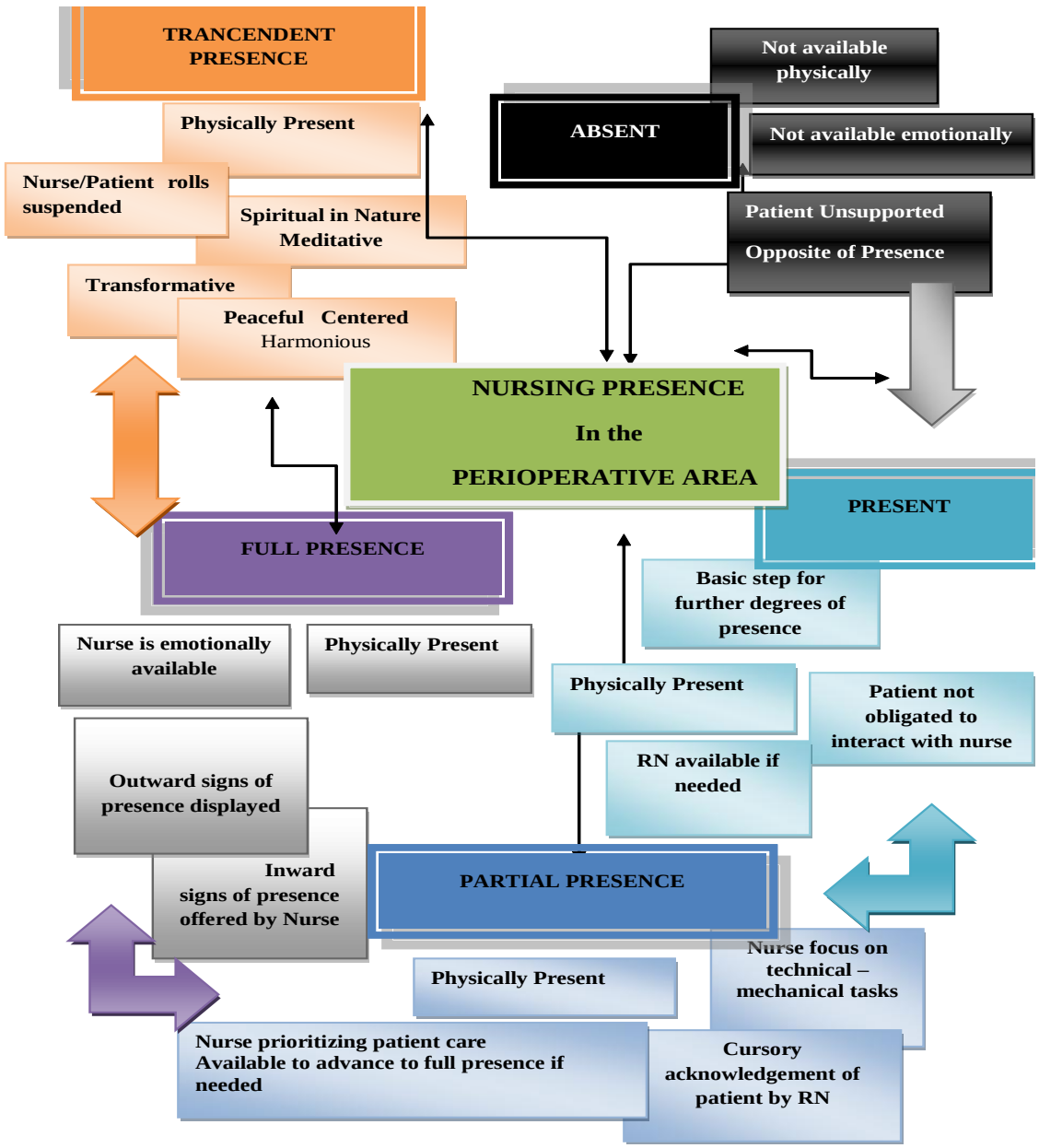
TRANCENDENT PRESENCE
Physically Present
Nurse/Patient rolls suspended
Spiritual in Nature Meditative
Transformative
Peaceful Centered Harmonious
ABSENT
Not available physically
Not available emotionally
Patient Unsupported
Opposite of Presence
NURSING PRESENCE
In the
PERIOPERATIVE AREA
PRESENT
Basic step for further degrees of presence
FULL PRESENCE
Nurse is emotionally available
Physically Present
Physically Present
Patient not obligated to interact with nurse
RN available if needed
Outward signs of presence displayed
Inward signs of presence offered by Nurse
PARTIAL PRESENCE
Nurse focus on technical – mechanical tasks
Physically Present
Nurse prioritizing patient care
Available to advance to full presence if needed
Cursory acknowledgement of patient by RN

Figure 1

CHAPTER TWO

PRESENCE AND THE SURGICAL PATIENT

> When people are facing a severe illness or a major surgery, that may be one of the most significant opportunities for spiritual transformation that they will encounter.
>
> —Allan Hamilton, *The Scalpel and the Soul: Encounters with Surgery, the Supernatural, and the Healing Power of Hope*

Patients who arrive at the hospital prepared for surgery come with a more unique blend of concerns than other patients. Surgical patients have scheduled procedures that will almost certainly be painful. Surgery involves an incision. Surgery involves taking something out such as a gallbladder. Surgery involves putting something in such as a total knee prosthesis. Surgery may be emergent—the result of a motor vehicle accident, or elective—the result of much medical planning. I note that surgery listed as elective sounds optional; in reality, it is not optional, most patients have few alternatives other than live with disease or pain. True, surgical patients come to the hospital under their own power; still most have little choice in the matter.

Patients about to experience surgical intervention are entitled to care from Operating Room nurses who offer the steadying quality of presence. I write what nursing presence looks like to surgical patients as well as how surgical nurses' presence is an invitation to safety. As a reminder, the definition of nursing presence for purposes of this dissertation is mindfulness by the perioperative nurse in the context of the surgical patient.

Those who consent to surgery are accepting a measure of risk however small. Patients realize that for a time others will manage their health. Even routine surgery has its own level of danger and unintended outcomes: sophisticated consumer-patients are

acutely aware of this danger. Given the easy access to nationwide accounts of medical errors and unplanned events in the Operating Room (OR), patients may arrive riddled with anxiety. Nevertheless, those scheduled for surgery swallow their fear and present to the Operating Room, also referred to as surgery.

Surgical patients have prepared to some extent to be out of commission after their procedure. They arranged for friends or family members to accompany them on the day of surgery and asked their neighbors to feed the cat. Few can appreciate the pre-surgical planning required of patients. Even then, the most careful planning can go awry adding another level of concern to the day.

I will never forget the striking professional woman who was my patient. She had saved her sick time for over a year to have enough time accrued for her hysterectomy. Her mother would drive her to the hospital then bring her son to school. Who could know a blizzard on the scheduled day would make the roads virtually impossible to travel. However, there she was on my OR table prepared for surgery. When I took a moment to be present and asked who was with her she started to cry thinking she was in trouble. This brave patient had driven herself to the hospital; she explained, "I just couldn't go through with this knowing my mom and son were on the road." Only then did I get to tell her how brave I thought she was. My hope was the reassurance would settle her heart with the confidence she had done the right thing.

This is an example of nursing presence: presence that confirmed my patient to be a hero who, in the face of major surgery, put the safety of her son and mother first. It is entirely possible I was one of the few people who could appreciate what a valiant act this was. Given her stalwart demeanor, my guess was the responsibilities of her life forced her

to keep a tight grip on herself. However, my job was to lift the burden of being a mother and adult daughter off her shoulders and allow her to be simply my patient: a patient whose only responsibly was to breathe, be in the moment, and allow me to be present with her at this point in time. I felt privileged to witness her courage. Did not this strong gutsy patient deserve a minute of nursing presence from me?

This chapter examines nursing presence through the eyes of surgical patients. It is an examination of just how nursing presence is a first-line defense against surgical errors. The chapter also addresses issues commonly faced by surgical patients as well as the effect nursing presence has on those issues. Finally, exactly what do nurses who are present look like to patients awaiting surgery? What are the outward indications to patients that their nurses are present?

It is important to note that journal articles describing nursing presence from the perspective of surgical patients were virtually nonexistent. I believe this dearth of information written from the OR bed is because surgical patients are not an organized group of medical personnel with preset agendas as surgeons and hospital administrators are. To be sure, patients in the Operating Room are just that; individuals whose focus is on the strain of completing a painful procedure not demanding mindful care from their surgical nurses.

True, there are volumes written on patient satisfaction scores and their effects on reimbursement rates for hospitals; however, these scores have their basis in pre-selected, easy-to-answer questions. The Patient Protection and Affordable Care Act (ACA) affects every part of healthcare including hospitals and ambulatory surgery centers.[57] The ACA

[57] Paula DeJohn, "When Patients Call the Plays, the Whole Team Wins." *OR Manager*, 2015: 1.

mandates payment based on care quality and patient outcomes as well as hospital ratings based on patient satisfaction scores.

Nevertheless, satisfaction survey instruments demonstrate a "considerable gap between the questions hospitals want answered and the important issues to patients."[58] This makes it is possible for patients to give their hospital experience a great score even though they did not receive the excellent care of nurses who were present for them. Conversely, patient satisfaction surveys give no credit to the caring OR nurses who were present and engaged.

To ensure the most pragmatic coverage of the effects of nursing presence on surgical patients, I chose an ethnographic model. That is the approach used by anthropologists as they describe people living within a culture. The method has proven valuable for studying patients' perceptions of care.[59] Ethnographers observe what people do and how they think, providing "a descriptive and contextual account"[60] of a select population. While surveys can furnish helpful information and benchmark numbers, a survey cannot expand details about the experience of care. Patients judge their care based on hard to quantify attributes such as the degree of staff "communication, sensitivity, and friendliness."[61] An ethnographic approach to patients' view of nursing presence was the

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[58] Christine Coughlin, "An Ethnographic Study of Main Events During Hospitalizations: Perceptions of Nurses and Patients." *Journal of Clinical Nursing* 22, (2012): 2328.

[59] Lynn Deitrick, Joanna Bokovoy, Glenn Stern, and Anne Panik, "Dance of the Call Bells: Using Ethnography to Evaluate Patient Satisfaction with Quality of Care." *Journal of Nursing Care Quality* 21, no. 4 (2006): 316.

[60] Deitrick, 316.

[61] Deitrick, 317.

only way to reveal the importance of presence at this critical point in their perioperative care.

Ethnographers try to understand a group, such as surgical patients, from a holistic perspective: looking at the complete picture. This holistic, descriptive research design yields information from an emic (patient-insider) and etic (nurse-outsider) viewpoint. Ethnography is theory-driven, seeking to answer specific questions such as, "How does nursing presence affect surgical patients?" The ethnological process allows the researcher to collect data and use it as "a basis for cultural change."[62] To be sure, Christine Coughlin's 2012 ethnographic study demonstrated there was a difference between the perceived care given by nurses and the perceived care received by patients.[63] That is, the score patients gave the care they felt received differed from the score nurses gave the care they felt they gave. Although to be fair, there are situations affecting patient care such as time constraints and noise levels that are out of the control of nurses. Interestingly, the longer Coughlin's study subjects remained in the hospital, the better they rated their experience because there was "more opportunity to interact with the patient" [64] and build the nurse-patient relationship.

I feel this finding is significant and transferrable to surgical nursing in that OR nurses have literally minutes to develop a nurse-patient relationship as opposed to hours or days in other hospital units. These precious few preoperative minutes, packed with

[62] Coughlin, 2329.

[63] Coughlin, 2335.

[64] Coughlin, 2335.

meaning for both nurses and patients, demand the highest concentration of nursing presence.

Patients are unaware they can chose to be cared for by perioperative nurses who are present and mindful. Patients are also unaware that administrators and managers may have virtually eliminated any time to offer presence: taking the choice for nursing presence out of the hands of patients and nurses alike. However, just because the voice of OR patients is under represented in print does not mean that other instances of nursing presence cannot serve as a reference to guide the care of patients in surgery. This chapter explores nursing presence through the lens of surgical patients.

Nursing Presence and Patient Examples

Suffering an acute illness or condition requiring surgical intervention renders even the most brilliant patients disorganized mentally and off balance emotionally. Operating Room nurses, also referred to as surgical or perioperative nurses, know these are the patients needing authentic connection with RNs who are there and present.

Presence is a subjective experience unique to each patient and each nurse-patient dyad. Granted, by citing examples of nursing presence in the OR there is the risk of typecasting patients and their one-of-a-kind surgical experience into some generic group. Obviously, distilling a surgical experience that is unique to individual patients down to good or bad is an over simplification of rich data and is not my intention. However, the OR is one of the most inaccessible places in a hospital and the majority of readers are unfamiliar with the Operating Room and its culture.[65] Without personal accounts from

[65] Robin Riley and Elizabeth Manias. "Foucault Could Have Been an Operating Room Nurse." *Journal of Advanced Nursing* 39, no. 4 (2002): 319.

the OR readers are left with dry theory and no way to view the concept's application in daily perioperative life.

It is my hope that incorporating living examples of nursing presence into this chapter will transform the concept of presence from "an intellectual activity to an actual experience."[66] To that end, I will try to include many real life examples of patients helped through nursing presence from my own practice. My patient examples illustrate burdens that can be eliminated or at least lightened by the presence of their OR nurses.

Nursing Presence and Patient Safety

Nurses represent the front line of patient defense: their unique positioning enables them to identify and correct medical errors. *AORN* reports surgical nurses "intercepted 77% of possible errors in one cardiovascular unit, and avoided the other 23% before they became errors."[67] These are not unusual figures; OR nurses' heightened watchfulness is part of their job description. To be sure, nurses in the Operating Room consider hypervigilance a highly regarded professional trait, one that makes them unique among other nursing disciplines. The complex nature of surgery and the grave consequences of surgical errors has produced the term "never events." Never events are those adverse incidents such as wrong-site surgery that should not happen, are indefensible, and are 100% preventable.[68]

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[66] Lacy White, "Mindfulness in Nursing: An Evolutionary Concept Analysis." *Journal of Advanced Nursing* 70, no. 2 (2013): 289.

[67] Tony Yang, Linda Henry, Mary Dellinger, Kersten Yonish, Brett Emerson, and Patricia Seifert, "The Circulating Nurse's Role in Error Recovery in the Cardiovascular OR." *AORN* 95, no. 6 (2012): 756.

[68] Elizabeth Berger, Caprice Greenberg, Karl Bilimoria. "Challenges in Reducing Surgical "Never Events"." *JAMA* 314, no. 13 (2015): 1386.

It is possible to prevent a number of errors through nursing presence before surgery when nurses provide a moment or two of distraction-free time with their patients. It is during the application of presence when patients are able to think and communicate clearly to OR nurses that errors are avoided. Patients who sense their nurses' authentic interest in the moments before surgery avoid "the conveyor belt mentality" [69] that can lead to surgical errors.

How important nursing presence is to patient safety was obvious when I cared for a patient born with *situs inversus totalis*: "total or partial transposition of the body organs to the side opposite normal."[70] [71] At no point before surgery was there an opportunity for this patient to notify us she had this condition. Even though she answered all our questions correctly and appropriately, no fitting time presented itself for her to inform the team she had this rare anatomy. Only when I stopped the pre-set hospital agenda to let her speak freely about her concerns did she have a moment to tell me of her condition. Nursing presence in this instance was a virtually invisible intervention that eliminated an error before it became "a knowledge-based mistake." [72] [73]

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[69] Joanne Reynolds and Roz Carnwell, "The Nurse-Patient Relationship in the Post-Anaesthetic Care Unit." *Nursing Standard*, December 2009: 41.

[70] Miller-Kean, Miller-Kean Encyclopedia and Dictionary of Medicine Nursing, and Allied Health. Philadelphia: W.B. Saunders, 1997: 1489.

[71] *Situs inversus totalis* is characterized by mirror-image location of the heart and viscera relative to *situs solitus*.' The cardiac apex, single spleen, stomach, jejunum, descending colon, and aorta are right-sided structures. The right lung is bilobed with a hyparterial bronchus, and the left lung is trilobed with an eparterial bronchus. The liver, gallbladder, ligament of Treitz, ileum, ascending colon, and inferior vena cava are left sided structures. Paul Shogan and Les Folio, "Situs Inversus Totalis." *Military Medicine* 176, no. 7 (2011): 840.

[72] Yang, 758.

[73] A mistake caused by critical patient information unavailable or not accessed.

Tony Yang et.al, in the 2012 study of surgical errors caught and corrected by OR nurses, includes "ameliorated medical errors—errors stopped before severe harm could occur to the patient."[74] Nursing presence before surgery is the invisible intervention that averts surgical errors before they become recognizable errors. Ameliorated medical errors are those blunders sidestepped by a simple clear conversation between patients and nurses when both are present.

Surgical patients are just that, people presenting for surgery, it is unrealistic to expect them to do much more than show up to the correct hospital on the correct day and time. Perioperative nurses know a distracted affect or forgetfulness on the day of surgery is entirely appropriate patient behavior. Speaking with perioperative nurses prior to surgery may be the first and last opportunity patients have to mention a condition or concern.

Patients arrive at the hospital on the day of surgery where the admissions secretary completes hospital deskwork and confirms the scheduled procedure. From there unlicensed assistive personnel (UAP) help patients change into their gown. At this point, admitting RNs or UAPs will take patients' vital signs, confirm again the procedure, and correct paperwork. Before surgery, an intravenous catheter (IV) is placed and patients talk briefly to their surgeons. Of note is that this period between admitting and incision is under the surveillance of financial analysts. Nurse Mark Mitchell observes that as far back as 1991 hospitals sought to "decrease the time people spent waiting for surgery."[75] The minutes prior to surgery are filled with anxious worry for most patients, eliminating

[74] Yang, 756.

[75] Mitchell, 356.

unnecessary delays on the day of surgery appears to be a sensible strategy for reducing pre-surgical jitters. Shortening the wait time for surgical patients has benefits to be sure; however, the reality is the fast pace of surgeons and nurses alike on the day of surgery "may do little to reduce the patient's anxiety."[76] Hospital administrators' efforts to trim preoperative waiting time have actually resulted in diminished time for nurses to offer a "known benefit to patient care;"[77] that is, emotional support to patients through nursing presence.

Only now, minutes before incision, do surgical patients have an opportunity to talk to the nurses who will be taking responsibility for their care in the OR. Only now do patients connect with the single professional group that does not want to take something from them, inject something into them, or rubber-stamp something about them. Only now do patients awaiting surgery have the freedom to express concern or reveal a personal issue that is important to them. Historically, it is primarily Operating Room nurses who connect with their patients in a holistic, non-judgmental way: stepping into the role of patient advocate. These moments with OR nurses who are present are the last stop before incision when patient errors of communication or even forgetfulness can be corrected.

Nursing Presence and Patients' Emotional Security

On occasion patients presenting for surgery have private questions only for the nurses' ears. I remember an older male patient whose young doctor admitted him to the

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76 Mitchell, 356.

77 Penque, 39.

hospital for a trans-urethral resection of the prostate[78] (TURP): treatment for prostate hypertrophy common in older males.[79] The patient was visibly anxious. Only when I took a minute to be present with him in a mindful way did he feel comfortable enough to ask a sensitive question about his post-operative recovery. He began, "I know I am old, but I still like to please my wife. Will I still be able to do that after the surgery?" Obviously, this patient was worried about the impact this surgery would have on an important aspect of his married life. It was important for this older gentleman to have direct, truthful information about his reproductive anatomy and postoperative recovery before proceeding with the surgery. That was my job and I could only accomplish it by being authentically present for him.

Joanne Reynolds and Roz Carnwell, both nurses, emphasize the importance of "putting patients at ease, acknowledging the individuality of each patient and the nature of the pending surgery, which may generate anxiety."[80] Concerns about their illness or the operation itself and its sequela[81] are appropriate patient emotions. Connecting with my male patient in an honest, non-judgmental way allowed him to broach an important but delicate subject preoperatively. For whatever reason my patient waited until this 11th

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78 Transurethral resection of the prostate (TURP) is a common surgical procedure to remove the enlarged section of the prostate. In the United States, there are approximately 150,000 TURP procedures performed annually. Complications specific to a TURP procedure are "urinary incontinence, infertility, bladder perforation, and erection disorder." Feng, 76.

79 Feng Feng, Zigang Chen, Jayne Cromer, Allyson Doerr, Ann Glow, and April Horstman-Reser, "Anesthetic Concerns for Patients Undergoing a Transurethral Resection of the Prostate (TURP)." *Urologic Nursing* 36, no. 2 (2016): 75.

80 Reynolds, 40.

81 Sequela is a condition resulting from an illness or treatment such as urinary incontinence or nerve damage resulting from transurethral resection of the prostate. *The Free dictionary.* http://medical-dictionary.thefreedictionary.com/sequela (accessed September 2016).

hour to ask for clarification of his procedure and recovery, the positive connectedness he felt enabled him to talk with me freely.

This case illustrates the unique positioning of OR nurses in the flow of patient care. This patient had seen his doctor (male) in the office, come to the hospital for pre-surgical testing, and talked to an anestheologist (male); nevertheless, his Operating Room nurse (female) was the one he counted on for honest information about this tender subject.

Regardless of how many medical professionals patients see before their procedure, one cannot assume any of them have offered their presence. Perioperative nurses are there in the final minutes to connect with their patients in a positive way, knowing patients will only relate to them if they feel the safety of nursing presence.

Gunilla Carlsson et al's study of violent episodes and psychiatric patients highlights the emotional security afforded patients whose nurses offer their presence.[82] This phenomenological study confirmed caregivers that were present and allowed themselves to connect with their patients were able to defuse violent psychiatric encounters; whereas, detached impersonal caregivers actually increased aggression in psychiatric patients. Carlsson states, "An inevitable conclusion from our research is that 'authentic personal' and 'undisguised' caring could help prevent violent encounters occurring or continuing."[83]Although not conducted in an Operating Room many of the mechanics of presence revealed by this study are transferable to OR nursing. The aim of

[82] Gunilla Carlsson, Karin Dahlberg, Margaretha Ekebergh, and Helena Dahlberg, "Patients Longing for Authentic Personal Care: A Phenomenological Study of Violent Encounters in Psychiatric Settings," *Issues in Mental Health Nursing* 27, no. 3 (2006): 292.

[83] Carlsson, 303.

the study was to explain, from the patients' worldview, how encounters with caregivers absent of presence escalated violence or de-escalated violence with presence.[84]

Patients in Carlsson's study classified care as either "authentic personal care" or "detached impersonal care."[85] Characteristics of authentic care included a straightforward sincere engagement with patients. Carers were present and able to give of themselves in an "unfeigned honest way."[86] This sincere care demonstrated to these patients an unrestricted respect caregivers showed them as fellow human beings. Because of this respect, patients were comforted and assured of nurses' good intentions: "such encounters left no room for violence."[87]

Psychiatric patients are fragile and insecure: not unlike surgical patients, who feel exposed and vulnerable knowing soon their health will be in the hands of others. Study participants looked to caregivers for signs of engagement and assurance they were on the job. The transferability of this data to surgical patients is obvious. Surgical patients have the same concern, needing confirmation their nurses are there for their sake and nurses really want to help. When patients, surgical or psychiatric, interact with nurses who avoid presence they feel "degraded, not respected, and helpless."[88]

Patients who experience an encounter devoid of nursing presence interpret it as a non-encounter in the eyes of the nurses caring for them. Detached impersonal nurses are

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[84] Carlsson, 291.

[85] Carlsson, 291.

[86] Carlsson, 292

[87] Carlsson, 296.

[88] Carlsson, 296.

signaling the patients are not worthy of our presence—non-persons.[89] The "expressionless blank"[90] faces of nurses, surgical or psychiatric, who are avoiding presence implies these patients are insignificant and unimportant.

On occasion patients awaiting surgery observe their nurses' demeanor change before their very eyes from "detached impersonal" to "authentic personal" when talking to others in the department. The psychiatric patients of Carlsson's study noted this phenomenon and concluded that the caregivers were capable of authentic conversation but would rather spend time with each other than with them, the patients.[91] From the perspective of the patients, nurses who could smile and engage with other employees but not the patients were "giving away their genuine care to others more worthy."[92] In the eyes of the patients, the nurses' apparent on/off switch reinforced their feeling of alienation and judgment. Only nursing presence keeps patients from feeling they are on the outside looking in. Nursing presence is an invitation to come inside and participate in the nurses' world. To be sure, surgical patients need assurance they are not non-persons but the center of their OR nurses' universe.

Interviews with Carlsson's study subjects revealed the need for an invitation to genuine presence, especially in situations characterized by unequal power.[93] Real

89 Carlsson, 292.

90 Carlsson, 295.

91 Carlsson, 300.

92 Carlsson, 300

93 Carlsson, 293.

undisguised communication between nurses and patients arises when nurses are able to open up in a straightforward, honest way.[94]

This invitation to patients signals nurses want to receive whatever concerns patients wish to give on terms patients want to give them. Mark Mitchell's conclusion after studying patients and their preparation for the day of surgery continues to ring true, "Everyone requires some reassurance or cognitive coping strategies to help them lie still and be anaesthetized."[95] To patients in the OR, nursing presence underpins a trusting nurse-patient relationship and establishes the solid emotional platform needed to prepare for surgery mentally and emotionally. Nursing presence indicates to patients their nurses' "acceptance of the patient as a person in need of help, which is manifested as respect."[96]

During undisguised presence patients experience steady, sound care from perioperative nurses and are assured of the nurses' professional confidence. To patients nursing presence implies the professional poise needed to handle any situation that may arise during surgery. It is important for surgical patients to know OR nurses are their advocate-in-control; otherwise, patients lose the emotional footing they need for a good surgical experience. Only when perioperative nurses genuinely engage before surgery do patients have the confidence the perioperative nurses will genuinely engage during

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94 Carlsson, 296.

95 Mitchell, 358.

96 Evridike Papastavrou, Georgios Efstanthiou, Artini Tsangari, Riitta Suhonen, and Helena Leino-Kilpi, "Patients' and Nurses' Perceptions of Respect and Human Presence Through Caring Behaviours: A Comparative Study." *Nursing Ethics* 19, no. 3 (2012): 370.

surgery. Patients want their OR nurses to offer authentic and undisguised presence in such a way patients can "gather support and energy for healing."[97]

Nursing Presence and Patient Anxiety

Patient anxiety before surgery is an expected and appropriate reaction. To be sure, surgical intervention is serious business and patient affect that is too casual is cause for alarm. On the other hand, patients' fears may appear out of proportion to the surgery at hand. The fear some patients or their families display may be agitation bordering on horror.

Prefacing my discussion of preoperative anxiety is a discussion of the pain cycle and how anxiety begins a cascade of events that is unhealthy and difficult to reverse. Anxiety—or its big brother fear—is a noxious emotion to surgical patients. Given that anxiety is an expected response to surgery, all nursing actions should "seek to alleviate its harmful effect in the surgical patient and break the loop leading to anxiety and thus further anxiety."[98] Interestingly, stress levels are as high in "patients undergoing relatively minor surgery as in those undergoing major surgery."[99]

Anxiety causes a wide range of responses including "tachycardia, hypertension, elevated temperature, sweating, nausea, and heightened sense of touch, smell, and hearing."[100] Patients may become so apprehensive they are unable to understand simple instructions. For years, Peggy, the grumpy unit secretary who greeted our OR patients

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[97] Aleida Drozdowicz and Dana Dillard, "Presence in the Neonatal Intensive Care Unit." *International Journal of Childbirth Education* 29, no. 4 (October 2014): 64.

[98] Caunt, 171.

[99] Caunt, 171.

[100] Prichard, 35.

preoperatively derided them for their inability to put on a simple snap-gown.[101] Peggy's disgust was visible as she impatiently left her desk to show these patients how to put two sides of the snap together and click. Yes, snapping was an uncomplicated task in a normal setting but not to patients in the suspenseful moments before surgery. This simple added step of snapping together the sleeves of a gown seemed beyond the ability of even the most intelligent patients. What Peggy failed to allow was that the next few hours for our preoperative patients most certainly held high-tension anxiety, pain, expense, and an altered anatomy; of course they were distracted and not thinking clearly. The following discussion reveals the physiological cause Peggy's sleeve snapping became a monumental engineering feat for patients awaiting surgery.

Activation of the sympathetic nervous systems starts with anxiety or pain that stimulates the hypothalamus to release neurotransmitters such as adrenaline and nor-adrenaline. The adrenaline in turn causes hypervigilance: a heightened sense of touch, smell, or hearing leading to intensified pain and additional anxiety. Interestingly, calming touch reverses the pain cycle as it "stimulates changes in the hypothalamic function to parasympathetic."[102] The parasympathetic nervous system then has an opportunity to bring all indicators such as blood pressure, heart rate and skin temperature back to normal.[103] Only during activation of the parasympathetic system can the body relax and begin the business of healing: one might say healing begins before incision.

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[101] Snap gowns are hospital gowns with snaps on the sleeves making gown changing after surgery easier.

[102] Caunt, 172.

[103] Caunt, 172.

Operating Room nurses are fully aware that children are not exempt from the anxiety of surgery. Pediatric patients who experience higher levels of preoperative anxiety experience higher levels of postoperative pain.[104] These nurses realize as well that postoperative pain in children is "often under-managed"[105] and "postoperative pain delays healing."[106] This cycle of anxiety-pain-anxiety in children and adults makes addressing preoperative anxiety even more important.

Debbie, a colleague of mine, experienced what appeared to be an instance of illogical patient fear. A young patient and her mother were in the preoperative holding area on the verge of panic before a routine tonsillectomy for tonsillar hypertrophy.[107] In this instance the fear that both patient and mother displayed appeared disproportionate to the actual danger a tonsillectomy presented. Only when this seasoned OR nurse provided an emotional safe haven for them did the logic of this illogical situation become apparent.

In the safety provided by my colleague's presence, the mother explained. Some years earlier, this young patient's sister died at our hospital as the result of a tragic car accident outside their home. Obviously, the hospital was a place of sadness and death for this young patient that created a legitimate fear of death she had for herself. Although the

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104 Ying Jai Shermin Chieng, Wai Chi Sally Chan, Piyanee Klainin-Yobas, and Hong-Gu He, "Perioperative Anxiety and Postoperative Pain in Children and Adolescents Undergoing Elective Surgical Procedures: A Quantitative Systematic Review." Journal of Advanced Nursing 70, no. 2 (2013): 243.

105 Chieng, 244.

106 Chieng, 244.

107 Tonsillar hypertrophy is another name for enlarged tonsils. *The Free dictionary.* http://medical-dictionary.thefreedictionary.com/tonsillarhypertrophy (accessed September 2016).

mother tried hard to remain positive and brave for her daughter, the mother could scarcely contain her own fear and grief.

Only after their OR nurse offered presence in a caring non-judgmental way, did the mother reveal the reason for their extreme apprehension. Had Debbie remained distant or critical of them, both mother and daughter would have endured the surgery bereft of understanding and compassion. Granted Debbie's presence did not change the need for the operation or the past tragedy, it did allow mother and daughter to proceed knowing their nurse validated their feelings.

Operating Room nurses accept all patients on their own terms knowing that fear is whatever patients say it is. "Anxiety and fear are genuine responses to undergoing surgery"[108] and patients are anxious for their surgical nurses to help them manage these negative emotions. Nurses who are present for their patients hold a "safe space" where patients are able to be themselves while maintaining their dignity.[109] However, until perioperative nurses take the time to connect honestly through their presence patients remain vulnerable and unsupported.

Nursing Presence: Bearing Witness and Validation

The concept of presence is an integral part of bearing witness and should be included in the daily practice of every nurse. Bearing witness is attestation by nurses to the authenticity of an event or condition because nurses were there.[110] When surgical

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[108] Prichard, 35.

[109] Chantal Cara, "A Pragmatic View of Jean Watson's Caring Theory." *International Journal for Human Caring* 7, no. 3 (2003): 52.

[110] Michelle Campbell and Lisa Davis, "An Exploration of the Concepts of Bearing Witness as a Constituent of Caring Practice." *International Journal for Human Caring* 15, no. 1 (2011): 7.

patients sense the genuine concern of their OR nurses, patients feel valued and respected as humans in legitimate need. Instead of seeing the surgery from a strictly rational-medical standpoint nurses seek to understand surgery from their patients' point of view. It is important nurses recognize the reality of their patients' perspective and attest to its validity. Only during nursing presence do nurses view their patients as suffering humans validating their patients' image of the illness that brought them to surgery. Bearing witness by OR nurses is a way to "recognize and attest to the reality of the patient instead of ignoring or belittling them."[111]

For much of my nursing career I worked 12-hour shifts in the OR which meant the last portion of the day was dedicated to unscheduled cases. Almost daily, we took care of women who were in the OR for a dilation and curettage (D&C) after having suffered a miscarriage. Most medical explanations for this surgery list a D&C as a simple surgical procedure. [112] The OR staff had little set up for these cases and the D&C could be completed in a very short time: all of which contributed to the idea that a D&C was inconsequential, just a snap. However, nothing could have been farther from the truth in the eyes of women who had suffered this spontaneous tragedy.

Repeatedly, I saw women who felt they had lost a beloved but unborn child, not unwanted bodily tissue. Others in the patient's world may never know of the pregnancy and the woman's loss, but the Operating Room nurse knew, witnessed, and validated this

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[111] Campbell, 8.

[112] D&C is a surgical procedure in which the cervix is opened (dilated) and a thin instrument is inserted into the uterus. A curette is the instrument used to remove tissue (uterine contents) from the inside of the uterus (curettage). American College of Obstetricians and Gynecologists. *American Congress of Obstetricians and Gynecologists.* February 2016. http://www.acog.org/Patients/FAQs/Dilation-and-Curettage-DandC (accessed April 2016).

grave experience. As a nurse I could confirm this sad event happened, it was not a non-event.

It would not be unusual for a woman to mourn this day for the rest of her life, reliving the what if's and if only's. It was thus the practice of most of the nurses in our OR to express condolences to women for their loss before any routine medical conversation. This moment of genuine compassion and concern was the least we could do for women who had just endured a life-changing heartbreaking event.

Patients report feeling lonely and abandoned because disengaged nurses ignored their emotional plight.[113] *Nursing Ethics*' article on cancer patients' definition of a good nurse reports patients experienced a feeling of confirmation when nurses were "mindful and took them seriously."[114] Perioperative nurses may not speak profound words; nevertheless, the fact that Operating Room nurses care enough to remain physically and emotionally available to patients during surgery restores surgical patients' dignity and self-esteem. A basic patient assumption of nurses who are present is that when nurses are on hand they act as a witness to their patients' experience.

Maria Arman, a nurse, explains the "ethics of the face" [115] in her article on bearing witness. That is, when patients see nurses choose to connect face-to-face it establishes an unspoken contract for care.[116] Such witnessing includes choosing to see and not avoid

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[113] Campbell, 8.

[114] Leila Rchaidia, Bernadette Dierckx de Casterle', Liesbeth De Blaeser, and Chris Gastmans, "Cancer Patients' Perceptions of the Good Nurse: A Literature Review." *Nursing Ethics* 16, no. 5 (2009): 536.

[115] Maria Arman, "Bearing Witness: An Existential Position in Caring." *Clinical Nurse* 27, no. 1 (2007): 86.

[116] Arman, 89.

patients' vulnerability and suffering. The engaged nurses validate their surgical patients' whole world reality, including sickness and whatever else is with them on the day of surgery.

Being present and witnessing are interwoven aspects of nursing care when nurses remain open and in the moment. The opposite of being a witness is to shut one's eyes to patient misfortune showing detachment and indifference. Refusal to bear witness by OR nurses is to turn away from suffering and in doing so "devalue patients as humans."[117]

Being a witness implies a responsibility to act in behalf of surgical patients.[118] Nurses who are present agree to meet patients' unique situations and see them through without prejudice. Patients are encouraged and heartened that their OR nurses have the courage to remain with them as companion-guides throughout surgery. [119]

In fact, Dee Marie Zyblock, RN, notes that presence has a "sustainability that last longer than the initial encounter."[120] The memory of nurses who were present grounds patients and sets the stage for good future nurse-patient encounters. Patients appreciate that nurses have remained present and connected as their life unfolded or maybe unraveled. Some patients ranked presence as "more important than technical skill."[121]

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[117] William Cody, "Bearing Witness to Suffering: Participating in Cotranscendence." *International Journal for Human Caring* 11, no. 2 (2007): 17.

[118] Arman, 88.

[119] Arman, 90.

[120] Dee Marie Zyblock, "Nursing Presence in Contemporary Nursing Practice." *Nursing Forum* 45, no. 2 (2010): 120.

[121] Zyblock, 123.

Presence is "transformative to the patient and has the potential to speed healing, recovery, and remission."[122] Alicia Bright, in her analysis of presence in nursing practice states that caring presence "has a profound effect on the healing process."[123] Positive energy from presence and attentive behaviors by nurses "actually potentiate healing" according to theorist Jean Watson.[124]

The question now begs asking, "Just what does nursing presence look like to surgical patients?" The following are discussions of the outward indicators nurses are present and mindful in the context of their patients.

Nursing Presence: Outward Signs

Paulette Osterman and Donna Schwartz-Barcott, in their 1996 seminal article, "Presence: Four Ways of Being There,"[125] clarify the concept of presence. These nurses reveal nursing presence to be an intervention that "reflects degrees of intensity in the context of another;"[126] that is, presence is more than just being there or not being there. This variation in presence is obvious in the clinical setting where patients experience perioperative nurses' connection to them move from simple physical presence to full presence and back again as needed. The following is a description of each of the degrees of presence as well as how and when each is appropriate for good patient care.

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[122] Zyblock, 123.

[123] Alicia Bright, "A Critical Hermeneutic Analysis of Presence in Nursing Practice." *Humanities* 4, no. 4 (2015): 958.

[124] Jean Watson, "Intentionality and Caring-Healing Consciousness: A Theory of Transpersonal Nursing." *Holistic Nursing Journal*, July 2014: 15.

[125] Osterman and Schwartz-Barcott, 24.

[126] Osterman and Schwartz-Barcott, 29.

A 2011 study of nursing presence in an oncology unit by Osterman, Schwartz-Barcott, and Asselin provides a practical background for viewing nursing presence in a clinical setting. These nurses conclude nursing presence is an "intervention delivered in degrees."[127]

> In the literature, one gets the impression, particularly under the discussion of presence, that nurses may be fully present throughout an entire encounter with a patient. There were no observations of the nurses in this study using only one way of being there throughout a single encounter with a patient. Instead, we saw a process in which the nurse moved initially from simply being there to partial presence and to full presence. This may be due to the fact that the care given here was provided in high-paced, technologically complex hospital unit in which it is hard to envision nurses being able to be fully present throughout an entire shift.
>
> This process was part of an ongoing patient-nurse interaction in which cues from patients became the stimulus for guiding the nurses' way of being there, as though it were an exemplar of patient-centered care. In some ways, this is in striking contrast to the literature that gives the impression that the nurse should be in control, and is the primary initiator and director of the interaction.[128]

The receptivity and willingness of nurses to respond and adjust levels of presence is based on the interplay of patients' medical need and feedback.[129] Surgical patients rely on OR nurses for information about their procedure, surgeon, or the Operating Room schedule as a means of remaining connected to the real world. The majority of pre-operative patients depend on OR nurses for emotional support: a result of the perceived threat to their body, mind, and spiritual integrity.[130] Nursing presence, in all of its

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[127] Osterman, Schwatz-Barcott, and Asselin, 205.

[128] Osterman, Schwatz-Barcott, and Asselin 203.

[129] Osterman, Schwatz-Barcott, and Asselin 204.

[130] Osterman, Schwatz-Barcott, and Asselin 204.

degrees, is the means by which perioperative nurses respond to their patients in ways not described in nursing textbooks but just as essential and timely.

It is important to note that I include absent as a degree of presence because it signifies there is a prequel to presence. Listing absent as the first step in nursing presence frames the concept in a larger picture. This first step reminds the reader that it is possible to have no presence and any degree of presence to follow is more than no presence at all. One might compare absence of nursing presence to the square on a color chart labeled *clear* or *none*. Like colors that have varying strengths and hues, nursing presence is a graduated spectrum of patient care. To surgical patients nursing presence, even in its most dilute form, is a change from care absent of nursing presence.

Having absent head the list is an additional reminder that nursing presence, in whatever strength it is applied, is a nursing choice. Patients feel grounded when their nurses offer their presence; conversely, an absence of presence results in free-floating self-care dependant on the patients themselves. Only the application of authentic mindfulness in the form of presence grounds patients and "facilitates positive coping."[131]

Figure two is a depiction of how the concentration of nursing presence may vary within a single nurse-patient encounter.

[131] Inger Engquist, Ginete Freszt, and Kerstin Nilsson, "Swedish Registered Psychiatric Nurses' Descriptions of Presence when Caring for Women with Post-partum Psychosis: An Interview Study." *International Journal of Mental Health Nursing* 19 (2010): 313.

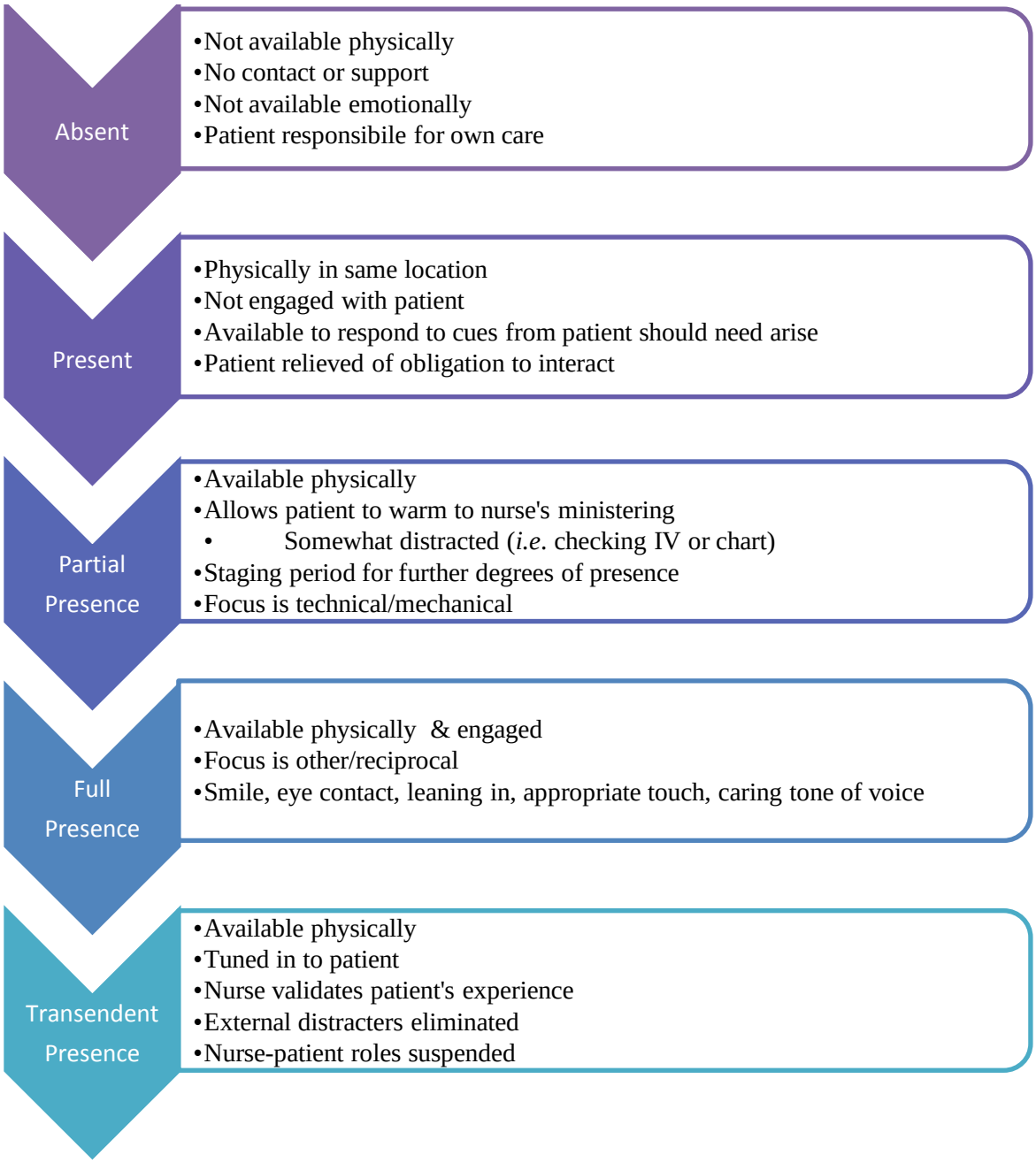
Absent
•Not available physically
•No contact or support
•Not available emotionally
•Patient responsibile for own care
Present
•Physically in same location
•Not engaged with patient
•Available to respond to cues from patient should need arise
•Patient relieved of obligation to interact
Partial Presence
•Available physically
•Allows patient to warm to nurse's ministering
• Somewhat distracted (*i.e.* checking IV or chart)
•Staging period for further degrees of presence
•Focus is technical/mechanical
Full Presence
•Available physically & engaged
•Focus is other/reciprocal
•Smile, eye contact, leaning in, appropriate touch, caring tone of voice
Transendent Presence
•Available physically
•Tuned in to patient
•Nurse validates patient's experience
•External distracters eliminated
•Nurse-patient roles suspended

Figure 2

Nursing Presence: Degrees

1. Absent

   Perioperative nurses are not available physically or emotionally. Care absent of nursing presence leaves patients alone to care for themselves, remaining unsupported and vulnerable. The state of being absent of nursing presence means patients have no connection to the real medical world they find themselves in, no access to information or updates. Nursing care absent of presence provides no extra set of trained eyes to observe patients prior to surgical incision. Noting the absence of nursing presence provides a reference point from which to measure further presence in whatever degree it may be.

2. Present

   Patients are physically in the same location as perioperative nurses. Although patients are not engaged with nurses RNs are available to respond to their patients should the need arise. Being simply present physically does have its place in good nursing care; to be sure, patients report feeling safe and comforted by having nurses nearby.[132] Those who participated in Engquist's study found the "silent physical presence of their nurse calming and reassuring."[133]

   Patients awaiting surgery may be quiet and reflective. They may find rational conversation requires massive effort on their part and is just

[132] Engquist, 313.

[133] Engquist, 317.

too taxing for them to engage in before surgery. Nevertheless, having professional registered nurses in close proximity and watchful allows patients to relax a little. In fact, a study of women with post-partum psychosis reveals more nursing presence equals more security in the eyes of the patient. Rather than feeling monitored or under surveillance nursing presence was "grounding and gave patients assurance they were being cared for" and supported.[134]

3. Partial presence

Patients are physically in the same location as perioperative nurses. Nurses may be connecting with patients to a degree but nursing focus is on some routine of care such as checking an IV or patients' electronic medical record. Partial presence enables patients to temper their preoperative anxiety by focusing on someone else. To be sure, patients may welcome the distraction of concentrating on OR nurses who are performing simple everyday tasks. Somehow seeing the ordinary business of life without the burden of talking bolsters surgical patients' "connection to reality"[135] and is an assurance their illness will end. Partial presence is the stage of presence where the rhythm of nursing care is visible and confirmation that we will get through this and life will go on.

Since partial presence has a mechanical/technical focus, it also is an occasion for patients to be convinced of their nurses' competence in

[134] Engquist, 319.

[135] Engquist, 317.

problem solving. Patients seeing nurses recognize normal values and watchful of problems, confirm they will be well cared for during surgery.

Partial presence is also a staging period for full presence. It is typical for patients awaiting surgery to be enmeshed in their own thoughts. As nurses enter their patients' space and begin ministering, patients have a moment or two to warm to the nursing presence. Partial presence is another point at which patients return to reality but with limited inter-personal connection with surgical nurses.

4. Full presence

Patients are physically in the same location as perioperative nurses. Patients sense their perioperative nurses' focus is on them as individuals and their wellbeing. Distractions have been set in the background and patients become the center of their OR nurses' world. During full presence preoperative patients' reality becomes their nurses' reality; that is, nurses seek to connect with their patients in their world. As the give-and-take of full presence unfolds, patients are able to reveal what is important to them—that is the patients' worldview.

I remember a female patient of mine whose scheduled procedure was for a breast biopsy/possible lumpectomy. As one can imagine a woman scheduled for a breast biopsy is looking at an uncertain future for herself and her family. Nevertheless, each patient is an individual with their own unique way of viewing their illness, their surgery, their world.

As I approached my patient in the preoperative holding area, I passed her husband who was leaving although it was perfectly fine for family members to remain with patients at this point. My patient had sent her husband to get breakfast for himself and return to the hospital some hours later. Why would a patient deliberately dismiss a supportive family member especially during this time of uncertainty?

After I greeted my patient, moving from partial presence to full presence, our conversation revealed she was the power hub of her family. It was evident this illness jeopardized not just the future of my patient but also the family's future. Her husband, consumed with jittery energy and concern, proved to be a source of despair for her rather than a source of comfort. In all fairness, not all family members act or react perfectly when their most basic life-landmarks are threatened. The reality of my patient's world was that her husband's despair was infecting her; at this critical junction, he was the one needing comfort not my patient.

However, it was only during full presence that the patient's position in the family as well as her family mechanics became evident. In my patient's world, she was not dismissing a wellspring of comfort for herself rather she was giving her husband permission to take a break from a trying situation. In reality, sending away her husband for a few hours was a healthy self-protective act. Only after the patient let her husband off the hook so to speak was she able to concentrate on her own self-comforting thoughts.

This simple situation reveals that all patients have their own one-of-a-kind life that nurses can only see in full presence. Fully present nurses, who are mindful in the context of their patients, view and accept their patients on their own terms in their own lives.

Full presence is the stage of presence where nurses' body language speaks to patients. By nature, nonverbal behaviors such as facial expression and touch are "chiefly unconscious actions that alert patients to their nurses' true intent."[136]

During full presence, patients witness "common physical indicators of nursing presence."[137] In fact, "active body language" [138] that includes honest facial expressions, intonation, and gestures indicates the stability of perioperative nurses.

5. Transcendent presence

The patient is physically in the same location as the nurse. Transcendence is commonly regarded as "exceeding the ordinary parameters of individual human experience."[139] It is gaining access to a sense of connectedness beyond oneself. In the world of nursing, transcendence is the connection of nurses and patients beyond the realm of

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[136] Yu Xu, Shelley Staples, and Jay Shen, "Nonverbal Communication Behaviors of Internationally Educated Nurses and Patient Care."*Research and Theory for Nursing Practice: An International Journal* 26, no. 4 (2012): 293.

[137] Osterman, Schwatz-Barcott 27.

[138] Carlsson, 294.

[139] Cody, 19.

consciousness; thus, one transcends the self. During transcendence, nurses confirm, “I see the situation the same way you do and I will stay with you:” patients’ feelings are validated and legitimized as genuine.

To be sure, nurse-patient transcendence is not a daily phenomenon in an Operating Room where the majority of cases are scheduled planned events. Nevertheless, on occasions where the patient’s future is uncertain as they enter the Operating Room, it is entirely appropriate for perioperative nurses to suspend all activity and co-participate with their patients in the here and now. External distracters are blocked or eliminated altogether.

Patients whose nurses offer transcendent presence receive an invitation into a relationship that offers courage in the face of devastation. During transcendent presence the patient-nurse roles are suspended as the two move further along life’s journey. Personal concerns of both patients and their nurses are set aside as the uncertain future unfolds. Patients and nurses together move beyond the present moment toward what is not yet here.

Outward Indicators of Nursing Presence

The following is a list of attending conduct and non-verbal behavior by nurses that would signal to patients their nurses are fully present.

- Smile

Although smile is the term listed here, the word is inclusive of any facial expression that signifies compassion and presence. To be sure, even in urgent situations most nurses instinctually smile when they greet their patients. A smile includes more than just up-turned corners of the mouth. The natural smile of nurses has a genuineness that involves the entire face and patients sense an open invitation to communicate.

Presence displayed by perioperative nurses in their smile shows concern for patients' emotional fragility and is an instinctive way to reassure patients without words. Smiling is a facial expression that conveys to patients the situation is as expected and their nurses have it under control.

Patients report when they encounter "a nurse's blank face with expressionless cold eyes staring back at me"[140] they interpret the nurse's intent as a signal their patients are insignificant, unimportant.

- Eye contact

Eye contact takes a special place in non-verbal communication. Anjanie McCarthy et al's study of the significance of eye gaze notes the following.

[140] Carlsson, 295.

> People use others' eye movements to regulate conversation e.g., turn-taking), to make character judgments (e.g., honesty, shyness), and to gain insight into their internal mental processes (e.g., thinking).[141]

Eye contact for Western cultures and "those of European ancestry is judged positively."[142] Listeners expect to look at the speaker and speakers look at the listeners to check whether there is an understanding of information. [143] Face-to-face contact is even more important when it is nurses and patients connecting before surgery. Appropriate eye contact, regarded as a positive professional trait, continues as a basic skill in communication between nurses and patients.

Appropriate eye contact is very different from staring, which appears accusatory and intrusive. Proper "eyegaze breaks on occasion"[144] as patients' response guides eye contact. Theodore Stickley, a nursing educator, advises nurses "always have eye contact at the ready for the moment the patient looks up."[145] Were patients to

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[141] Anjanie McCarthy, Kang Lee, Shoji Itakura, and Darwin Muir, "Cultural Display Rules Drive Eye Gaze During Thinking." *Journal of Cross-Cultural Psychology* 37, no. 6 (2006): 717.

[142] McCarthy, 717.

[143] Wilma Caris-Verhallen, Ada Kerkstra, and Jozien Bensing, "Non-Verbal Behaviour in Nurse-Elderly Patient Communication." *Journal of Advanced Nursing* 29, no. 4 (1999): 809.

[144] Theodore Stickley, "From SOLER to SURETY for Effective Non-Verbal Communication." *Nurse Education in Practice* 11 (2011): 397.

[145] Stickley, 397.

respond to nurses' invitation to connect and find them checking the clock or otherwise distracted, it would result in a loss of trust.

Patients receive warmth and empathy when nurses make eye contact. Eye contact at appropriate levels contributes to patients' perception of perioperative nurses' competence; that is, patients perceive nurses as qualified and honest.[146] Sadly, some patients noted how detached caregivers "avoid eye contact coming only to see their disease, not them as a patient."[147]

Avoiding eye contact by nurses has a double meaning for surgical patients. Communication where nurses avoid eye contact messages, "I am afraid." [148] It is important to patients preparing for surgery that their OR nurses are confident and in control. Patients whose surgical nurses are fearful lose their "emotional footing" [149] and faith in their nurses' competence. Nurses who are afraid are not in control, are not there for their patients, and are incapable of open communication with their patients.

Avoiding eye contact also messages, "I am above you" or "you do not count."[150]Averting one's eyes damages the nurse-patient rapport

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[146] Caris-Verhallen, 809.

[147] Campbell, 10.

[148] Carlsson, 294.

[149] Carlsson, 294.

[150] Carlsson, 296.

and is a signal of nurses' disinterest, detachment, and dislike for their patients.

- Leaning in

Leaning in is a term that includes all behavior "signifying active listening."[151] Leaning in is part of interactive communication between surgical patients and OR nurses. Posturing by nurses toward their patients as well as shortened spatial distancing between nurses and patient are indicators to surgical patients their nurses want to connect.[152] Forward leaning is important in patient care because this posture signals to patients their nurses have "good personal attitude"[153] and are offering their empathic presence.

Patients who see the body language of their OR nurses as stiff and removed in the moments before surgery, can only conclude these nurses will be stiff and removed during surgery. Most surgical procedures require some form of nursing contact with anatomy normally covered by clothing. Shaving personal areas, insertion of a urinary catheter, and application of prep solution to the incision site all involve close personal contact between nurses and the sleeping surgical patients. How can patients be assured their OR nurses will

[151] Lynn Kacperek, "Non-Verbal Communication: The Importance of Listening." *British Journal of Nursing* 6, no. 5 (1997): 275.

[152] Xu, 294.

[153] Xu, 295.

complete these interventions during surgery when the nurses only distance themselves before surgery?

To have a good surgical experience, patients in the OR must see the coordination of their nurses' verbal and nonverbal communication. That is, what the nurses are saying with their words has to correspond to what they are saying with their body language. Considering nonverbal cues are more reliable indicators of nurses' true intent than verbal cues, "patients instinctually give nonverbal cues more weight."[154] Specifically, surgical patients will believe more in what they see their OR nurses do than what they hear their nurses say. Open body posture that invites connection with patients signals OR nurses will be close by during surgery.

- Caring tone of voice

Tone of voice, as opposed to the actual words spoken, is significant for the meta-analysis it provides the listener. That is, the intonation used by a speaker is "an aggregation of nonverbal information such as mood, temperament, outlook, and viewpoint." [155]

The spoken word in human communication may embellish or contradict the nonverbal messages. These nonverbal messages that are messages delivered without words, include tone, volume, and quality

[154] Kacperek, 275.

[155] Kelly Haskard, Summer Williams, Robin DiMatteo, John Heritage, and Robert Rosenthal, "The Provider's Voice: Patient Satisfaction and the Content-filtered Speech of Nurses and Physicians in Primary Medical Care." Journal of Nonverbal Behavior 32, (2008): 2.

of the speaker's voice. Warm tone of voice used by nurses and doctors was the 'greatest predictor of patient satisfaction" in Kelly Haskard et al's study.[156] It is through vocal intonation the speaker delivers feelings (encoding) and it is through sensitivity to tone that the listener receives these feelings (decoding.)[157] When surgical patients decode warmth and empathy in the tone of perioperative nurses, the result is relief in knowing that at a core level the nurses have good motives.

Tone conveys emotion, kindness, sympathy, or prejudice; it has the ability to bolster or negate the spoken word. Changing the volume, tempo or intonation of one's speech changes its meaning. Caring tone of voice is the outward sign of nursing presence the patient receives at the most basic level. In the tension-filled minutes before surgery, the compassionate tone of voice of surgical nurses may speak to preoperative patients clearer than actual words.

Hearing, and thus intonation, is the last sense affected by anesthesia and the first sense re-activated when surgical patients emerge from anesthesia. I can still remember the last words I heard when I was rushed to surgery after the birth of my first son. Although it was many years ago even now I can hear the voice of my surgeon saying, "Let's get this young lady back to her new baby." As a young mother who was exhausted physically and emotionally fragile, hearing

156 Haskard, 2.

157 Haskard, 2.

those simple words as I drifted off assured me that things would be all right—and they were.

Actually, patients can understand the emotional state of those speaking in the OR even when they cannot comprehend the words.[158] Aleida Drozdowicz, in her article on nursing presence in the neonatal intensive care unit advocates explaining the plan of care to even newborns: conversation is an effort to gently connect with her tiny fragile patients.[159] Nurses' warm tone of voice studied by digital audio recording of content-filtered speech[160] was "positively associated with the satisfaction patients reported."[161] Specifically when the words were removed from speech and only tones remained to be analyzed, those nurses whose tonal qualities expressed caring received better patient satisfaction scores.

Healthcare professionals who participated in eight hours of communication skills training which centered on patient connection improved patient satisfaction scores, improved professional empathy

[158] Haskard, 1.

[159] Drozdowicz, 65.

[160] Content-filtered speech is a research procedure that eliminates the linguistic channel of speech, masking the words; only retaining the vocal quality of the speech that is then analyzed. Content-filtered or content-free speech produces muffled sounds and yields speech as though heard with earmuffs on. Haskard, 2.

[161] Haskard, 4.

and lower burnout rates.[162] It is through vocal expressiveness, namely tone, where those subtle elements of communication affecting patient's emotion transfer from nurses to patients.

- Appropriate touch

As a new nurse in the Operating Room, I was timid about getting close to patients during the induction of anesthesia. No one who knows me would describe me as a kisser or a hugger. Nevertheless my preceptor, Bernie (short for Bernice), would constantly call from across the room, "Rebecca, why are you so far away? Snuggle on in there nice and close!" Bernie's insistence that I stand close to my patients as they drifted off to sleep set a pattern for my practice that I kept for 20 years. "Snuggling in close" was also an expectation I had for nurses I trained and precepted over the years. Of all the ways a patient can obtain "calming energy from a nurse, touch is the most direct."[163]

Only select professions have our permission for bodily contact and there is a distinction between procedural touch and expressive touch. Procedural touch is required to complete a task such as taking blood pressure or changing a dressing, "expressive touch is relatively

[162] Adrienne Boissy, Amy Windover, Dan Bokar, Matthew Karafa, Katie Neuendorf, Richard Frankel, James Merlino, and Michael Rohtberg. "Communication Skills Training for Physicians Improves Patient Satisfaction." *Journal of General Internal Medicine*, 2016: 1.

[163] Karin Bundgaard and Karl Nielsen, "The Art of Holding Hand: A fieldwork Study Outlining the Significance of Physical Touch in Facilities for Short-Term Stay." *International Journal for Human Caring* 15, no. 3 (2011): 38.

> spontaneous and not necessary for the completion of a task."[164] Some suggest scarcely four groups have license to touch us: "hairdressers, family, lovers, and healthcare professionals."[165]
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> To be sure, Bundgaard and Nielsen's study of hand holding in the endoscopy suite revealed patients felt rejected and insecure when nurses were unwilling or unable to employ physical touch.[166] On the other hand, expressive touch has the ability to short circuit the fear-anxiety-pain cycle by activating the parasympathetic nervous system and returning the system to normal.[167]
>
> Expressive touch demonstrates mindfulness by perioperative nurses in the context of the patient and is a direct conveyance of warmth, security, and connectedness.[168] [169] In the most literal sense, nurses must be present to touch their patients.

Patients about to experience surgical intervention are entitled to care from their Operating Room nurses who offer the steady confidence of their presence. This investigation of what nursing presence looks like to the surgical patient as well as how perioperative

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[164] Caris-Verhallen, 810.

[165] Richard Albardiaz, "Teaching Non-Verbal Communication Skills: An Update on Touch." *Education for Primary Care* 25, (2014): 164.

[166] Bundgaard, 39.

[167] Caunt, 172

[168] Xu, 294.

[169] Joyce Burr, "Jayne's Story: Healing Touch as a Complementary Treatment for Trauma Recovery." *Holistic Nursing Practice* 19, no. 5 (2005): 215.

nurses' presence is a primary element of safety, sets the stage for the effect nursing presence has on the surgical nurses themselves. Nursing presence in the perioperative area and the Operating Room nurses will be the subject of the next chapter.

CHAPTER THREE

PRESENCE AND THE OPERATING ROOM NURSE

Few delights can equal the mere presence of one whom we trust utterly.
-- George MacDonald

As an Operating Room nurse for over 20 years, I can say perioperative nursing was a practice of two minds for me. It is the kind of nursing that is simultaneously infuriating and inspiring, sad and satisfying, scary and sacred. Why would anyone stay in a discipline that produces such mixed feelings? I was not alone in staying. Surgical nurses historically practice in the OR for their entire careers. Over 63% of perioperative nurses in one survey had remained in the perioperative area for over 20 years—some 43.73% for over 25 years.[170] To be sure, I treasured my nursing practice in the OR because I was able to witness firsthand the absolute best in the human spirit. Being present meant opening my eyes to unbelievable courage, unfathomable love. What could be more inspiring than that? Daily, surgical nurses get to see ordinary-looking people who are really superheroes.

I witnessed the single dad of two young girls who virtually forced his surgeon to operate on double hernias on a Friday. This young father insisted on this time slot because it was the only time his mother (the girls' grandmother) could take off work to babysit. He would make it work—he had to.

Another superhero I met was the mother of two teenage daughters who opted for a prophylactic double mastectomy. Her body harbored the dangerous BRCA1 gene mutation that took the lives of her mother and sister the previous year. When I met her

[170] Rebecca. Dufner-Mantore, "Nursing Presence in the Perioperative Area." *Study Results.* 2011.

she was so overcome with grief and fear, she could scarcely walk. Nevertheless, there she was choosing her own fate that included being alive for her daughters.

Meeting another brave patient in our preoperative area is a memory I hope I never forget. The young woman had suffered a spontaneous abortion that day. This lost baby was the product of in vitro fertilization and many weeks of medical intervention. Her husband was visibly upset, holding back tears, and emotionally spent—all expected, appropriate reactions to this tragedy. Yet here was my patient sitting pretty-as-a-picture, hair in a ponytail and cheery smile. Only after we sent her husband to the waiting room and got her settled on the OR bed, did I get to speak to her nurse-to-patient. As I held her I said, "You know you don't have to be brave for us. It's alright to cry." And cry she did. Until I gave her permission to grieve, she held this profound sadness in her heart.

Over the years, it was humbling to care for countless workers who suffered tragic work-related injuries: mostly men who were trying hard to provide for their families and put food on the table. The list of trauma included bilateral broken wrists in a fall from a roof, severed fingers from all manner of saws and snow blowers, deep lacerations from shovels or sheet metal, even a heavy framing nail imbedded in a femur. Being present for these patients revealed them to be hard working fellows doing backbreaking work—an effort that had to be applauded.

Wives and mothers, who were my patients because of an accident or acute illness, routinely brushed aside concern for their own health in the interests of their young children. Being present for all of these brave patients was as much a gift to me as it was to them.

Patients about to undergo surgery are entitled to care from their Operating Room nurse who offers the steadying quality of their presence. In this chapter, I investigate the effects nursing presence has on perioperative nurses as well as precursors to the offering of presence by these nurses. As a reminder, the definition of nursing presence for purpose of this dissertation is mindfulness by the perioperative nurse in the context of the surgical patient.

Offering nursing presence to patients has obvious benefits to the patient and chapter two explores these patient benefits. When research began on the subject of presence, I was surprised to find nursing presence has multiple benefits for nurses as well. The benefits to nurses include reduced burnout rates, increased job satisfaction, and proficiency in using presence. My research on nursing presence revealed pre-conditions to presence; that is, conditions such as professional maturity, personal maturity, skill maturity and moral maturity that must be in place to offer presence.[171]

How do Operating Room nurses feel about the subject of presence? Included in this chapter are the results of a survey of forty-nine Operating Room nurses and their opinions on the value of presence to both patients and nurses. Study composition as well as theoretical underpinnings and the design process that led to the study are included.

This chapter examines these benefits to perioperative nurses as well as barriers to nursing presence. As noted in the preceding chapter, patients identify that their nurses are present and in the moment by outward indicators of nursing presence.[172] This chapter

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171 Michelle McMahon and Kimberly Christopher, "Toward a Mid-Range Theory of Nursing Presence." Nursing Forum 46, no. 2 (2011): 75.

172 Kacperek, 275.

examines the inward indicators of presence only nurses can identify as well as why nurses who offer presence are as rewarded as their patients.

Nursing Presence: Precursors to Presence

Michelle McMahon and Kimberly Christopher expand the understanding of nursing presence, viewing presence as a "foundational skill for practicing nurses."[173] Specifically, competency in nursing presence is an expectation of nurses who practice in any clinical setting. These two nurses caution baccalaureate educators that current nursing education that relies heavily on simulation labs, even though evidence-based, has the potential to undermine students' interpersonal skills. Simulation is a safe and convenient form of teaching nursing competency; however, it is just that, a replication of nursing in the real world. I mention this to emphasize that the ability to interact with patients and offer presence is as much a learned art as other nursing duties that nurses develop over time. As nurses expand their professional roles, they increasingly draw on clinical expertise and previous experience with presence.[174] The following are the precursors to nursing presence enumerated by McMahon and Christopher.[175]

1. *Professional Maturity*

   Professional maturity is required of nurses if they are to be comfortable being present authentically with their patients. What exactly is professional maturity and why would it be required for nursing presence? Professional maturity includes "theoretical, practical, and

[173] McMahon, 71.

[174] McMahon,74.

[175] McMahon, 72.

experiential knowledge."[176] Notably, professionally mature nurses no longer have to consciously think through the steps to nursing and are able to "just know" nursing process.[177] These nurses have grown into their professional roles and are comfortable in their ability to handle most situations as they arise.

The reason professional maturity is a prerequisite to nursing presence is because being present is inviting patients to interact in an unfeigned honest way. This means there is no pre-set script for patients or nurses for that matter. Patients' concerns are unique to themselves and their illness; they will not always say what one expects. Professional maturity is the quality that allows nurses to respond with grace and self-assurance. Professionally mature nurses "engender patient confidence" in the surgical experience about to unfold.[178]

An example from my own practice of a patient saying the unexpected is included here. I began my preoperative interview with a middle-aged man scheduled for a knee arthroscopy. Before I could do more than introduce myself, confirm the surgical site and procedure, he confronted me with a question. "How do I know you won't operate on the wrong knee?" he challenged. This is where professional maturity came in

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[176] Jane Sumner, "Communication as Moral Caring in Nursing: The Moral Construct of Caring in Nursing as Communicative Action." *International Journal for Human Caring* 16, no. 2 (2012): 23.

[177] Jane Sumner, "Reflection and Moral Maturity in a Nurse's Caring Practice: A Critical Perspective." *Nursing Philosophy* 11, (2010): 167.

[178] McMahon,72.

to play. Plainly, the subject of wrong-site surgery is a hot topic in Operating Rooms nationwide and the patient's question felt like a dare to me or a test of my honesty.

Over the years, I had witnessed doctors and nurses being less than forthright with patients when there was a mistake and it never seemed to go well. On the other hand, I also had witnessed doctors and nurses being brutally honest about a medical error or near miss that had occurred. Amazingly, those professionals who were starkly candid with their patients had better outcomes, better patient understanding, and better cooperation. Seeing this phenomenon for myself helped me develop professionally and vow to be straightforward with patients despite how uncomfortable the consequences might be to me.

To be sure, brushing aside my patient's concerns about wrong-site surgery would appear deceitful—as if I had something to hide and was dodging the issue. On the other hand, denying that wrong-site surgery ever happened obviously contradicted what most informed patients knew to be true. Having professional maturity grounded my perspective and allowed me to answer his question directly.

I explained. True, wrong-site surgery does occur and I would be lying if I said it never took place. However, to my knowledge it had not happened at my hospital or on my watch—but could; I was careful to note that mistakes are always possible and can plague even the best of

nurses.[179] I also was able to point out how the hospital took multiple steps and had many fail-safes in place to prevent wrong-site surgery; still people are human. Actually, the best assurance of a good outcome was an alert informed patient such as he was. This patient appeared to accept my answer, but it was professional maturity and honest presence that allowed me to respond to his question with directness equal to his.

Professional maturity is the first quality nurses need in developing the ability to offer presence.[180] Nurses with this quality have synthesized practice, theory, and experience enabling them to be intentional in their actions. Rather than having to "think through every nursing intervention in a conscious way" these nurses are able to concentrate on how to be present for each unique patient.[181] They have developed a high level of competence that frees up time for presencing with patients. Perioperative nurses must develop proficiency in surgical procedures as well as comfort within the OR's unique culture. This professional development then leads to confidence and the ability to anticipate problems.

Professional maturity allows nurses to engage patients in presence deliberately rather than center on task-oriented care. This is an especially

[179] Although not a scientific fact, it is important to note the unwritten rule in the Operating Room that as soon as one brags about not having made a mistake that is exactly what will happen.

[180] McMahon, 75.

[181] Sumner, 166.

challenging accomplishment in the Operating Room where machines, technology, and instrumentation play a major role in surgical nursing.[182] Through conscious awareness and intention, mature nurses choose to be openly available to their patients.[183]

Perioperative nurses also have to learn how to manage their own personal style of nursing and how they interact with surgical patients in their own way. Most perioperative nurses who are present with their patients would say that presence is not a deliberate nursing strategy nor is it easily quantified; even so, patients have no difficulty identifying nursing presence. That is to say, nursing presence imbeds itself spontaneously in the practice of individual nurses as evidenced by their manner and patient interaction.

Paulette Osterman et al. note the following of the nurses in her study.

> In contrast to the literature, the nurses' ways of being present in this study did not reflect a highly conscious nor deliberate nursing strategy. Instead, nurses were observed being tentative and cautious as they evaluated the approachability and openness of the patient to nursing presence. Seasoned nurses who have professional maturity 'test the waters' so to speak, calculating the degree of presence each patient requires. [184]

The path to professional maturity takes time and may include self-protective techniques at first, such as limiting patient interaction. At times

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[182] Bundgaard, 35.

[183] McMahon, 75.

[184] Osterman, Schwatz-Barcott and Asselin 202.

perioperative nurses simply must conserve their attention and concentrate on the job at hand. Self-protective behaviors are typical of new nurses or new-to-OR nurses. Novice nurses employ self-protective measures as a means of staying on track clinically and keeping the patient safe in their care. This is as it should be. Nursing, especially in the Operating Room, is a serious undertaking; to be sure, new nurses who are too relaxed or over confident in their immerging practice could easily pose a real danger to patients. On the other hand, perioperative nursing is complex and can be so overwhelming that fear of harming patients might virtually paralyze new nurses. Professional maturity is the balance seasoned perioperative nurses strike between overconfidence and fear. With professional experience comes comfort being present for patients making it less likely nurses will require self-protective behavior.[185]

Another self-protective behavior of new nurses is concentrating on obeying the rules and trying to perform their work well. New nurses are obeying institutional policies at first and turn protectively inward so nursing presence is essentially impossible. Only in later practice will they become experienced nurses who are able to view patients as unique individuals rather than generic patients.

A different strategy used by novice OR nurses who cannot yet be present for their patients is selective hearing or failure to listen. Novice nurses at this stage of practice generally speak but cannot effectively listen

[185] Sumner,160.

to their patients—another behavior designed to protect self by limiting distracting activities. Understandably, these nurses are so preoccupied with tasks that they are unable to be present.[186]As stated previously, new RNs or new-to-OR-RNs have limited problem-solving experience; therefore, allowing patients to speak freely in an unscripted way risks presenting problems for which new nurses are unprepared.

Jane Sumner, author of the article "Reflection and Moral Maturity in a Nurse's Caring Practice: A Critical Perspective," explains the dilemma of new nurses.

> The new and inexperienced nurse is so busy trying to manage all the tasks required for the day and to complete the work that empowerment and self-determination are likely to be the last things on his or her mind. Thinking about self is not in the forefront of that nurse's daily experience: clock-watching, crossing the tasks off the list, patient demands and wishes are the nurse's first focus and responsibility. [187]

Maturing in one's professional role affords OR nurses the opportunity to reflect on their practice over time as a means to empowerment. Only empowered nurses have the heart to offer presence. Skill and experience empower nurses and are required to function and reflect as multiple events unfold simultaneously. Ultimately, topping the "to do" list for professionally mature nurses is being present for their patients.[188]

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186 Sumner, 165.

187 Sumner, 163.

188 Sumner, 164.

2. Moral Maturity

Moral maturity is also an influencing factor in nursing presence. Committed nurses who "choose to be present with their patients rather than detached" demonstrate moral maturity.[189] Operating Room nurses who wish to be present accept the responsibility of unconditional availability to their surgical patients. This professional obligation to be available to patients makes presence a moral imperative for nurses in the perioperative area.

Moral maturity develops over time, as does nurses' comfort with presence. The more morally established and committed nurses are to perioperative nursing, the more likely they will willingly be present for surgical patients. Finfgeld-Connett's synthesis of presence in nursing literature supports the idea of a moral component related to nursing presence. Her meta-synthesis of presence describes the "moral foundation that precedes presence" by nurses.[190] To be sure, the supporting moral underpinnings of presence are respect for patients' individual differences that enable nurses to view each patient with positive regard. In fact, even in hopeless situations presence grounds and tempers nurses' hope that things can be improved in some way.

One might assume that connecting with patients with poor prospects for the future would increase hopelessness in nurses; actually,

[189] McMahon, 75.

[190] Finfgeld-Connett, 114.

the opposite is true.[191] Being present and in the moment for patients with poor prognoses is often the single thing nurses can do to make an ill-fated situation better.

Nurses who are present for their patients avoid the overwhelming burden of solving their patients' bleak future; instead are empowered to mindfully continue the nursing intervention of presence. To be sure, being present relieves nurses of the responsibility to cure an incurable situation but allows them to accompany their patients in their life journey.

3. Personal Maturity

Personal maturity is about self-care and is a prerequisite to the gift of presence: nurses must be personally mature to avoid potential burnout.[192] It is difficult to overemphasize the importance of self-care for Operating Room nurses in a practice that daily confronts patient suffering. It is the personal maturity of OR nurses that grounds them psychologically, balancing their care with the pragmatic application of scientific knowledge. The ability to perceive and set aside external influences, intentionally focusing on presencing, is the hallmark of personally mature nurses.

Presence characterizes personal sensitivity to patients as it targets patients' needs—it can only be offered if nurses have a level of personal maturity. Because of personal maturity, nurses can empathize with their patients' situations and provide compassionate care. Personal maturity leads to

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[191] Lillekroken, 42.

[192] Finfgeld-Connett, 115.

presencing with patients and creative nursing—nursing that goes beyond the routine. Personally mature nurses are aware they may be compelled to think and treat in non-traditional ways on behalf of their patients at some point. It is their maturity that keeps these nurses secure in the knowledge their patients' wellbeing is their principal goal.

4. Skill Maturity

Skill maturity is the recognition of patient needs and the "skillful use of therapeutic communication" by attuned nurses.[193] Sometimes known as relational skills, this set of attributes includes nurses' ability to key into client needs and use the right words and gestures for the situation. Relational skills include the capacity to be available as needed for their patients: skills that include active listening, appropriate touch, eye contact, smiling, and caring tone of voice.

Proficiency in relating to others is a pre-condition for presence because it represents the key component to all relational skills in nursing.[194] Since presence is a reciprocal process between nurses and their patients, nurses must be secure enough in their personhood to connect with their patients. Nursing literature describes therapeutic use of self, creative use of self, and gift of self as methods personally mature nurses use to build rapport with their patients.[195]

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193 McMahon, 76.

194 McMahon, 76.

195 McMahon, 76.

Nursing Presence: Benefits to the Nurse

An intimate relationship between perioperative nurses and their patients develops when nurses decide to be present. Nurses are held as trustworthy partners in care and are invited into their patients' world. As a result, nurses who choose to be present and emotionally available to their patients sense a "mutual give-and-take."[196] In line with the notion of a shared experience, nurses receive positive outcomes when they use nursing presence in their practice.[197] There is a sense of mental wellbeing and personal satisfaction: "a feeling of calm renewal and inner growth."[198]

Nursing Presence: Barriers

Technology

Advances in technology have proven to be another level of safety for surgical patients. Items such as allergies or past surgical history or important patient information are included in patients' electronic records. These records are available to all who care for patients in the perioperative area and are not dependent upon the memory of just one person. Technology in nursing may seem at odds with nursing presence, however, some feel technology and caring aspects of nursing can be used to augment caring presence.[199] That is, "the power technology exerts on nursing practice is not from technology itself but stems from the manner of its use in patient care and patient safety."[200]

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[196] Finfgeld-Connett, 116.

[197] Grissel Hernandez, "The HEART of Self-C.A.R.I.N.G.: A Journey to Becoming and Optimal Healing Presence to Ourselves and Our Patients." *Creative Nursing* 16, no. 2 (2010): 50.

[198] Finfgeld-Connett, 116.

[199] Bundgaard, 39.

[200] Bundgaard, 39.

On the other hand, advances in the field of technology have also come between OR nurses and their patients. Nurses can easily spend more time with their hands on a computer keyboard than touching their patients: more time looking into computer screens than into the faces of their patients. Researchers Nystrom, Dahlberg, and Carlsson, studying Swedish emergency department nursing concluded practical/technical skills were highly prized by employers; whereas, caring skills were not prized and not considered an important part of professional nursing.[201] Most research in caring behaviors—of which presence is a major part—indicates that a "balance of technology and humanism is a very difficult state to maintain."[202]

Analysis of the Nystrom et al study in Sweden shows much of the study data is transferrable to the Operating Room. The difficulty in achieving a caring perspective in the Operating Room seems to be due to the overvaluation of measurable tasks such as incision time or time between cases. Meanwhile, there is the undervaluing of non-measurable tasks, such as being present. As a result, caring interventions fail to strengthen perioperative nurses' self-esteem or professional value to the same high degree as speed or efficiency.[203]

Computer screens may be where Operating Room nurses feel obligated to direct their presence rather than their patients. I am reminded of a time I was called into my manager's office for recording the patient's entry into the OR suite as 8:01 a.m. She was

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[201] Maria Nystrom, Karin Dahlberg, and Gunilla Carlsson, "Non-Caring Encounters at an Emergency Care Unit - A Life-World Hermeneutic Analysis of an Efficiency-Driven Organization." *International Journal of Nursing Studies* 40, no. 7 (2003): 761.

[202] Bundgaard, 39.

[203] Nystrom, 762.

furious. The OR staff had been under strict orders to begin the first case of the day on time (8:00 a.m.) as a means of improving our quality of care. The electronic record showed my login at 8:01 a.m. and was unalterable. My apology and explanation meant little; this one-minute failure on my part brought down the department's statistics. Yes, from then on I was very circumspect regarding on-time start. And yes, most OR managers would agree with her; but I had to reflect on the absurdity of this situation. I was being severely chastised for not meeting a time goal by one minute yet never in my 20 years of practice was I ever chastised for lack of nursing presence. Indeed, it would be a *rare* occurrence in *any* OR to counsel nurses for uncompassionate care; yet a *common* occurrence to warn nurses whose practice did not support the department's statistical goals.

To be sure, I appreciate the cost of Operating Room time and have devoted an entire chapter of this dissertation to that subject; nevertheless, OR nurses are called upon daily to choose between (invisible) presencing with their surgical patients and (very visible) time restrictions.[204]

Increased responsibility

As nurses take on more medical responsibility, they spend increased time collecting and monitoring data. This is nursing attention directed away from the patient further reducing time for nursing presence. In the Operating Room, nurses are responsible for coordinating the activities of anesthesia care providers, x-ray personnel, pathology, and lab services. Besides being attentive to the sterile field, surgical nurses constantly monitor patient positioning, blood loss, counted supplies, and instrumentation. Surgeons,

[204] Chapter four, Nursing Presence in the Perioperative Area: *The Business of Presence*.

physician assistants, surgical technologists, and nursing students all depend upon the vigilance of the OR nurse to keep surgery safe and smooth running. Constant multi-tasking leaves little of perioperative nurses' day left for quality patient care—in many ways presencing with their surgical patients looks like a luxury.

Limited or no experience

Many nurses, and most new graduates, lack confidence in their communication skills to connect in an authentic way with patients. The ability to apply knowledge of presence in the clinical setting takes practice. As new nurses see the benefits of offering presence to patients, they become more comfortable "being with" patients as opposed to "doing for."

New nurses are more likely to think about caring behavior in terms of practical things like giving their patients a warm blanket or providing current information. Whereas over time, seasoned nurses seek to understand patients' deeper needs and support them in their unique life-world.[205]

Time constraints

Of all the places in the hospital, the Operating Room is the most likely department to experience a continual sense of time urgency. It is no surprise nurses fall victim to the distorted view that completing the most *urgent* task is better than completing the most *important* task. Really, what could be more important than authentic connection with patients about to undergo surgery?

[205] Nystrom, 764.

Business and finance

This topic, covered more fully in Chapter four, is the reality-based part of perioperative nursing. The Operating Room is an expensive department in the hospital with the highest operating cost and the highest return on investment. That is, the all around cost of keeping a surgical suite in the black is complex and costly. Any process that would delay the efficient use of valuable resources, such as the time of Operating Room nurses, has to pay for itself in other ways.

Nurse presence takes time and Operating Room time is costly. A hospital's surgical schedule works on a collection of fixed time periods: nursing tasks must be accomplished within those time periods if the OR is going to run efficiently. Perioperative nurses strive minute-by-minute to adhere to that schedule. Problems arise, however, because nursing tasks require completion regardless of the time on the clock. For example, something as minor as a patient wanting to use the bathroom before going to surgery may upset the scheduled incision time. Perioperative nurses are acutely aware of the unforgiving surgical schedule thus are constantly called upon to advocate for their patients regardless of clock time.[206]

Nursing Presence: Perioperative Nurses Speak

Presence is a conscious effort by perioperative nurses to be there for and be there with surgical patients. However, in an effort to utilize the Operating Room efficiently, these valuable nurses are constantly being pressed to reduce the time spent interacting preoperatively with their patients. The quality of this time is ultimately judged by how well surgical patients' needs, both medical and emotional, have been met. Operating

[206] Riley, 547.

Room nurses realize connecting with patients in these final, few moments before surgery is critical for safety as well as the satisfaction of both patients and registered nurses. The survey discussed here of forty-nine Operating Room nurses conducted in 2011 by the author, nurse Dufner-Mantore RN, MSN, reveals just how important presence with their patients is to these skilled nurses. [207]

Nursing Presence: Study Operational Definitions

- *Presence*: Purposeful mindfulness by the registered professional nurse in the context of the surgical patient
- *Time*: Interaction counted from initial greeting of the patient by the perioperative nurse including interview, transport to the Operating Room, transfer to the OR bed, concluding at the induction of anesthesia
- *Nurse:* Registered professional nurse assigned to perform the preoperative interview. This nurse may circulate during surgery, be present during wake up, and transfer to the Post Anesthesia Care Unit (PACU.) This nurse may also be referred to as surgical nurse, perioperative nurse, and OR nurse.
- *Patient*:
    - Adult surgical patient in a community-based hospital or ambulatory surgical setting

[207] Methodology: The data were entered manually into SPSS software from the Survey Monkey website. The dataset has 28 variables, with 49 observations. Next, the data file was loaded into R/R-Studio software. All graphs and tables were generated in R.

"R is a programming language and free software environment for statistical computing and graphics supported by the R Foundation for Statistical Computing."

Elizabeth Pemberton, Statistics Ph.D. candidate Stony Brook University as well as graduate of Drew University (Bachelor of Arts in Physics, Minor in Mathematics)

    - Pediatric patient accompanied by an adult in a community-based hospital or ambulatory surgical setting.

- *Operating Room*: Hospital-based surgical suite or ambulatory surgical suite or doctor's office procedure room
- *Surgery*: Procedures commonly performed in a mid-size community hospital including general surgery, vascular and thoracic surgery, neurosurgery, orthopedic surgery, head and neck, plastic and reconstructive, gynecological, urological procedures, and trauma.

Nursing Presence: Study Development

In early fall of 2011, I developed a survey of OR nurses known to me in an effort to determine what part presence played in the practice of my fellow RNs. I was passionate about the topic and had seen its positive influence on patients in my own practice. My interest in this area of study obliged me to begin compiling a body of journals and articles on the subject. Realistically though, I was aware that presence was *my* passion and many RNs felt taking time for presence was a luxury saved for theorists or those lucky nurses who never had to look at a clock. Maybe it was only my issue, and OR nurses in the real world had a different opinion of presence and its priority in clinical practice. A study to let perioperative nurses speak for themselves was the only solution, as I saw it.

In the midst of designing the study, a colleague suggested I simply have a conversation with my nurse friends at work rather than struggle with survey questions and design formatting. After all, she reasoned, face-to-face interviews could be informal, less preparation for me and a potential source of rich data not possible through an online

study. Just talk – that certainly sounded easier than survey designing. Nevertheless, I slogged on with the online setup for the following reasons.

The argument for choosing the online format is important for other nurse researchers who also practice in the clinical setting to consider. True, just talking was a tempting alternative to the online design, but the nurses I was surveying were longtime friends and colleagues. Almost certainly any interview, no matter how structured, would get off track quickly with no diplomatic way of staying on topic. Also, as my friends and workmates it might be possible they did not share my passion for nursing presence but would feel an obligation to agree with me. Therefore, having an online venue afforded these experienced nurses the opportunity to answer questions anonymously, uncomplicated by work or social obligation. There was a better chance unsigned answers would reflect the nurses' true sentiments. Ultimately, unless participants' answers are genuine, the study was worthless.

An example of one nurse who did not share my opinion of nursing presence was M.R. While explaining the outward signs of presence to M.R., and how often Operating Room nurses employ them, she stopped me to say she never made eye contact with her patients. I was shocked. M.R. was a fantastic nurse with much fellow feeling and compassion: why would she avoid eye contact with her patients? She explained: looking directly into a patient's eyes was intrusive and meddlesome in her mind. To M.R., the eyes are a window to the soul and, as such, out of her scope of practice. She had no need to pry into the soul of her patients to give them good nursing care. Nevertheless, she felt nursing presence was important and considered herself very present for her patients even sans eye contact.

I mention M.R. as an example of one who might be less forthcoming in a group discussion of presence but truly honest in an anonymous survey. As a quiet and private person, M.R. was sharing her closely held beliefs with me as a friend and I acknowledged that. I could not expect her to do that in a group setting: yes, online was the way to go if I wanted truthful responses.

Why has the design development of this study been included here? The thought process of how the survey came about is included in this chapter because it is important to realize much of the research done in nursing is by practicing RNs. Namely, nurses just like me who plan research, collect data as well as work in a demanding specialty field that leaves little energy at the end of the day. I feel my challenges and successes in completing the survey are typical of nurses in all disciplines and may guide other RNs. In addition, I argue that my simple survey of forty-nine perioperative nurses represents a broader segment of nurses in the surgical discipline.

Beginning in September of 2011, collection of names and e-mail addresses of Operating Room nurses began with a convenience sample of nurses I worked with. Of note is that each nurse who gave me a name and e-mail knew it was for the purpose of participating in the study. As a lone nurse-researcher, I had limited access to the names of nurses in general and OR nurses specifically. To be useful, my focus needed to be on only the very small sub-group of perioperative nurses: notably, including nurses from other disciplines in the survey would dilute survey results and their pertinence to the Operating Room.

True, having access to a national database of perioperative nurses would have been the ideal, nevertheless getting forty-nine OR nurses to respond seemed like a

monumental accomplishment. In my view, those forty-nine nurses who took the time to complete my survey represented far more OR nurses in the real world of surgery.

I obtained a list of RNs working in the hospital's main OR, cardiac OR, and ambulatory surgery with the goal of asking all of them to participate. As each person accepted my survey invitation and gave me their e-mail, I crossed off their name on the list. No nurse refused to participate, although I was careful to mention that the e-mail was for this anonymous survey and nothing else. Some nurses had colleagues at other hospital or surgicenter ORs and brought their names and e-mails to me later. In addition, the survey had in its introduction the following explanation.

> Things you should know about the survey
> Participation is voluntary and all responses are anonymous.
> No identifying information links individuals with their responses.
> Completion of the on line survey implies your agreement to participate.
> The survey takes about 10 minutes or so.
> Free text boxes are provided for additional comments you may like to include.[208]

It is important to explain why I chose an online survey method of research as opposed to e-mail-only questionnaire or the traditional paper survey. Creating an e-mail questionnaire using only e-mails and no commercial formatting was possible and avoided web-based software such as Survey Monkey that was used. However, this approach has many failings; the main weakness in freestyle e-mail based surveying is that answers lack organization.[209] Nurses do not respond in a uniform format, complicating analysis of the data. The study did have an opportunity for some unstructured answers in the ten free-text boxes. Although I provided free-text opportunities, free-text options proved to be a

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[208] Dufner-Mantore, 1.

[209] Word Press. May 24, 2013. http://www.analyticstool.com/pros-and-cons-of-online-surveys/ (accessed June 9, 2016).

small complement to the major data provided by survey questions. Of note is that free-text boxes afforded responding RNs the same anonymity as the rest of the study.

E-mail based questionnaires may be subject to researcher bias in assembling the returned data which also weakens survey results. True, some researchers benefit from using e-mail questionnaires due to the ability to track individual responses. In addition, researchers like e-mail surveys because they reveal who has responded, or not, as well as how the respondents answered the questions. Online surveys have equal strength as e-mail-only or traditional paper survey methods.[210]

Efforts to collect paper questionnaires were just as challenging as they risked revealing the identity of the respondents through handwriting or just the curiosity of others. Paper surveys depend on a physical location and the hospital seemed a logical place. I rejected this setting as I thought the hospital would add another layer of subtle influence that I could not control. Successful paper questionnaires depend largely on formatting and an overall pleasing design, a formidable task in itself. Whereas quality online formatting was relatively simple to achieve, as style, color and design elements can be custom-tailored by the researcher. The cost of a paper survey is also a consideration since printing supplies, envelopes, and collection equipment all take some monetary investment: an additional deterrent to research by staff nurses.

Another advantage of an online survey service is that web-based surveys allow the participants to complete the survey at a convenient time. This time factor was a major consideration for the population I was surveying. Perioperative nurses at my hospital were busy professionals, completing the survey was a favor to me; I had to make the

[210] Word Press, 2.

experience as convenient as possible respecting their time. Operating Room nurses I surveyed worked various shifts of the day, days of the week and weeks of the month. The perioperative nurses who participated in my study could take their time when answering as well as complete the survey when they chose to do so. The anonymous and private nature of the study design insured responding nurse's answers were as genuine as possible. Attempts to have in-person interviews or distribute and collect paper questionnaires by one researcher with any consistency were virtually impossible.

I mention the convenience of web-based survey sites, as it was essential my results be reliable and professional grade. On the other hand, I was not a professional survey designer so the ease of use was an important aspect to me. My 2011 web-based study, administered as an anonymous response survey, proved better at eliciting honest answers than in-person answers because I, the interviewer, was not present asking questions directly. It is my hope that other practicing nurses will look at this easy web-based method of research as something very do-able in real life by real nurses.

One option of study design that I decided to include in the survey was the ability of each respondent to see the answers of other nurses. Even though it was impossible to identify which nurse answered a specific question a certain way, I thought it would be helpful for each responding nurse to see what other perioperative nurses at the hospital said regarding nursing presence. One might argue that knowing the answers of their peers would influence nurses in the study, thus weakening the study's strength. I did not think so. The general character of an OR nurse is one of an independent practitioner, seeing the answers of other nurses would not be an influencing factor to any degree in their responses, as I saw it. To be sure, one hallmark of a professional nurse is an unusual

degree of autonomy at work as well as personal identity with the profession.[211] I knew these nurses to be self-determined professionals who would provide honest answers to the survey questions.

Another design element used was the opt-out feature that allowed the responding nurses to leave the study unfinished at any time without recording any answers. Opt-out for this survey was an all-or-nothing element that did not permit any partially completed surveys to be included in the data. Conversely, study design made it impossible to skip a question: completion of each question was required before proceeding to the next question. This was an important feature to include since some questions were irrelevant without the additional information provided by neighboring questions. For instance, how much time my OR nurses *actually had* for presence with their patients was irrelevant without answering the next question: how much time did these self-same nurses *actually need* for presence. Without the answers to both questions, neither provided useful data on its own. Namely, to answer how much time OR nurses *did have* with their patients before surgery, made no sense as a stand-alone question. It was possible that perioperative nurses in my survey were perfectly happy with the time they had for presencing with their patients. To answer how much time OR nurses in my study *needed* with their surgical patients, again was irrelevant information by itself. Conceivably, nurses who participated in the study may have had plenty of time for nursing presence. Nevertheless, only by completing both questions did nurses reveal they had less than optimal time with their surgical patients and required more time for presence. [212]

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[211] Yam, 979.

[212] Interestingly, study data revealed that over 57% of the responding nurses felt they needed more time with their surgical patients.

Some demographic information was sought from the perioperative nurses who responded to the study. Questions about how long each nurse had been in nursing as well as how long each nurse had been in Operating Room nursing were included. Questions regarding age, ethnicity or gender did not seem relevant when I designed the survey questions. At the time, those factors appeared to be data that would add little but had the potential to cloud the study's results. Reflecting on the survey and its results now, I see more demographic questions could have been included in the study: their answers providing a springboard for further studies.

In all honesty, not all nurses were so happy to see me coming with my notebook: some nurses rolled their eyes when asked to participate because this survey business appeared as theoretical foolishness to them while they were caring for real surgical patients in the real world. To be sure, the majority of nurses in my hospital's Operating Room were diploma and associate degree nurses who had no need to return to school after passing their boards and began practicing in the OR. They were good nurses and the backbone of our department: I respected that. At the time of the study, only two of the over forty nurses (full time, part time, and per diem) employed in the OR were in school. It is important to acknowledge Operating Room nurses had their own individual reason to continue their education or not, or not yet.

Nevertheless, this study provided a firsthand view to the staff of actual nursing research done by an actual nurse. The nature of Operating Room nursing incorporates a significant element of technical skill that plays into the vocational image of perioperative nurses. True, much of perioperative nurses' workday involves a large degree of

psychomotor skill that undermines their professional image.[213] Although to be fair, work in even the most privileged professions involves a significant element of banal tasks. I recall a neurosurgeon I often worked with complaining that much of the labor in performing a laminectomy was "blue collar" work.

Here was a chance to see a grass-roots effort elevating nursing from a service vocation to a respected profession. To be sure, the traits of a true profession include expanded use of theory and conceptual knowledge. Nursing presence was a perfect concept to investigate as it incorporated the historical nursing elements of skill and caring with the theoretical elements of researcher and scholar. Research promoting nursing presence was the ideal blend of "know-how" knowledge, namely experiential knowledge gained through hands-on nursing, with "know-that" knowledge, or knowledge derived from theory and research.[214]

Participation in the study and observation of how it developed in the Operating Room afforded my nursing colleagues a look at the professional roots of nursing. To be sure, Bernard Yam lists six traits of a profession that distinguish professional affiliation from an occupational job.[215] (Figure 2) Of importance to Operating Room nurses who want to be viewed as professionals, is the need for the theoretical foundation that can only come to one through advanced education and scientific inquiry.

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[213] Psychomotor skill is the ability to perceive instructions and perform motor responses that include an element of speed and reaction time. Farlex. *The Free dictionary.* http://medical-dictionary.thefreedictionary.com/psychomotor (accessed June 2016).

[214] Yam, 981.

[215] Yam, 979.

The claim of nursing in general, and perioperative nursing specifically, to be a true profession has been an elusive one. The fact that Florence Nightingale distinguished between psychomotor nursing knowledge and professional medical knowledge has not been helpful in elevating the image of nursing.[216] Sadly, some nurses unknowingly perpetuate this devaluation of nursing knowledge by failing to discover the theory behind their nursing interventions.

The Traits of a Profession

- An extensive theoretical knowledge base
- A legitimate expertise in a specialized field
- An altruistic commitment to service
- An unusual degree of autonomy in work
- A code of ethics and conduct overseen by a body of representatives from within the field itself
- A personal identity that stems from the professional's occupation

Figure 3

Advancing nursing theory is not just an intellectual exercise. Theoretical inquiry compels nurses to take an elevated view of their profession much like looking down from an airplane to see where nursing interventions lay in the topography of healthcare. A theoretical perspective eliminates the minutiae of nursing care and reveals the critical location of nursing at the point where medicine and patient care converge. Perioperative nursing is perfectly positioned to translate the conceptualized theory of presence into practice and see its immediate effects.

An essential part of scientific inquiry is developing a language that standardizes basic concepts. To that end, AORN commissioned an investigation of the concept of language standardization in surgery as far back as 2008.[217] This professional organization

[216] Yam, 980.

[217] Bonnie Westra, Rhonda Bauman, Connie Delaney, Cynthia Lundberg, and Carol Petersen, "Validation of Concept Mapping Between PNDS and SNOMED CT." *AORN Journal* 87, no. 6 (2008): 1217.

realized that charting in electronic health records would require standardized terminology by perioperative nurses if they were going to excel at electronic charting.[218] Only through the consistent use of nursing terms can best surgical practices be determined, trends in perioperative care tracked, and OR documentation made transferrable to other departments. Indeed, lack of uniformity in charting nursing care has plagued the nursing profession from the beginning.[219] Some feel lack of consistent terminology has been a roadblock to nursing in that "numerous interpretations of data increase confusion and the potential for error."[220] Clarification of the concept of presence by explaining the outward signs as well as inward signs contributes to nursing's professional body of knowledge.

Although nurses consider nursing to be a profession, in the past some have viewed it as a para-profession, a category below major professions.[221] A key issue with the designation of nursing as a profession lies with the issue of formal knowledge and nursing's apprenticeship training.[222] In all advanced countries, a university education formalizes the theoretical knowledge that is unique to a profession.[223] The disparity in

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[218] The American Nurses Association (ANA) has developed criteria based on the International Standards Organization to recognize nursing terminologies that are reliable, valid, and useful for practice. The Joint Commission requires the use of standardized terminologies in electronic health records (EHRs) as does the federal government in its certification process of information systems. The certification process for information systems exists as a result of an executive order of President George W. Bush in 2004 that all Americans will have an interoperable HER(*i.e.*, one that is transferable between all health care settings) by 2014. Westra. *AORN Journal*, 1217.

[219] Westra, 1218.

[220] Westra, 1218.

[221] Yam, 979.

[222] Yam, 978.

[223] Yam, 979.

nursing educational requirements of registered professional nurses was evident firsthand in our very Operating Room. True, all nurses had to pass the state's Board of Nursing exam but diploma, associate, baccalaureate, and masters prepared nurses worked side by side in the same OR. This inequity in education of perioperative nurses has weakened the professional image and claim to autonomy.

Susan Tame, in her study of the effect higher education has on the practice of perioperative nurses, concludes that continuing education leads to intrinsic changes in the practice of nurses in the OR. [224] Increased knowledge and confidence gained through additional education equalizes the balance of power between perioperative nurses and surgeons, positively affecting the care of surgical patients.[225] The perioperative nurses in her study believed attending a university resulted in a more reciprocal and collaborative relationship with surgeons and anesthesiologists alike.[226] Better communication and freeness of speech in the Operating Room, where the essential elements of teamwork and collaboration are crucial, can only benefit surgical patients.

Historically, perioperative nurses report being neither understood nor appreciated by medical colleagues, and the paternalistic nature of surgery in a closed male dominated unit does not appear to be changing soon. [227] [228] Despite this inequity, most nurses in

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[224] Susan Tame, "The Effect of Continuing Professional Education on Perioperative Nurses' Relationships with Medical Staff: Findings from a Qualitative Study." *Journal of Advanced Nursing* 69, no. 4 (2012): 817.

[225] Tame, 822.

[226] Tame, 821.

[227] Tame, 822.

[228] Tame, 818.

Tame's survey noted how their confidence and knowledge, after achieving an advanced degree, proved to be a positive influence on their relationships with surgeons.[229] Enhanced communication and inter-professional collaboration improved patient care. Following formal study, nurses were empowered with increased assertiveness and the ability to challenge the *status quo* as well as function as an information network for other nurses in the Operating Room.[230]

One hallmark of a profession is the legitimate expertise in a specialized field; Operating Room nurses certainly possess this expert knowledge in a very specialized field. However, a true profession also closes *at entry level* all other avenues into the profession—effectively retaining a monopoly on delivery of its service. It is important for perioperative nurses to realize that only through advanced degree education, comprehension of theoretical values, and complex ideology can members of their profession "tighten the boundaries between themselves and others."[231] As I saw it, Operating Room nurses were in exclusive possession of knowledge in the very difficult surgical discipline and they should be capitalizing on that knowledge.

It was my hope that if any nurses in the department were thinking of continuing their education, they would see a real-life example in me. The Operating Room nurses I knew were dynamic professionals with years of expert understanding that no other occupation, nursing or technical, could duplicate. The survey on nursing presence served as an example of how nurses could advance concept development, conduct research, and

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[229] Tame, 822.

[230] Tame, 822.

[231] Yam, 1979.

continue clinical practice concurrently. The knowledge gradient of the study moved both ways: it informed me of the perioperative nurses' opinions on presence as well as illustrated to OR nurses in the department how to conduct research.

The majority of survey questions were in a Likert-type scale in even numbered choices to ensure all data was either side of midpoint: odd numbered choices allowed respondents to neither agree nor disagree. Given the survey's small sample size of forty-nine OR nurses, it seemed allowing responding nurses to neither agree nor disagree was a waste of precious survey time. The study needed to reveal if OR nurses valued or did not value presence: offering a non-committal, on-the-fence category to possible answers seemed a useless complication to research.

This was a quantitative study, which has its origins in positivism: the philosophical idea that there is one reality. Positivism asserts, something either exists or does not and the existence is measured in numbers.[232] This philosophy guided me in my decision to offer only response options that either valued or did not value nursing presence in the OR.

As stated before, a free-text box was included on some questions to allow for further explanation of answers if the respondent was so moved. Likert-type answers also facilitated the synthesis of information, as there was virtually no interpretation needed of nurses' answers. Yes, additional correlations and trends emerged from the collective data

[232] Leica Sarah Claydon, "Rigour in Quantitative Research." *Nursing Standard* 29, no. 47 (2015): 43.

requiring interpretation, but the actual answers provided by the OR nurses were clear and straightforward in nature.[233]

The research was quantitative and deductive. A study proves to be deductive if the research question is based on, or deduced from, a theory.[234] Study data supports or disproves the validity of the deduction. Quantitative research is explanatory by way of numerical data to test an assumption; whereas, qualitative research is exploratory, inductive and interpretive. Using a pragmatic approach to the investigation of nursing presence allowed the research question itself to dictate the method of inquiry. I felt a numerical value would illustrate answers to the research question best.

By way of a reminder, this dissertation seeks to examine the subject of nursing presence in the perioperative area; that is mindfulness by the nurse in the context of the patient. I argue that nursing presence in the perioperative area is essential for a safe, high quality surgical experience. The hypothesis driving this research is; there is a *direct* relationship between the amount of time spent with a surgical patient preoperatively offering presence by the perioperative nurse and improved patient satisfaction and RN satisfaction. Specifically, more nursing presence equals better patient satisfaction scores. There is an *inverse* relationship between the amount of time spent with the surgical patient preoperatively offering presence by the perioperative nurse and patient anxiety. Specifically, more nursing presence equals less patient anxiety.

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[233] Care was taken to insure that the instructions for the survey, item questions and response options remained within the reading level that was appropriate for registered nurses in the Operating Room. Because successful perioperative nursing involves a high degree of reading, verbal and comprehension skill, the reading level of the study was never a serious issue.

[234] Elisabeth Bergdahl and Carina Bertero, "The Myth of Induction in Qualitative Nursing Research." *Nursing Philosophy* 16 (2015): 111.

As a result of this relationship between patient experience and nursing presence, OR nurses value nursing presence and want time to demonstrate that presence. Simply put, I was investigating if my fellow Operating Room nurses valued nursing presence or not. I chose to conduct a quantitative study considering its impartiality and reduced need for interpretation as is required in qualitative studies.

To be sure, allied health professions place a great deal of faith in the objectivity of quantitative research. The use of quantitative data in nursing is an established practice. Florence Nightingale was a statistician and used numbers, charts and statistics to argue for healthcare changes that saved hundreds of lives during the Crimean War.[235] The current study of Operating Room nurses' perception of presence was the means I was using to argue for healthcare changes in my world.

Quantitative research has its basis in measurements and the systematic collection of data; that is, this research relies upon the collection of numerical data to explain a phenomenon.[236] These numbers make sense of a situation; for example providing the percentage of nurses who would like more time for nursing presence with their surgical patients. Statistical values are a numerical representation of degrees; for instance, the degree to which OR nurses in the study use eye contact generated a numbered value. Teresa Hagen, BSN, notes if something is not measureable, it cannot be tested.[237] Some measures in nursing research are easily quantifiable such as patient temperature; whereas, abstract ideas such as nursing presence depend on self-reports of nursing attitudes

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[235] Claydon, 43.

[236] Claydon, 43.

[237] Teresa Hagan, "Measurements in Quantitative Research: How to Select and Report on Research Instruments." *Oncology Nursing Forum* 41, no. 4 (2014): 431.

relevant to that concept.[238] To measure the value of presence to OR nurses, their self-reported use of presence was required.

Measurement, which is the cornerstone of nursing research, requires careful planning. It was evident that the more time I spent in carefully forming each question and its possible answers, the less time I would spend explaining and interpreting the results. Quantitative data are useful in healthcare settings as they focus on numbers as a means to judge effectiveness or need. Ultimately, the results of a study, such as the one conducted by this author/researcher, hinged on how the sample of perioperative nurses responded to the study questions.

Nursing Presence: Study Results

Although most of my fellow surgical nurses had been practicing for several years, seeing their experiential data in graph form was impressive. (Figure 3) Over forty-seven percent of the nurses I worked with had at least twenty-five years experience as a nurse: almost sixteen percent had twenty to twenty-four years experience. These mature nurses provided a level of skill and experience novice nurses did not yet posses. Few nurses, new to the profession, could relate to nursing's past image in comparison to its current image as older nurses could. Seasoned nurses in the department were often the voice of reason, having practiced nursing throughout the years. In fact, should elder nurses decide to leave the department there were not enough new perioperative nurses trained to fill the vacancy.

Veteran OR nurses are also good mentors having weathered healthcare's vicissitudes and changing priorities. Unlike nursing in the late 1970's where mentoring

[238] Hagan, 431.

was never spoken of or expected, forward-looking leaders recognize the value of good mentors and work to keep expert nurses in the field.[239]

However, what nursing most stands to lose when nurses leave their positions is efficiency-knowledge; that is knowledge of how to get a job done faster and better. In fact, the expertise of experienced nurses can be difficult to articulate because it is often abstract and dynamic, reflecting the complicated, interconnected background gained over the years.[240] Also knowing organizational history, specifically understanding how and why hospital policy and culture evolved, adds much to accepting and appreciating life as a nurse in the hospital. Conceivably, expert nurses who leave take with them the rationale for organizational procedures and safety measures.

After viewing the data in Figure 3, I could appreciate how much experienced nurses had seen with their own eyes: unforgettable sentinel events, near misses, tragedies, and triumphs that shape their professional and private world-view. The opinion of these veteran nurses on *any* nursing subject was valuable and I wanted to hear what they had to say. The survey revealed an interesting correlation between nurses with more years of experience and how much time they spent with their patients. Nurses with more years of experience generally took more time presencing with their patients. (Figure 7) I would like to think that seasoned nurses had learned the value of spending time on the most important aspects of nursing, such as presence, rather than yielding to the pressure of immediate tasks. It was an honor to mine their views on presence.

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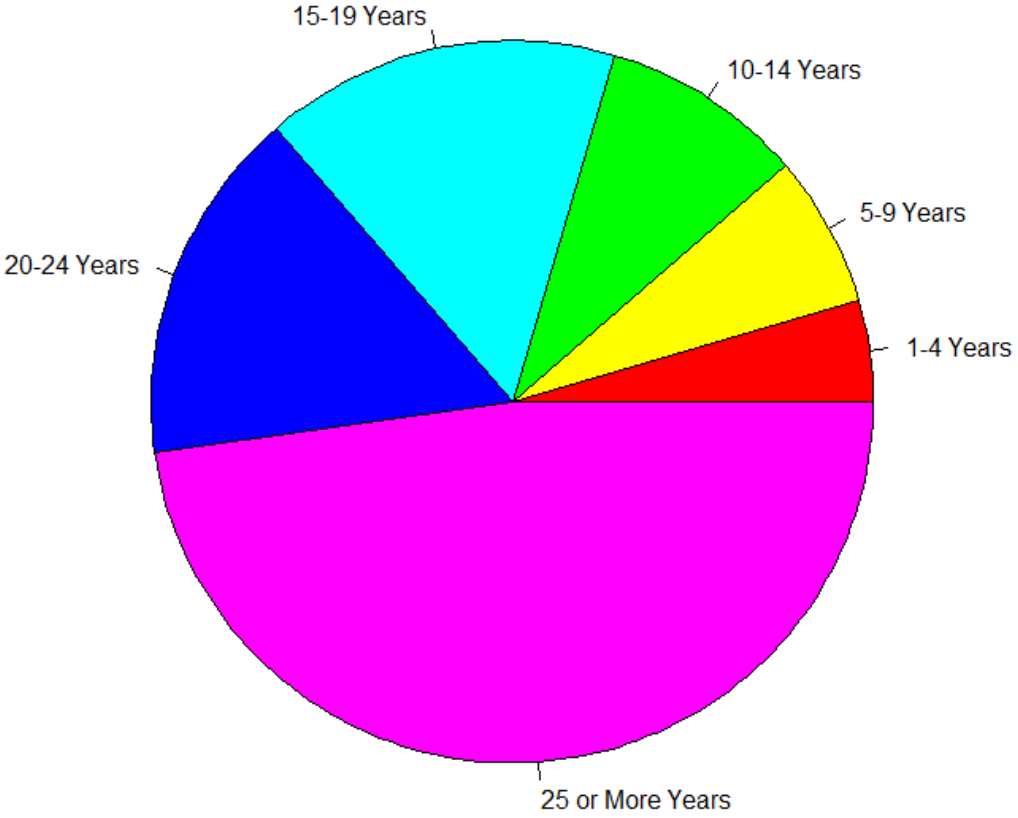
[239] Nickitas, Donna. "Investing in Nursing: Good for Patients, Good for Business, And Good for the Bottom Line." *Nursing Economic$* 32, no. 2 (2014): 69.

[240] Rose Sherman, "The Ageing Nursing Workforce: A Global Challenge." *Journal of Nursing Management* 21 (2013): 901.

I have been a Registered Nurse for

47.73% of the registered nurses in this sample (*N = 44*) have 25 or more years of experience.



I have been a Registered Nurse for						
	1-4 years	5-9 years	10-14 years	15-19 years	20-24 years	25+ years
Count	2	3	4	7	7	21
%	4.54	6.82	9.09	15.91	15.91	47.73

Figure 4

Operating Room nurses historically remain in the department for the life of their career. This phenomenon was certainly evident in the population of nurses that participated in the survey. Fully thirty percent of responding perioperative nurses had been in the OR for over twenty-five years. (Figure 2) Another fifteen percent of the nurses had logged in between twenty to twenty-four years in the OR, making those with over twenty years in the perioperative setting a full forty-five percent. Regardless of the reason nurses make perioperative nursing their life-long specialty—these were just the professionals I wanted to hear from. Certainly, the thoughts of individuals in a caring profession like nursing and a demanding discipline like surgical nursing for over a quarter of a century would have something worthwhile to say.

I have been an Operating Room Nurse for

30.00% of the OR nurses in this sample (*N = 40*) have 25 or more years of experience in the Operating Room

I have been an Operating Room Nurse for						
	1-4 years	5-9 years	10-14 years	15-19 years	20-24 years	25+ years
Count	2	6	8	6	6	12
%	5.00	15.00	20.00	15.00	15.00	30.00

Figure 5

As mentioned at the beginning of this chapter, the participating nurses in the survey were a convenience sample of surgical nurses known to me, consequently a little over ninety percent of the respondents worked in a hospital setting. (Figure 5) True this is a limitation; however, this factor in no way voids the study's results. In fact, a hospital setting would likely provide more time for presence with the surgical patient than a surgical center or doctor's office. That is, estimates of time spent preoperatively with patients in a hospital setting would be at the upper limits of time as opposed to a surgical center or doctor's office where speedy throughput is a selling point to participating surgeons.

Primary Place of Employment

For 90.91% of the nurses in the sample (*N=40*), their primary place of employment is a hospital.

Primary Place of Employment				
	Hospital	Surgical Center	Doctor's Office	College
Count	40	2	1	1
%	90.91	4.55	2.27	2.27

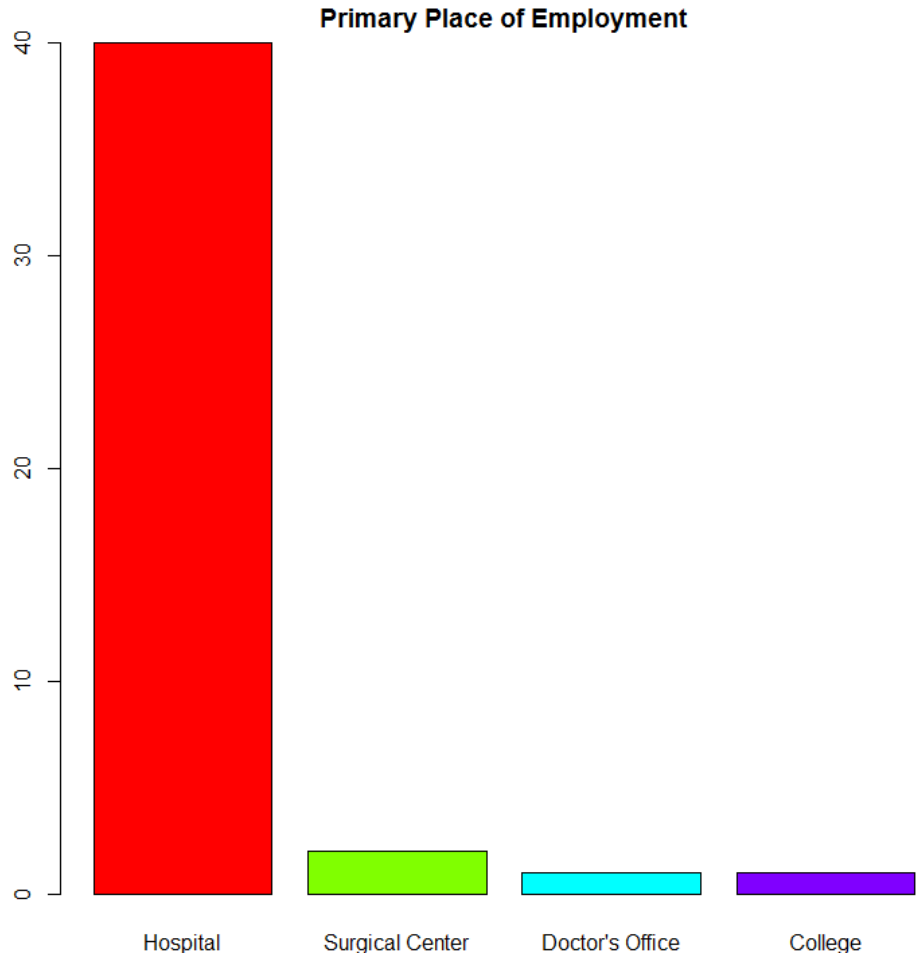
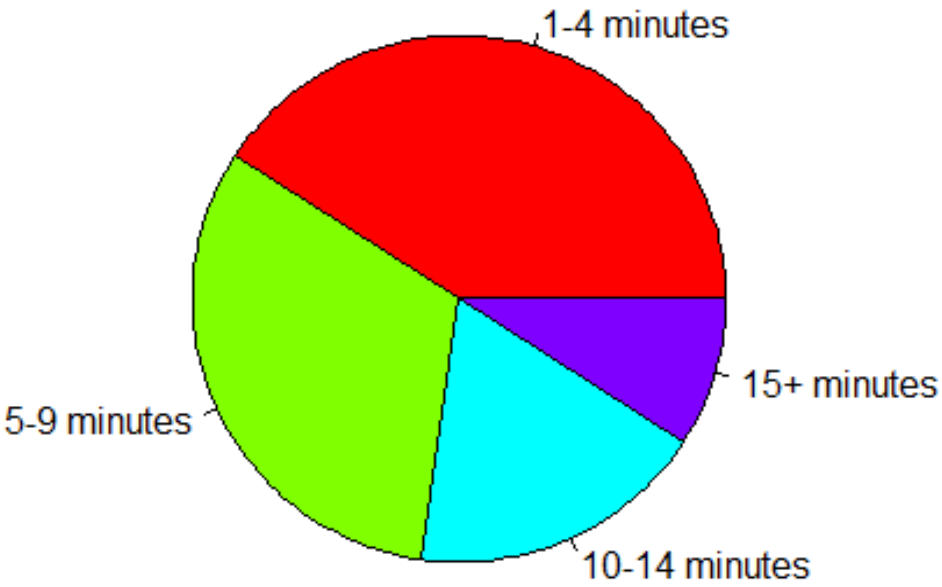


Figure 6

When asked how much time did individual perioperative nurses have with their patients, their answers surprised me. (Figure 6) Even though I am an OR nurse myself, to see in black and white that most nurses have less than nine minutes with their patients prior to surgery was a shock. A little over forty percent of my respondents had even less time; that is nurses had between one and four minutes to connect with a patient undergoing a life changing procedure. Obviously, the next logical question is if the allotted time was sufficient for presencing with surgical patients.

Time Usually Given to Establish Authentic Presence with Patient

40.91% of the registered nurses (*N = 44)* are usually given one to four minutes to establish an authentic presence with their patients.



Time Usually Given to Establish Authentic Presence for Patient				
	1-4 minutes	5-9 minutes	10-14 minutes	15+ minutes
Count	18	14	8	4
%	40.91	31.82	18.18	9.09

Figure 7

When asked if the time given for presencing with the surgical patient was adequate, again, the answers of my colleagues proved to be another surprise for me. (Figure 7) Nursing presence seemed to me to be something that should never be rushed and having less than nine minutes with a patient constituted rushing in my world. Nevertheless, the nurses in my survey divided themselves on the subject. Fifty-seven percent of the nurses felt they did not have adequate time with their surgical patients; whereas, forty-two percent said their time was sufficient.

This was the first survey I had ever conducted; in all honesty, I wanted one hundred percent of my responding nurses to be dissatisfied with such little time for presence. The answers were disappointing to say the least, how could forty-two percent of these fabulous nurses be happy with such little time with their patients? A comparison of survey data in the next chart provided the answer.

Is Time Usually Given to Establish Authentic Presence with Patient Adequate?

57.14% of the registered nurses in this sample (*N=42*) do not consider the amount of time they are given to establish an authentic presence with their surgical patients to be adequate.

Is Time Usually Given to Establish Authentic Presence with Patient Adequate?		
	No	Yes
Count	24	18
%	57.14	42.86

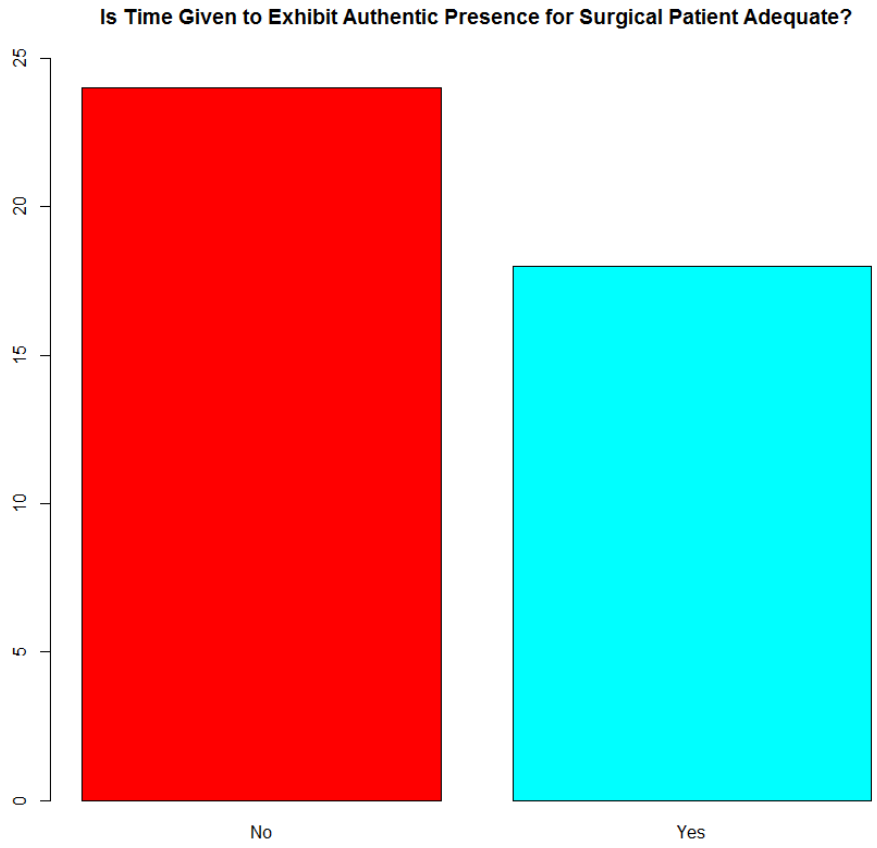


Figure 8

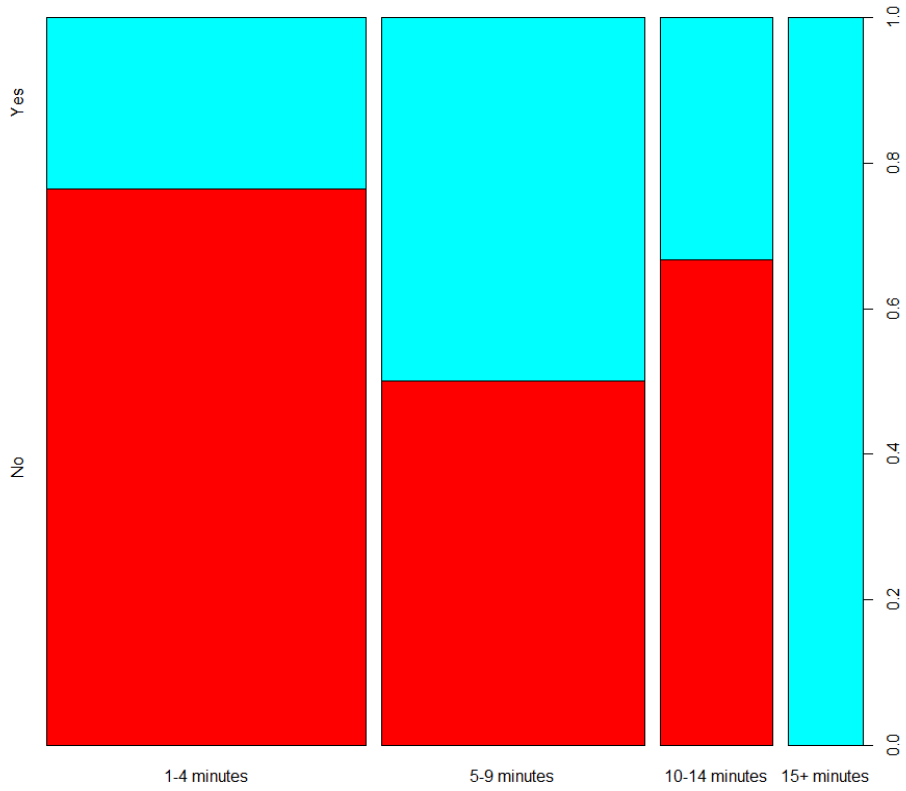
This is the table that makes sense of how any of the surveyed OR nurses could be happy with the time they spend with their patients. Figure 8 is a comparison of the data from Figure 6 and Figure 7. Registered nurses given more time with their patients preoperatively (15 minutes or more) felt the time was adequate to offer presence; of course, that makes sense. Nurses given less time with their patients (1-4 minutes) were dissatisfied with that time. To be sure, the nurses who responded having over fifteen minutes with their patients were perfectly happy with that time for presence.

Time Usually Given to Establish Authentic Presence with Patient vs. Is Time Given Adequate?

Spearman's rho *= 0.34* (moderate, positive relationship)

Registered nurses *(N=41)* with a *higher* amount of time given to establish an authentic presence with patients tended to consider this time to be *adequate*.

Registered nurses with a *lower* amount of time given to establish an authentic presence with patients tended to consider this time to be *inadequate*.



	1-4 min	5-9 min	10-14 min	15+ min	Total
No	13	7	4	0	24
Yes	4	7	2	4	17
Total	17	14	6	4	41

Figure 9

A comparison of years of experience in the Operating Room with time spent presencing revealed what I had witnessed in my professional career; that is, nurses with more experience knew the value of spending time with their surgical patients preoperatively. (Figure 9) Alvisa Palese and her international team studied 1,565 patients' perception of the value of nurse caring or connectedness: "Patients have shown that their satisfaction is mainly determined by 'positive connectedness.'"[241] True, patients appreciate a nurse's clinical skill and efficiency, but connectedness is what raises patient satisfaction scores. Elder nurses who responded to the survey, knew there was no substitute for taking the time to authentically connect in presence with their patients.

[241] Alvisa Palese, Marco Tomietto, Ritta Suhonen, Georgios Efstathiou, Haritini Tsangari, Anastasios Merkouis, Darja Jarosova, Helena Leino-Lilpi, Elisabeth Patiraki, Chrysoula Karlou, Zoltan Balogh,and Evrdiki Papstavrou. "Surgical Patient Satisfaction as an Outcome of Nurses; Caring Behaviors: A Descriptive and Correlational Study in Six European Countries." *Journal of Nursing Scholarship* 43, no. 4 (2011): 342.

Time Usually Given to Establish Authentic Presence with Patient vs. RN Experience in Years

Spearman's rho *= 0.15* (weak, positive relationship)

Registered nurses (N=42) with more years of experience tend to usually be given more minutes to establish an authentic presence with their patients.

	1-4 min	5-9 min	10-14 min	15+ min	Total
1-4 Years	1	1	0	0	2
5-9 Years	1	1	0	1	3
10-14 Years	3	0	1	0	4
15-19 Years	3	3	1	0	7
20-24 Years	3	0	4	0	7
25+ Years	6	8	2	3	19
Total	17	13	8	4	42

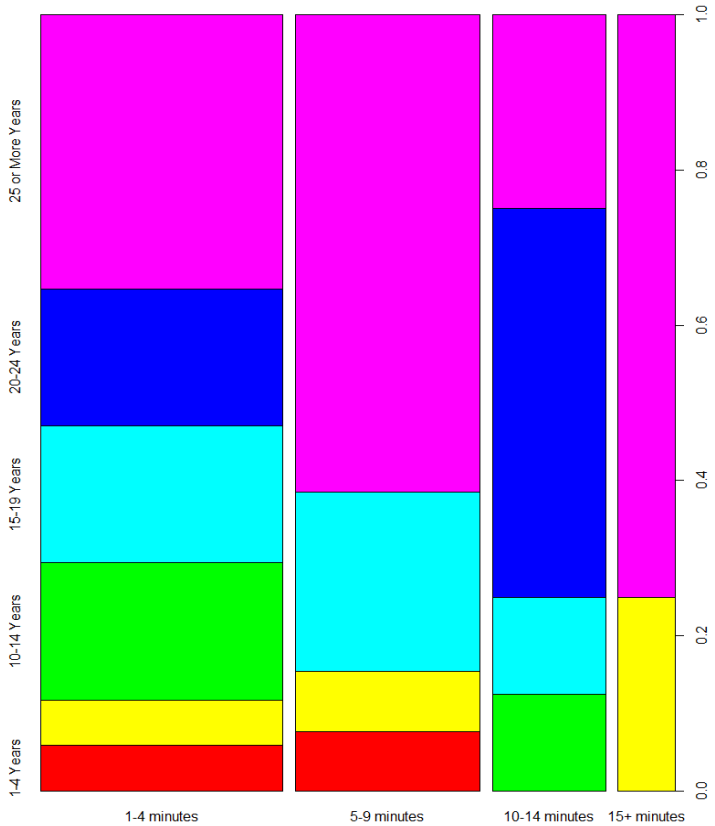


Figure 10

Again, reestablishing the connection between spending more time with patients by more experienced perioperative nurses, Figure 10 illustrates senior nurses proved to be dissatisfied with shortened time for presencing more often than less senior nurses are. Newer nurses and those with less experience in the Operating Room found their limited time adequate to comfort patients prior to surgery.

In the spirit of full disclosure, I must admit bias interpreting this finding. My own experience was that, when rushed, I was more apt to overlook important issues and rushing jeopardized patient safety and satisfaction. Elder nurses had learned it is possible to prevent a number of errors through nursing presence before surgery when the nurse provides a moment or two of distraction-free time with the patient. It is during the application of presence, when the patient is able to think and communicate clearly to the OR nurse, that errors are avoided. Presencing takes time.

The patient who senses the nurse's authentic interest in the moments before surgery avoids the "conveyor belt"[242] mentality that can lead to surgical errors. Gelene Thompson, speaking specifically about nursing presence in the perioperative setting states: "Showing genuine care and concern for patients is also good business. Patients are much less sedated than in previous years and they remember how they were treated while they were vulnerable, practically naked, and afraid. Anyone who has had a surgical procedure may recall the experience as one of the most anxious times of his or her life."[243] Showing genuine concern through nursing presence takes time.

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[242] Reynolds, 46.

[243] Gelene Thompson, "The Concept of Presencing in Perioperative Nursing." *AORN Journal* 82, no. 3 (2005): 468.

Is Time Usually Given to Establish Authentic Presence with Patient Adequate? vs. Operating Room Experience in Years

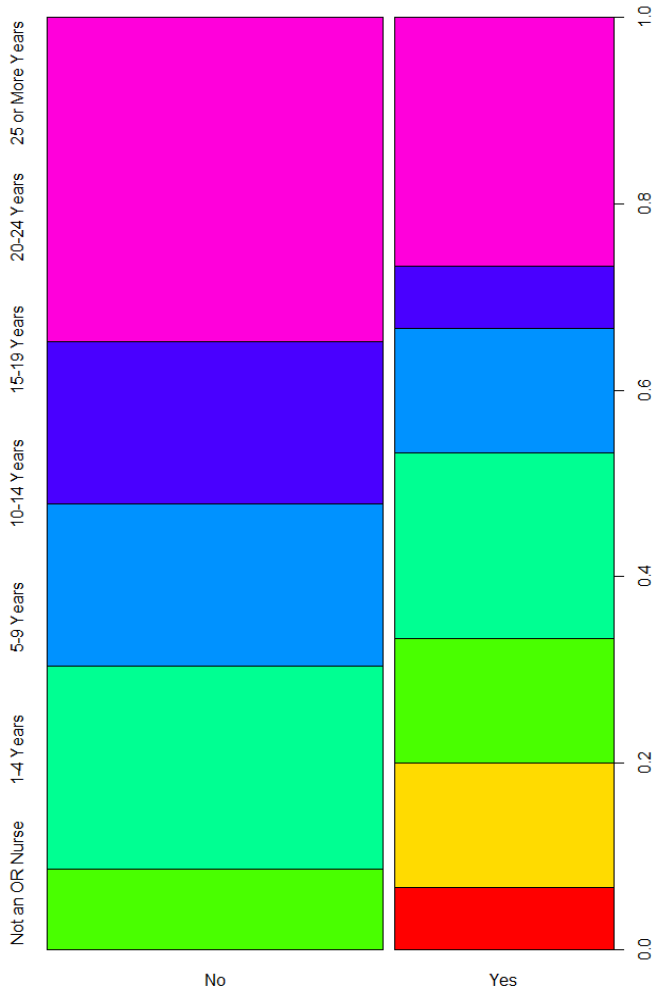
Spearman's rho *= -0.25* (weak, negative relationship)

Operating room nurses with *less* years of experience tend to consider the time usually given to establish an authentic presence with their patients to be *adequate*.

Operating room nurses with *more* years of experience tend to consider the time usually given to establish an authentic presence with their patients to be *inadequate*.

	Yes	No	Total
Not an OR Nurse	0	1	1
1-4 Years	0	2	2
5-9 Years	2	2	4
10-14 Years	5	3	8
15-19 Years	4	2	6
20-24 Years	4	1	5
25+ Years	8	4	12
Total	23	15	38

Figure 11



Of all the data produced by the study of perioperative nurses and nursing presence, Figure 11 is the single figure OR nurses would like to show their manager. That is, how much time do you really need to demonstrate to your patient you are there and with them? Fifteen minutes was the median (midpoint) number surveyed nurses wanted.

Interestingly, when discussing this fifteen-minute request of time with nurses from other disciplines such as Intensive Care Unit (ICU), Dialysis or Hospice, theses nurses are in disbelief. A nurse in one of these units spends hours and days with patients at a time: they reason, how could anyone dispute taking such a small amount of time with an anxious patient? Yet the possibility of having over nine minutes with a surgical patient before surgery was, for the most part, the perioperative nurses' impossible dream.

How much time would you ideally require to establish an authentic presence?

Mean = 13.8

Median = 15.0

Registered nurses who do not believe they are given adequate time to establish an authentic presence with their patients typically, ideally require 15.0 minutes of time.

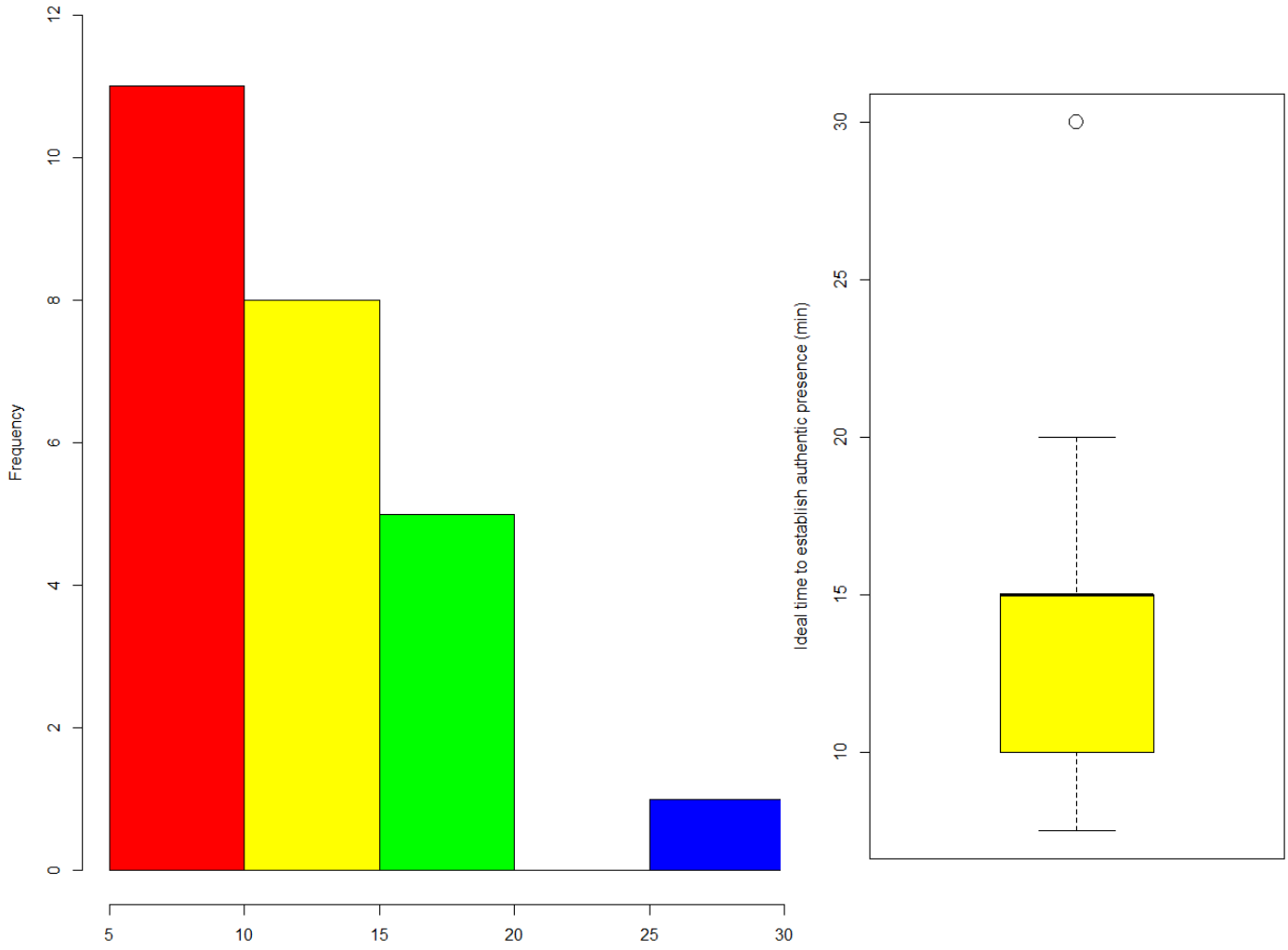


Figure 12

Figure 12 reinforces the data showing nurses with less Operating Room experience require less over all time before surgery with their patients. Although, it is possible that as time goes on and these newer nurses become more seasoned nurses, that time requirement may increase.

How much time would you ideally require to establish an authentic presence? vs. Time as a Registered Nurse

Spearman's rho *= 0.17* (weak, positive relationship)

Registered nurses with less years of experience tend to ideally require fewer minutes with their patients to establish an authentic presence.

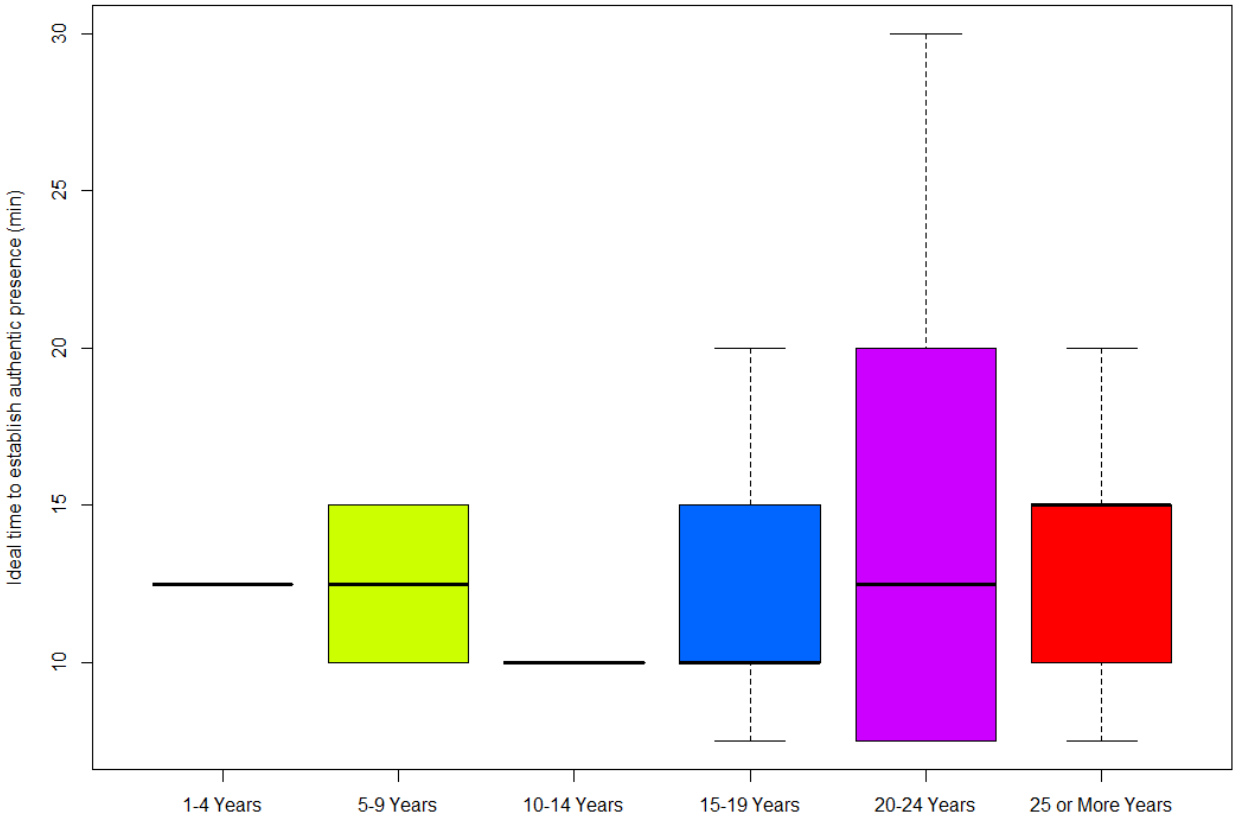


Figure 13

A succinct answer to how much time do perioperative nurses require for presencing is five minutes more than they already have. Interestingly, in visible areas of perioperative nursing such as patient positioning, scrubbing, or electronic charting, OR nurses complete the task efficiently and skillfully: rarely asking for more time. On the other hand, when performing an invisible, but just as valuable, intervention as nursing presence Operating Room nurses feel the pressure of reducing the little time they have. Although as discussed in Chapter two, nursing presence is invisible and un-chargeable but also critical for patient and nurse satisfaction and safety.

How much time would you ideally require to establish an authentic presence? vs. Time usually given

Pearson's R = 0.66 (strong, positive relationship)

Registered nurses who are usually given a low amount of time to establish an authentic presence with their patients tend to ideally require fewer minutes.

The registered nurses typically, ideally required about five more minutes to establish an authentic presence with their patient than they were usually given.

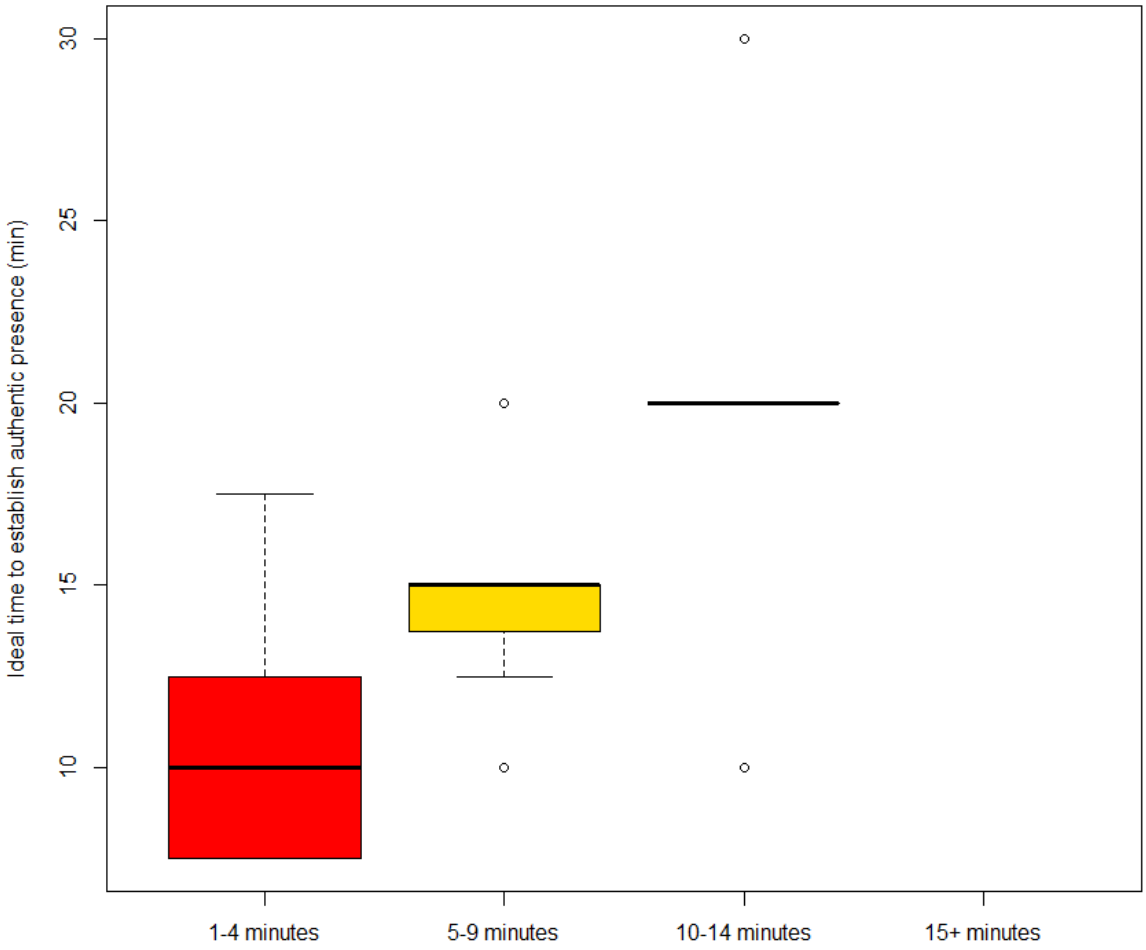


Figure 14

This graph is the wish list for perioperative nurses. For the most part, surveyed nurses wished for about five extra minutes with their surgical patients before surgery. Newer nurses and those with less Operating Room experience wished for less than an extra five minutes.

Figure 13 is telling in that perioperative nurses who took the time to respond to survey questions felt simply a few more minutes offering presence before surgery would be helpful. I feel these answers are honest ones since nurses were not extravagant in their estimation of how much more time they needed with their patients. More importantly, a request for five additional minutes in almost any other nursing discipline would be a reasonable request—a given; where as in the OR, the subject of additional minutes is viewed as unreasonable.

Still one has to acknowledge the absurdity of a situation where registered professional nurses in the critical moments prior to surgery must dream of having a few more minutes with anxious patients.

Any discussion of taking the time for nursing presence in the Operating Room eventually leads to the cost of this intervention. Utilization of time in the surgical unit has important implications on hospital finances and any request for additional minutes must be justified. The following chapter examines the global view of healthcare's financial philosophy as well as the OR's unique economy and its effect on hospital finances.

CHAPTER FOUR

THE BUSINESS OF PRESENCE

> We still have the same amount of work. We're just getting paid a whole lot less to do it.
>
> —*OR Manager*

Any discussion of nursing presence in the Operating Room (OR) would be incomplete without considering how nursing presence affects the Operating Room's financial picture. One could easily argue taking time to offer nursing presence is a waste of precious surgical time—precious time in a department that charges "per OR minute."[244] Efficiency in the Operating Room has important implications on hospital finances as well as "surgeon, patient, and staff satisfaction."[245] This chapter will discuss the association of nursing presence in the Operating Room with hospital economics—nursing presence through a financial lens.

My discussion of business and presence begins with a global view of the healthcare financial philosophy as it affects hospitals today. Then, because the Operating Room is a unique unit of the hospital closely tied to current medical products and costs, I will explore its particular economic culture.

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[244]Alex Macario, "What does One Minute of Operating Room Time Cost?" *Journal of Clinical Anesthesia* 22, no. 4 (2010):233.

[245] Katerina Sohrakoff, Carrie Westlake, Elizabeth Key, Elizabeth Barth, Joseph Antognini, and Vincent Johnson v. "Optimizing the OR: A Bottom-Up Approach." *Hospital Topics: Research and Perspectives on Healthcare* 92, no. 2 (2014): 22.

The next subject I examine is the influence of global and local business on the practice of Operating Room nurses and their use of time. Remote as it may seem, hospital financial analysts in the past have heralded driving Operating Room nurses to "reduce non-operative time by 5 minutes" as a breakthrough in cost containment.[246] Finally, there is the discussion of the cost of time in the Operating Room and the complicated formula used to calculate that time.

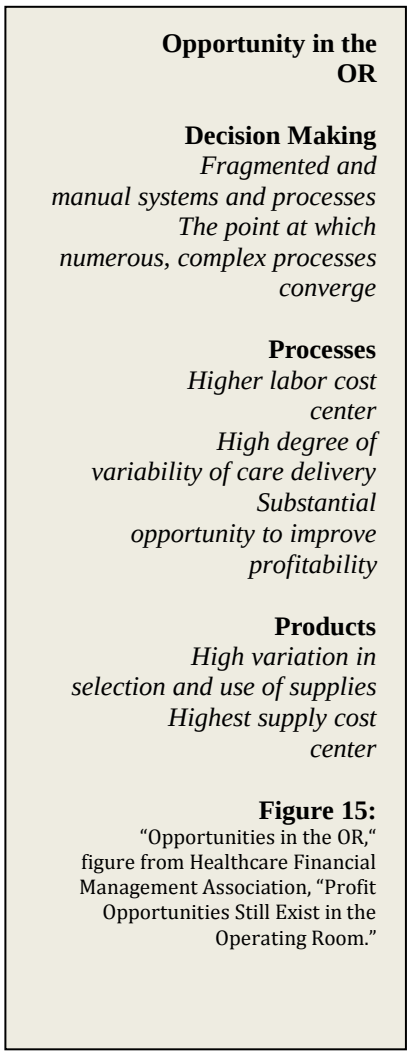

Figure 15: "Opportunities in the OR," figure from Healthcare Financial Management Association, "Profit Opportunities Still Exist in the Operating Room."

Healthcare's Financial Philosophy

It is hard to imagine that business analysts believe spending a few minutes of time offering nursing presence to surgical patients could jeopardize the solvency of a hospital. Nevertheless, that is the essence of financial predictions for the Operating Room. Healthcare Financial Management Association concludes in its report on profit opportunities, "the Operating Room represents the biggest opportunity" to increase profits.[247](Figure 14) "Increasing profits" in the OR is

[246] Dan Krupka and Warren Sandberg, "Reducing Non-operative Time: Methods and Impact on Operating Room Economics." *International Journal of Healthcare Technology and Management* 9 no. 4 (2008): 336.

[247] Healthcare Financial Management Association, "Profit Opportunities Still Exist in the Operating Room." (2002): 2.

financial-speak for trimming every available minute of idle, non-operative time by the surgical staff. [248]

The time between surgical cases is referred to as turnover time by those in surgical services, and it is the source of much discussion. Hospital economists believe turnover time is equivalent to non-operative time and as such is wasted time. The May 2014 issue of *OR Manager* captures Operating Room managers' viewpoint when it states, "Most perioperative leaders are concerned about turnover time. And rightly so—lengthy turnovers squander expensive OR minutes."[249]

To those familiar with the actual workday of the surgical team, non-operative time is anything but idle time or squandered minutes. Nurses find this mentality of non-operative-time-as-idle-time disturbing since it is only during the few minutes between surgical cases that perioperative nurses can meet their patients and offer presence.

As an Operating Room nurse, I am amazed that anyone would label the time from closing incision in one case to opening incision in my next scheduled case unproductive. To the contrary, every minute of turnover time is packed with absolutely essential tasks that are crucial for safety and efficiency. After each case the surgical team—for which I am responsible—clears the room of dirty instruments and equipment, has the room cleaned, as well as gathers and sets up instruments and supplies for the next case.

Orchestrating all of these activities in a matter of minutes with many participants, as well as centering myself enough to interview my next patient, and offer genuine

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[248] Krupka, 325.

[249] *OR Manager*, "Smart and Simple Process Changes Help Cut Case Times and Costs." *OR Manager* 30, no. 5 (2014): 1.

presence is a monumental task.[250] Personally, I am resentful of hospital financial analysts—I am imagining with softer hands than mine—who imply my surgical team and I are unproductive and slothful between cases. This chapter represents an effort to combine these opposing views on the value and cost of nursing presence—an attempt to integrate time consciousness with time for connectedness.

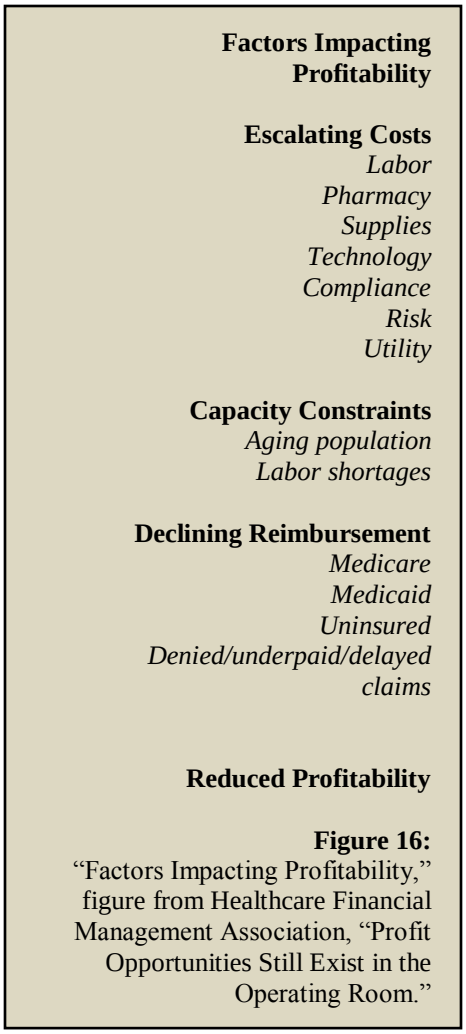

Figure 16: "Factors Impacting Profitability," figure from Healthcare Financial Management Association, "Profit Opportunities Still Exist in the Operating Room."

The healthcare industry is at an economic deadlock. Costs of doing business in the medical field have increased while reimbursement rates have decreased. (Figure 15) Escalating prices as well as shrinking income have created a financial vortex hospital economists cannot ignore. The remarkable challenge for healthcare leaders is to handle a volatile combination of rising costs, declining reimbursements, and increasing economic uncertainty.

OR Manager noted in 2011 that hospitals are experiencing declining revenue growth that meant lower growth rates leading to "nonprofits' rate of growth is the lowest in two decades." [251]

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[250] Sabriyna Rice, "Making Checklists Work." *Modern Healthcare* 46, no. 4 (2016): 1.

[251] Healthcare Financial Management Association, 2.

> With reimbursement pressure from the major payers—Medicare, Medicaid, and private insurers—falling revenue growth is a big challenge for nonprofit hospitals, Moody's Investors Service said August 9, 2011.
>
> "Continued rate reductions for Medicare are inevitable as Washington seeks to reduce the deficit and rein in program's costs," said Goldstein, the report's author. That's critical because Medicare makes up nearly half—43%—of hospitals' revenue.
>
> The lagging economy and unemployment mean fewer people are seeking care, including elective surgery.
>
> "This decline is noteworthy because stable-to-growing patient volumes are essential to revenue growth," said Goldstein. [252]

This state of reduced revenue growth is at odds with a greater demand for health services, with surgical services at the top of the list. Aging baby boomers are already on the verge of needing more medical care and more advanced care. Some predict "over the next fifteen years demand for skilled nursing and medical care will increase by 23 percent in patient days." [253] [254] Unless health systems improve their bottom line, increased patient volume will be more a detriment than an advantage.

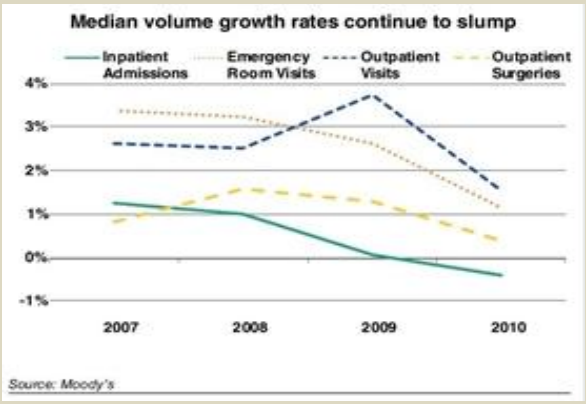

Figure 17: "Median Volume Growth Rates Continue to Slump," figure from Moody's Investors Service as cited in *OR Manager*, "Fewer Patients, Less Revenue for Hospitals."

[252] *OR Manager*, "Fewer Patients, Less Revenue for Hospitals." *OR Manager* 27, no. 9 (2011): 13.

[253] Healthcare Financial Management Association, 2.

[254] A patient day is the unit of measure for one patient to stay one day in the hospital; for example, 100 patients in the hospital for one day = 100 patient days.

(Figure 16)

Hospitals are entering an age of profitless growth; namely, a phenomenon where beds are full and resources maximized yet profits are at a standstill. Converging forces have created a decade of growth without growing profits. For two decades, healthcare organizations have faced dramatic changes in technology and medical advances: all with increasing price tags. Demographics of healthcare workers, labor markets, compensation, and benefit levels all compete for a portion of the healthcare dollar.[255]

Going forward to 2014 author Elizabeth Wood, writing in *OR Manager*, makes the following dire observations.

> A recent report from Moody's Investors Service paints a bleak picture. Its authors say that in 2013, expenses at not-for-profit hospitals grew by 4.3% while operating revenue growth dropped to 3.9%—down from 5.15 in 2012.
>
> The main culprits, not surprisingly, are lower reimbursement for services and the shift from inpatient care to outpatient care, according to Jennifer Ewing, a Moody's analyst and coauthor or the report. We expect continued financial weakening due to volume declines in a predominantly fee-for-service environment, reinforcing our negative outlook on business conditions for not-for-profit hospitals. [256]

Other factors to blame for the financial challenges hospitals face are a competitive healthcare market and higher patient care costs.[257] Malpractice claims and awards are on the rise. Publication of the Institute of Medicine's study of the consequences of medical

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[255] Angela Wicks and Linda St.Clair, "Competing Values in Healthcare: Balancing the (Un) Balanced Scorecard." *Journal of Healthcare Management* 52, no. 5 (2007): 310.

[256] Elizabeth Wood, "Untitled." *OR Manager* 14, no. 30 (2014): 1.

[257] Joe Williams, Michael Matthews, and Muhamud Hassan, "Cost Differences between Academic and Nonacademic Hospitals: A Case Study of Surgical Procedures." *Hospital Topics: Research and Perspectives on Healthcare*, (2007): 3.

errors has increased the public's awareness, creating enormous pressure for improved patient outcomes. Legislators, responding to informed and alert patients, have addressed patient safety and quality-of-care issues forcing hospitals to "reevaluate their care and delivery of service."[258]

The prospect of increased volume yet decreased profitability makes cost management the top issue for financial executives in healthcare. To survive, hospitals are adopting new strategic frameworks to evaluate performance with the goal of bolstering profits. Hospitals that shorten the revenue cycle reported higher profit margins and improved financial performance. So managing the flow of patients through the OR from surgical scheduling and patient registration at the front end of the cycle to billing and cash collection at the back of the cycle is crucial for hospitals to survive.[259]

Even considering all the foregoing factors, one has to ask, "How do all of these fiscal components affect the OR?" and "What could economics possibly have to do with nursing presence in the OR?"

A succinct answer to those questions is, nurse presence takes time and Operating Room time is expensive. Nurses work in a fixed time schedule and have to accomplish several nursing tasks within that clock time. Nursing time is, however, separate and distinct from clock time in that a nursing intervention such as offering a surgical patient caring presence must be completed regardless of clock time.[260]

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[258] Wicks, 310.

[259] Simone Singh and John Wheeler, "Hospital Financial Management: What is the Link Between Revenue Cycle Management, Profitability, and Not-for-Profit Hospitals' Ability to Grow Equity?" *Journal of Healthcare Management* 57, no. 5 (2012): 326.

[260] Riley, 547.

As established previously, of all the departments in the hospital the Operating Room historically has been a revenue-producing area. There is tremendous pressure on hospitals to improve the bottom line and they look to the OR to be a major contributor to that improvement.[261]

In 2002, Richard Jackson stated it was the "Operating Room driving 68% of a hospital's revenue."[262] That figure is virtually unchanged in 2013 as noted in *Healthcare Financial Management*.

> Considering that OR revenue accounts for more than 65 percent of margin in better-performing hospitals, the answer is critical.
>
> The bottom line is that OR revenue now depends on reducing surgical complications and readmissions, eliminating surgical errors, and controlling perioperative costs.
>
> Surgery is arguably the most complex of all hospital services. Every surgical procedure is the culmination of an intricate flow of information, equipment, supplies, processes, and expertise.[263]

Moreover, these figures do not include supportive services such as laboratory and x-ray departments that also do business in the OR. Nursing and medicine aside, sound economics demonstrate if any unit of a business, such as surgical services, produces most of its profits that is one's business. Hospitals are in the business of surgery. Adding to the economic equation of the Operating Room is the fact that the cost to the hospital for running the OR is 20-40% of its revenue.[264] It makes sense that any hospital-run

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[261] Pat Paterson, "For ORs, More Pressure to Perform." *OR Manager* 26, no. 5 (2010): 6.

[262] Richard Jackson,"The Business of Surgery." *Health Management Technology* 23, no. 7 (2002): 1.

[263] Jeffry Peters, David Young, John White, and Cindy Mahal-van Brenk, "Managing OR Revenue Under New payment Models." *Healthcare Financial Management*, 2013: 108.

[264] Jackson, 22.

department requiring high maintenance, high operating cost, and high profitability will also require high involvement by hospital administration.

How does financial accounting propose to maintain or increase this profit margin? Plans designed to augment Operating Room earnings include such strategies as monitoring, surveillance, streamlining, reducing costs, and increasing efficiency.[265] [266] [267] Studies continue to monitor how much time elapses between cases when cleaning and next case set up of the surgical suite takes place.[268]

Interestingly, even hospital initiatives billed as "a means to improve patient and staff satisfaction"[269] can mask an agenda of financial benefit that "senior leadership purposely avoided mentioning."[270] As a seasoned surgical nurse for two decades, I was proud of and comforted by the financial stability of my hospital; however, any program that ultimately jeopardized my patients or the care I gave would not have had my support.

OR Manager's editor Pat Paterson notes that surgical service directors nationwide are evaluating every minute of time in the OR including a "detailed look at turnover times"[271] as well as "walk time"[272] from the preoperative area to surgical suite. Nurses

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[265] Jackson, 20.

[266] Riley, 322.

[267] Michael Ryon, "Sacred Cows Revisited." *AORN* 80, no. 6 (2004): 1030.

[268] John Mathais, "Benchmarking OR Turnover Times." *OR Manager*, 2000: 17.

[269] Sohrakoff, 22.

[270] Sohrakoff, 22.

[271] Pat Paterson, "Cost Management for ORs Moves from Minor to the Major Leagues." *OR Manager* 27, no. 12 (2011): 10.

[272] Paterson, 10.

Riley and Manias remind us because time in the OR is so valuable control of that time is a "source of tension and power."[273] By virtue of the closed nature of the Operating Room, few people outside the OR can appreciate the enormous pressure and time constraints surgical nurses work under daily.

Measuring profit in the Operating Room as profit per minute, profit per case, profit per surgeon, and profit by service is part of the established financial surgical services strategy.[274] Hospital audits use computerized data to predict average times for every possible surgery performed by each individual surgeon. Electronic charting used by nurses in surgery has produced an ironclad method of observation by which hospital financial analysts scrutinize each surgery, each nurse, and each surgeon for wasted minutes or seconds. That is, nurses who circulate during surgery are responsible for "accurate time-stamping"[275] of the minute-by-minute activity of every team member as a way to identify squandered time.

Advice to sharpen the financial skills of Operating Room managers is given in *OR Manager* and includes how to measure productivity and efficiency of staff by Alecia Torrance, MBA, BS, RN, CNOR.

> The most effective measure of labor productivity, Torrance says, is worked hours per minute of surgery. For any given time period, obtain worked hours data from human resources and total surgical minutes from the perioperative information

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[273] Riley, 547.

[274] Jackson, 22.

[275] Surgical Directions, "Smart and Simple Process Changes help Cut Case Times and Costs." *OR Manager* 30, no. 5 (2014): 1.

> system. Worked hours should include both productive and nonproductive time for both direct care and support staff.[276]

The Operating Room's economic impact on hospital finance is no longer something that hospital management can take for granted or allow to self-run. Executives interested in maximizing OR returns are encouraged to hold the Operating Room manager[277] personally responsible for the profitability of each individual surgical case.[278] This mindset cannot help but have a trickle-down effect on perioperative RNs. Added to this increased pressure to perform is the lack of support from Operating Room management by failing to implementing changes that bolster and uphold nurses' professional responsibilities. Some hospitals have sought to reduce their perioperative workforce "through attrition, early-separation agreements, and lay-offs," leaving remaining nurses to provide more surgical care with less help.[279] Sigurdsson, writing in *AORN*, concludes that across the board ORs have recorded increased productivity "despite the reduction in full-time employees."[280]

Interestingly, when administrators impose changes in the Operating Room designed to speed up throughput[281] and reduce non-operative time, they rarely provide

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[276] *OR Manager*. "Master Five Key Concepts to Sharpen Financial Management Skills." *OR Manager*, 2015: 1.

[277] Operating Room manager is the individual responsible for facilitating scheduled operations, staffing, quality improvement, and job performance.

[278] Jackson, 22.

[279] Paterson, 10.

[280] Helen Sigurdsson, "The Meaning of Being a Perioperative Nurse." *AORN Journal*, 2001: 216.

[281] Throughput is the speed with which a patient is admitted, treated, and discharged from the OR.

corresponding support to help nurses fulfill their professional responsibilities.[282] Working harder and working smarter is now the lot of the perioperative nurse.

For years, management of the 300-bed community hospital I worked at in upstate New York expected the OR nurses to shorten the time it took to transfer patients from the operating table to stretcher after surgery. Hard as we tried most RNs simply could not move patients any faster than we already were. Keep in mind that after surgery patients are sluggish and confused by anesthesia as well as uncomfortable or in pain. Many patients have casts, drains, or urinary catheters making the transfer from the OR bed to stretcher a dicey maneuver at best. It was only after the OR director hired and trained an orderly—there are now three—to help with patient transfers that our numbers improved. This simple situation illustrates the law of diminishing returns because at some point perioperative nurses cannot work any faster, safer, or more efficiently than they already are without more help. Paula DeJohn's 2015 article on patient-centered-care in the Operating Room cautions, "it is all too easy to become involved in regulations, financial strategy, and technology—elevating the quality of care but leaving out the person who should be the center of the healthcare team: the patient."[283]Allowing time for nursing presence is an essential way to ensure surgical patients remain at the center of OR nurses' care.

The Business of OR Nurses

Sadly, amid all this data about time used, time wasted, and time needed, the literature is, for the most part, silent regarding time allotted for nursing presence in the

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[282] Riley, 553.

[283] DeJohn, 1.

Operating Room. Research does however exist about patient satisfaction and (non-OR) nurses' caring behaviors. Nursing presence and caring have many overlapping facets as they both involve nurse-patient give and take, sensitivity to the patient, and are "both employed by expert nurses."[284] Alvisa Palese and her international team studied 1,565 patients' perception of the value of nurse caring or connectedness: "Patients have shown that their satisfaction is mainly determined by 'positive connectedness.'"[285] True, patients appreciate a nurse's clinical skill but connectedness is what raises patient satisfaction scores.

Little research exist linking pre-operative nursing presence with nurse satisfaction, or more importantly, patient satisfaction. Once again, critics render OR nurses' contribution to the success of the perioperative department marginal and invisible. Decreasing throughput as well as trimming time between cases is the culture in most ORs. Ultimately, this time consciousness results in more responsibility for perioperative nurses.[286] Unrelenting pressure to increase speed equals more mistakes. Indeed a multinational study of Finnish, British, and American OR nurses confirms surgery is a complex environment that does not tolerate errors well.[287] The need to manage multiple demands simultaneously while providing high-quality nursing care in

[284] Papastavrou, 370.

[285] Palese, 342.

[286] Riley, 548.

[287] Silen-Lipponen, 21.

the Operating Room imposes crushing pressure on perioperative nurses and is a "documented source of potential errors."[288]

The Operating Room nurse in me would like very much to disregard the forgoing as heartless economics. Of course, that is a shortsighted idealistic view: without financial stability, there would be no hospital or Operating Room in which to practice. Nevertheless, it should be here noted that a healthcare financial analyst might have a different view of time and nursing presence if he lay in my OR about to undergo surgery. Would a minute or two of comforting nursing presence then constitute wildly extravagant care or would it be essential care?

Hansson and Soderhamn, both nurses,[289] point out the value of this pre-surgical conversation as allowing the patient to experience comfort from being treated as a unique individual. Although these two astute nurses suggest *creating* opportunities for preoperative dialogue: more often than not, time for comfort through nursing presence is *eliminated* by the constant sense of. To be sure, caring and being present are the hidden unrecognized, un-reimbursable time urgency work of nurses.[290]

Operating Room nurses view this high-speed pace as a threat to patient safety and the ability to provide appropriate support to surgical patients.[291] Surgical nurses are

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[288] Silen-Lipponen, 22.

[289] Elsa Hansson and Olle Soderhamn, "The Attitudes of a Group of Operating Room Nurses and Nurse Anaesthetists Towards Peri-Operative Conversation." *Learning in Health and Social Care* 3, no. 1 (2004): 37.

[290] Dax Parcells and Rozzano Locsin, "Development and Psychometric Testing of the Technological Competency as Caring in Nursing Instrument." *International Journal for Human Caring* 15, no. 4 (2011): 12.

[291] Riley, 324.

routinely rushed and driven to continue the rapid tempo by both anestheologists and surgeons. Maintaining the unrelenting speed needed to appease surgeons—for nurses in the OR—is inconsistent with high-quality patient care, safety, and good aseptic practice.[292]

The February 2009 issue of *OR Manager* was able to proudly declare that a particularly motivated OR team was proficient enough to shave 12.92 minutes off an orthopedic case.[293] Few nursing positions endure such intense scrutiny. Indeed, Riley and Manias use the philosophy of Michael Foucault, prison designer and author of *Discipline and Punish* to compare characteristics of the Operating Room to that of a theoretical prison. These authors parallel work in the OR as a nurse with work in a prison: given the confined spaces, constant surveillance, and detachment from society, at large.[294]

Clinical nurses in the OR dispute the ethics of continually striving to reduce non-operative time. Researchers Riley and Manias found nurses in surgery felt speed negatively affected aseptic technique and patient safety as well as caring interventions.[295]

To be sure, Overdyke and his team were able to reduce the time between surgeries by using a multidisciplinary approach and two weeks of efficiency training for the medical and OR staff. [296] Nevertheless, he concludes that just saving time is not always

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[292] Riley, 550.

[293] *OR Manager*, "Building a Business Case for Teams." 25, no. 2 (2009): 12.

[294] Riley, Robin and Elizabeth Manias. "Foucault Could Have Been an Operating Room Nurse." *Journal of Advanced Nursing* 39, no. 4 (2002): 316.

[295] Riley, 324.

[296] Frank Overdyk, Susan Harvey, Richard Fishman, and Ford Shippey, "Successful Strategies for Improving Operating Room Efficiency at Academic Institutions." *Anesthesia and Analgesia* 86, no.4 (1998): 896.

efficient. That is just because one can complete a task faster than before does not mean that the work is more efficient. If the quickly done task now requires more work of others, it is ultimately *in*efficient. Operating Room nurses feel it is self-contradictory and inefficient to rush through nursing presence with a surgical patient. After all, nursing presence is connecting with one's patient to the exclusion of distracting thoughts and time pressures.

David Tarantino, in his three-part series on Operating Room redesign, appeals to physician executives to hold the OR team to a 15-minute time limit for room set up between cases. He cautions that an increase in infection rates would reflect the sacrifice of sound cleaning practice for the sake of speed.[297] To distill Tarantino's re-design philosophy: OR staff should constantly compress or eliminate any non-operative activity, such as room cleaning, until postoperative infection rates go up. Operating Room nurses think proving the law of diminishing returns through postoperative infection rates is a poor strategy.

The Business of Presence: Benefits vs. Cost

Virtually every item used in an Operating Room is costly. Many supplies are one-time-use supplies that need to be discarded after they touch a patient. Manufacturers design surgical equipment for use with disposable pieces that need replacement after each case to avoid contamination and infection as well as a means of quality control. Single use items such as blades, bits, hand pieces, tubing, staplers, and positioning supplies—all sterile and disposable—contribute to the high cost of surgical cases. Even reusable supplies require decontamination, cleaning, and reprocessing by trained staff in a

[297] David Tarantino, "Process Redesign Part 3: Implementation." *The Physician Executive* 30, no. 2 (2004): 69.

dedicated department of the hospital. Nevertheless, few would dispute these expenses are simply part of conducting the business of surgery safely, responsibly, and sustainably.

I mention the expense of surgical supplies as a backdrop to the intervention of nursing presence that is by contrast low tech, low cost, highly effective, and highly efficient. Presence by perioperative nurses is frontline safety at its most basic level—human to human. Presencing by perioperative nurses is easy to implement, adjustable, and sustainable.

The article, The Effect of Nursing Presence on Patient Satisfaction," suggests hospital programs that encourage the use of presence and notes the following.

> The low cost of the intervention, ease of implementation, and potential for significant impact for both patients and financial considerations are strengths of such a program and warrant further testing and investigation.[298]

One has to wonder if technical language, computer software, expensive equipment, or sterile processing complicated the use of nursing presence would it have more value in the eyes of hospital economists. Considering the simplicity and effectiveness of nursing presence in enhancing the experience of patients undergoing surgical intervention, the financial wisdom of its use seems obvious.

The Business of Presence: Cost of Time

It must be here asked, if time is so valuable in the Operating Room, what is the exact cost of OR time? Does the cost of OR time justify compromising sterility, patient safety or forgoing the expression of nursing care through presence? Can one quantify the cost of the time for nursing presence with a surgical patient? Or does each nurse/patient conversation have its own value?

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[298] Penque, 44.

Although I continue to champion using OR minutes for nursing presence, it was not until I read Dr. Alex Macario's article, "What does one minute of operating room time cost?"[299] that I could grasp the complexity of such a question. What follows is a simplified version of Dr. Macario's simplified explanation.

The adage, "If you can't measure it, you can't manage it," is true even in the Operating Room. Knowing the actual dollar-per-minute price tag on OR time is information everyone in surgical services should be aware of. Squandering of a precious commodity, time for instance, is irresponsible and counterproductive especially in the Operating Room where the shortfall can affect everyone equally. Knowing the price of time in the OR is an essential step toward responsible use of time.

Improved management planning and control of valuable resources in the OR is consistent with responsible stewardship: OR nurses could not agree more. However, an estimate of what a commodity—such as time—costs depends on one's frame of reference. Obviously, nurses, insurers, hospitals, surgeons, and patients will estimate the value of time from a different angle. Ultimately the cost of OR time depends on the resources consumed and the unit cost of those resources.[300]

Reasons to measure the cost of time in the OR typically fall into four categories:[301]

- Economic decisions for use of resources
    - Purchase of new time-saving equipment
    - Update equipment to comply with safety regulations

[299] Macario, 236.
[300] Macario, 234.

[301] Macario, 234.

- Justification for reimbursement or as a basis for establishing fair price
    - Added time per surgical case for new procedure
    - New procedure using efficient equipment or expensive disposable goods
- To encourage or discourage the use of services
    - Encourage cost-saving procedures
    - Discourage unnecessary or wasteful time-consuming procedures
- To measurement income for external parties
    - End-of-fiscal year expenses
    - Cost savings from vendors for high-volume use

It is a challenge for hospitals to determine the true cost attached to the delivery of care. Since no published formal data on Operating Room costs exist, any figure would be a very broad estimation of costs. Individual hospital-specific elements that affect cost-per-minute are such things as fixed overhead costs and salaries of OR staff.[302]

When establishing a dollar amount for OR cost-per-minute it is important to clarify two important terms: cost and charge.

Cost = the amount of hospital expenditures in providing medical services. That is, cost is how much the hospital has to spend buying such things as supplies to deliver medical care.

Charge = the amount of money a hospital bills for a procedure. Hospitals do know what the exact charges on the patient's bill are but charge data are not a true reflection of what the cost is to the hospital.[303]

As preface to a discussion on cost-per-minute of OR time, it should be noted that hospital charges are determined over years. Updating the charge master[304] is infrequent;

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[302] Macario, 233.

[303] Macario, 233.

on the other hand, thousands of items have inflationary charges built into an ever-changing cost index. In truth hospital financial experts may be unable to explain the rational for some of their charges.

A hospital's costing approach affects the cost-per-minute of OR time. For example, if the cost-to-charge approach is used, the hospital estimates costs by computing the overall ratio of facility costs against overall facility charges. If a surgical case incurs an added charge, such as extra time, the item is multiplied by that ratio. Using the cost-to-charge ratio approach renders cost estimates for any item imprecise. In addition, ratios vary among hospital departments; for instance, the ratio for a surgical procedure may be 0.92, ratio for a bed on med/surg. 0.52, and ratio for ICU 0.37.

An alternative costing approach is micro costing. This method is more accurate in its charges but is also more difficult to institute because it requires every step of care analyzed and costed individually. Micro costing began when hospitals negotiated with payors for a single payment for a type of surgery; then hospitals needed to determine their exact costs to avoid losing money per case. An advantage to micro costing is the separation of costs into fixed and variable components. Fixed elements are such things as salaried labor, building expenses, hospital departments, insurance and housekeeping. Variable costs are such things as disposable supplies, sutures, medications, drapes, one-time-use items and intra-operative x-rays.

Now this is the important piece in understanding Operating Room time. Fixed costs do not change in proportion to the volume of surgical cases. Whether there are scheduled cases or not, the OR is heated, cooled, lit, insured and staffed. As patient

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[304] Charge master is a master list of chargeable items used by hospitals.

volume decreases, average cost per patient increases: spreading fixed costs among fewer patients.

Dr. Macario did provide some actual figures that are as follows:[305]

- For a U.S. hospital (not on a fixed budget) the contribution margin (monies the hospital is paid minus variable costs) is $1,000 - $2,000 per hour (not minute)
- A low complexity case may be billed at $29 per minute of OR time
    - (not including surgeon, or anesthesia)
- A high complexity case may be billed at $80 per minute of OR time
    - (not including surgeon or anesthesia)

In today's economic environment, it is imperative to realize the greatest potential for profit exists in the Operating Room. Hospitals are in the business of surgery. Operating Room nurses want their hospitals to be strong financially but they also realize taking time to offer nursing presence is worth the cost or maybe priceless.

[305] Macario, 233.

CHAPTER 5

CONCLUSION

> To listen there must be an inward quietness, a freedom from the strain of acquiring, a relaxed attention.
>
> —Jiddu Krishanamurti, *The Book of Life: Daily Meditations*

The same week I sat at my desk to pen the concluding chapter to this dissertation the current issue of *AORN*, the official journal of perioperative nursing, arrived in the mail. As if made to order, the journal included an article entitled, "Improving OR Efficiency."[306] There Patricia Vassell, DNP, includes a sample timeline for Operating Room team members outlining how many minutes each member should ideally spend with patients before surgery. The timeline is telling in that, of the three licensed professionals who interact with patients before surgery, it is perioperative nurses whose time allotment is the least—five minutes.[307] Surgeons and anesthesiologists rated more time with patients despite the fact they were the least likely to connect with patients other than ask a few routine standard-issue questions. Perioperative nurses, the professionals most likely to key into problems or provide emotional support, had one-sixth the combined time surgeons and anesthesiologists had with patients. Again, perioperative nurses are expected to do more with less.

Yes, nursing presence in the perioperative area, the subject of this dissertation, is still as timely now as it was when I began my surgical nursing career in 1995. Yes,

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[306] Patricia Vassell, "Improving OR Efficiency." *AORN* 104, no. 2 (2016): 125.

[307] This five-minute time slot likely includes such things as identifying the patient, arranging for antibiotics to be given, addressing problems, providing emotional support, *and* bringing the patient from a pre-surgical area to the OR suite.

patients undergoing surgical intervention still need caring nurses who are there for them and in the moment; that is, nurses who are present. And yes, OR nurses still need someone to give voice to their desire to connect and demonstrate true caring for their patients. These nurses offer their mindful presence and still need time to do that.

Conclusion One

Perioperative nurses want time to be present for their patients. The primary goal of this dissertation is to articulate the deep feelings of perioperative nurses and communicate their wish to support surgical patients through surgery to wellness. Creation of this dissertation is for that purpose. This goal might seem ridiculous to the uninformed who assume that nurses in the Operating Room have all the time they need to demonstrate genuine presence to their patients. Those unaware of the relentless time constraints of OR nurses would have no way of knowing these nurses are being monitored minute-by-minute and it is the turnover time—time for presencing—that has been earmarked for reduction or virtual elimination.[308]

Perioperative nursing is demanding, exhausting, and rewarding all at the same time. The noble and unique nurses who practice in the Operating Room have little time in a workday to spend formulating arguments in favor of more time for presencing with their awake patients, much less put those thoughts to paper. It is my hope that I have expressed their thoughts.

[308] Sohrakoff, 22.

Conclusion Two

Time for presencing by perioperative nurses is being phased out by hospitals in the interest of cost containment and speed.[309] True, long delays on the day of surgery are stressful for patients; however, the seminal article by Paul Mitchell reveals that the fast pace of surgeons and nurses alike on the day of surgery, "may do little to reduce the patient's anxiety."[310] Whereas, nurses who offer emotional support to patients through nursing presence are providing an intervention that is, "a known benefit to patient care."[311] Labeling the frantic tempo perioperative nurses must maintain as a patient-stress-reducer is simply unsupportable.

Conclusion Three

Operating Room nurses who are present and in the moment reduce surgical errors. The secondary goal of my writing is to address those who would minimize the importance of nursing presence. To be sure, Campbell and Davis argue that presence by nurses is fundamental to the nurse-patient relationship and is crucial to patient safety and the healing process itself.[312]

> Nurses feeling pressured for time because of the task-oriented business model of healthcare are much less likely to offer true presence or engage in any meaningful nurse-patient relationship and may, therefore, unknowingly ignore crucial details about the patient's mental, physical, or emotional state of suffering and deny appropriate care.[313]

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[309] Sigurdsson, 202.

[310] Mitchell, 356.

[311] Penque, 39.

[312] Campbell, 11.

[313] Campbell, 11.

Presencing by perioperative nurses is not frivolous chatting. Some contend presencing is the extravagant use of time—a limited commodity—yet nurses who are present for surgical patients are first-line defense against surgical errors. Errors in the Operating Room are costly, usually painful, and always unnecessary. It is false economy to think that a minute or two of nursing presence that avoids an error during surgery is too expensive.

Presence by perioperative nurses is that last minute distraction-free time when patients are able to think and communicate clearly. Speaking with perioperative nurses prior to surgery may be the first and last opportunity patients have to mention a condition or concern. However, there is no box to check for the application of presence in the chart; hence, this valuable nursing intervention is invisible and unchargeable. Nursing presence is a failsafe measure that derails the conveyor belt mentality that causes errors.

Conclusion Four

Nursing presence validates the surgical experience as the sobering event it is. Surgery for most people is life changing: being present and in the moment authenticates the grave nature of surgery to patients. Nurses who are present offer emotional support providing dignity and respect for patients who will soon be exposed and helpless. Surgical intervention is a serious undertaking, OR nurses through their presence, assure patients you are not a non-person, this is not a non-event.[314] William Cody, RN, distinguishes between nurses who bear witness by co-participating in their patients' experience and nurses who are detached onlookers observing suffering from afar.[315] Only

[314] Campbell, 8.

[315] Cody, 20.

nurses who are present are able to "attest to the authenticity" of an event and enable patients to feel listened to.[316]

Nurses Michelle Campbell and Lisa Davis explain that when patients experience the nurses' "authentic attendance" patients feel valued and respected.[317] Operating Room nurses who bear witness seek to understand surgery from their patients' point of view with an "awareness and openness to the entirety of the patient's needs without avoiding subjects simply because they are awkward or uncomfortable."[318] Validating and witnessing the surgical experience of their patients is exquisitely straightforward care by nurses who are present.

Conclusion Five

Nursing presence improves patient satisfaction scores more than any other intervention. The multi-national study by Palese et al. of 1,565 patients confirms that it is nurses' "connectedness" that mainly explains and improves patient satisfaction; whereas, nurses' "knowledge and skills" had no influence on patient satisfaction.[319] Nurses Sue Penque and Gina Kearney reported similar results in their 2015 study of nurses who were able to time their application of presence with patients. As little as 15 minutes of nursing presence—as evidenced by active listening, courtesy and mindful respect—correlated with statistically significant improvement in patient satisfaction scores.[320]

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[316] Cody, 18.

[317] Campbell, 7.

[318] Campbell, 7.

[319] Palese, 347

[320] Penque, 42.

Patients judge their care based on hard to quantify attributes such as the degree of staff "communication, sensitivity, and friendliness."[321] The importance of patient satisfaction scores intensifies when one realizes these scores are part of a formula used to grade hospitals and ultimately determine the reimbursement rates at which they are paid.

As with all grading systems, there are shortcomings: while surveys provide helpful information in quantifiable form, they cannot capture the rich details of care that make a surgical procedure good or bad for patients. Surveys may not list such things as nursing presence—possibly the single moment of true caring that made surgery endurable—thus patients never have an opportunity to grade their surgical experience in this essential element. At a "cognitive and emotional level," patients consistently connected more nursing presence with improved satisfaction.[322]

Conclusion Six

Perioperative nurses have literally minutes to offer their presence before surgery.[323] Developing a rapport in these few minutes, saturated with meaning for both nurses and patients, is a herculean feat that cannot be condensed further.

The author, Dufner-Mantore, documents the amount of time for presencing perioperative nurses in her study typically had with their patients. Surveyed nurses reported having an unbelievable one to nine minutes prior to surgery.[324] Yet again,

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[321] Deitrick, 317.

[322] Palese, 342.

[323] Vassell, 125.

[324] Dufner-Mantore, 105.

dwindling opportunities to offer nursing presence due to increased workload, decreased staffing, and the frantic tempo of work is the lot of surgical nurses.

The study by Coughlin et al. exposed an interesting phenomenon related to shortened nurse-patient conversations. Her study revealed there was a difference between the poorer ratings patients gave nursing care and the better ratings nurses gave that same care when there was limited time for nurse-patient interaction.[325] When patients were surveyed again, satisfaction scores improved the longer patients remained in the hospital; namely, patients were more satisfied with their nursing care when they stayed longer and there was more time to develop a good nurse-patient relationship.

Studies like those of Coughlin and Dufner-Mantore underscore the amazing job perioperative nurses accomplish within the limited time they have with their patients.

Conclusion Seven

Nursing presence is of benefit to OR nurses themselves. These added dividends of presence to nurses include reduction in burnout, increase in job satisfaction, and increased proficiency in presencing.[326] Nurses who offer their patients presence are connecting with them in an honest unfeigned way that renews nurses' commitment to a caring profession. Nurses, who are present, experience the enhanced consciousness and transformation of self that is the essence of nursing practice.[327] Interestingly, the symbiotic relationship between high staff satisfaction and high patient satisfaction is a

[325] Coughlin, 2335.

[326] McMahon, 75.

[327] Penque, 42.

documented correlation in some settings.[328] That is, when staff arrive to work committed and authentically present, patients respond positively which increases nurses' desire to connect.

This connection to patients through presence grounds the practice of surgical nurses and is the basis of self-care. It is during nursing presence and the shared experience that nurses receive the positive outcomes that combat burnout.[329] Deborah Finfgeld-Connet depicts this nurse-benefit as a sense of mental wellbeing and personal satisfaction, "a feeling of calm renewal and inner growth."[330]

Conclusion Eight

Operating Room nurses value presence but have limited time to offer it and would like more time for presencing. The majority of nurses surveyed by Dufner-Mantore displayed outward signs of presence almost always and inward signs of presence frequently or almost always.

The convenience study of 49 perioperative nurses conducted by the author, Rebecca Dufner-Mantore, revealed that 85.71% felt presence was "extremely important" and the remaining 14.29% felt presence was "very important." Of the surveyed nurses, 69.56% had less than nine minutes to offer presence to their patients.(Figure 7) In addition, the majority of those surveyed felt their allotted time was too short; that is, well over half—57.14%—of these perioperative nurses recognize this time as inadequate for safe nursing care.

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[328] Penque, 40.

[329] Finfgeld-Connett, 116.

[330] Finfgeld-Connett, 116.

Study respondents overwhelmingly valued nursing presence and offered the outward indicators of presence to their patients. These external indicators are smile, eye contact, leaning in, caring tone of voice, and appropriate touch. This group of surgical nurses also valued the private side of presence known only to nurses themselves. Perioperative nurses experienced inward indicators of nursing presence such as emotional availability, fellow feeling, connectedness, compassion, spontaneity, mutual give-and-take, and authentic interaction frequently or almost always.

Conclusion Nine

Offering nursing presence makes perfect economic sense. Given that essentially every item used in an Operating Room is expensive due in part to safety concerns and error prevention, a frontline intervention such as presencing is a bargain. Nursing presence by contrast has a low price tag compared to the benefits in patient response, improved patient satisfaction scores, and improved job satisfaction of nurses.

Authentic presence by perioperative nurses is a straightforward modality that essentially bypasses the involvement of other hospital departments or healthcare individuals: involvement that has the potential to complicate care, drive up cost, and lower effectiveness. Nursing presence is low tech and highly successful.

The undisguised presence of perioperative nurses prior to surgery is a means to humanize healthcare: its effect is cumulative in that patients are more likely to return to a facility where they felt their nursing care was genuine. In fact, the residual end product of nursing presence offered at a critical moment in one surgery may carry over to other surgeries as patients remember the encounter and are comforted again.

Future Studies and Significance to Nursing

Future studies of nursing presence could include demographic information and such things as age, gender, or ethnicity affect nursing presence. Years practicing in the Operating Room may also be a subject for examination: namely, do nurses newer to the OR feel time for nursing presence is as important as more senior nurses?

Continued research questions could investigate the quality of this presurgical time, the significance of the preoperative interview to patients as a moment to reflect, or asking that last important question before surgery. Nursing research subjects may include tension-relieving exercises as part of surgical nurse's preoperative interventions.

There is an additional call for studies that measure patients' perception of nursing presence given the healthcare climate and significance of patients' satisfaction scores to reimbursement rates. In addition, nursing has an obligation to develop new instruments based on the improved conceptual definition of presence and its benefits to both nurses and patients.

Concluding Thoughts

Taking a minute or two of distraction free time before surgery to connect with patients about to undergo surgery is a necessity, not a luxury, for perioperative nurses. Being present is a fundamental obligation for good nursing and one that OR nurses are not willing to abandon.

This writing emerged as the product of my twenty plus years of perioperative nursing. In some ways, I have been writing this chapter from my first day in the OR; it is a relief to put these thoughts to paper. It is wonderful to have researched information that

proves mindfulness by perioperative nurses in the context of surgical patients is essential for safe high-quality surgical experience.

I am hopeful nursing presence will continue to hold a valued and respected place in the practice of Operating Room nurses whose primary goal is to safely guide their patients through surgery to wellness.

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VITA

Full name: **Rebecca Louise (Hildebrandt) Dufner-Mantore**

Place and date of birth: **Milwaukee, Wisconsin September 30, 1948**

Parents' name: **Virginia Helen Billmayer and**

Lewis George Hildebrandt

Education:

Institution	School	Place	Degree	Date
Secondary	El Camino HS	Sacramento, CA	Diploma	June 1966
Collegiate	Orange County Community College	Middletown, NY	AAS	May 1999
Collegiate	College of Saint Elizabeth	Madison, NJ	BSN	January 2008
Collegiate	College of Saint Elizabeth	Madison, NJ	MSN	May 2012
Graduate	Drew University	Madison, NJ	DMH	May 2017