The cultivation of caring presence in nurses: a systematic review

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"Yahweh is my strength and my shield. My heart has trusted in Him, and I am helped. Therefore, my heart greatly rejoices. With my song I thank Him." Psalms 28:7

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ABSTRACT

Caring presence is crucial in quality healthcare since it promotes trust, honesty and boosts esteem for both the patient and the nurse; therefore, contributing to a high level of holistic care. Prior to this study, no research synthesis was available on cultivating caring presence. Such a synthesis will be very helpful in order to develop strategies for the cultivation of caring presence and to identify gaps.

The purpose of this study was to critically review available research-based literature on strategies to cultivate caring presence in nurses and, to synthesise research-based literature on how caring presence is cultivated in nurses.

A systematic literature review was conducted, using an explorative and descriptive design. The five steps for a systematic review as adapted from the Academy of Nutrition and Diabetics Manual (academy of nutrition and dietetics) (2016) were followed. These steps included formulating a focused review question, gathering and classifying the evidence, conducting a critical appraisal, summarising evidence and drafting conclusions.

After the execution of the first two steps, a sample of 19 studies was obtained, and was eligible for critical appraisal after which 17 studies were finally included. Studies that met the inclusion criteria were retained for data extraction, analysis and synthesis. These studies included qualitative studies (n=4), literature reviews (n=5), a meta-synthesis (n=1), case reports (n=3) and text and opinion (n=3).

Five main themes, with or without sub-themes, emerged from the synthesis. The main themes included that caring presence in nursing can be cultivated through critical thinking skills and awareness, holistic care, awareness of the concept of presence and types of presence, fostering personal and professional growth and, the cultivation of caring presence through reflection.

This systematic review answered the review question which is: what strategies lead to the cultivation of caring presence in nurses in order for them to enact caring presence, improve their wellbeing and, to frequently improve the wellbeing of the patients. Strategies to cultivate caring presence in nursing emerged in the form of themes, sub-themes and conclusions synthesised from the available literature. The limitation, that evidence on how these strategies cultivate presence could not be found, is acknowledged. However, valuable suggestions through which caring presence can be cultivated in the clinical settings and in nursing education could be made, as well as recommendations for nursing practice, education and research.

KEY TERMS:

Caring presence, healing presence, nursing presence, therapeutic presence, cultivation, nursing

LIST OF ABBREVIATIONS AND ACRONYMS

AND: Academy of Nutrition and Diabetics Manual

CNS: Clinical Nurse Specialist

CRD: Centre for Reviews and Dissertations

DoH: Department of Health

HREC: Health Research Ethics Committee

NDoH: National Department of Health

NWU: North-West University

OPHLA: Ontario Public Health Libraries Association

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CHAPTER 1:
OVERVIEW OF THE STUDY

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1.1 Introduction

In this study, a systematic review was conducted with the aim of synthesising and describing the best available literature on cultivating caring presence among nurses. In Chapter 1, an overview of the background is given, followed by the problem statement, the rationale for the current study, the research question and purpose of the study, paradigmatic assumptions, the research design and methodology, measures to ensure rigour, ethical principles and structure of the study. Chapter 2 focuses on the methodology used in conducting this study. Chapter 3 focuses on data analysis and presentation of the findings of the study, while Chapter 4 focuses on the conclusions, recommendations and limitations of the study.

1.2 Background

Caring presence, as a concept, emerged in the 1960s and has been discussed within and outside nursing literature (Bright, 2013: 3). Researchers maintain that caring presence is crucial in quality healthcare since it is profitable to both health care workers and patients (Du Plessis, 2016b:49). Although research has been conducted on caring presence worldwide, few studies have focused on South Africa and no systematic review has been done on cultivating caring presence in nursing, hence the rationale for conducting this study.

Currently, there is a need for caring presence in nursing. Looking at the current situation in South Africa, the South African Minister of Health, Dr Aaron Motsoaledi, emphasised that it is essential to upgrade the quality of healthcare in order to promote self-confidence of nurses and the well-being of patients in public and private health institutions and, to improve South Africa's existing poor health care (NDOH, 2011a: 5). Six domains have been identified in the National Core Standards (NDOH, 2011a) for the attainment of better quality care, namely, cleaner facilities, shorter waiting time, better safety of patients and care, prevention of acquired infections, ensuring availability of medicine and accomplishing a more positive esteem and consideration among health care workers and managers. All these areas require caring and respectful attitudes towards patients and among health care workers (NDOH, 2011a: 5). Furthermore, the National Core Standards for quality improvement and health establishment stresses the importance of domains in caring for patients such as providing safety for patients and the respect of patient's rights in accordance with "Batho Pele" (people first) principles and the patient's right charter (NDOH,

2011a:16). One way to convey such a caring attitude is through caring presence. Caring presence is cosmopolitan and is, therefore, discussed in many studies that emphasise its importance in quality healthcare (Bright, 2013; Du Plessis, 2016a; McMahon & Christopher, 2011).

Caring presence can be a natural gift or acquired from childhood, but can also be learned through on-going training, and throughout the years as experience and maturity is gained (McMahon & Christopher, 2011: 75). Caring presence must be encouraged from the first level in nursing education (McMahon & Christopher, 2011:75). Caring presence can be cultivated through self-care practices, reflection on transformative experiences during practice and through role-modeling (Bright, 2013: 6). Another approach is to emphasize traditional nursing arts such as holding hands, being with patients, sitting and talking to them and giving backrubs (Tokpah & Middleton, 2013: 91). On-going training in spiritual care in nursing may also contribute to cultivating caring presence in nursing (Bright, 2013: 6).

Being present during care, is an advantage, as it promotes trust, honesty and boosts esteem for both the patient and the nurse; thus, contributing to a prominent level of holistic care (Du Plessis, 2016b: 50). Another rationale for the significance of caring presence is that it can be used by nurses to assist patients overcome psychological challenges and trauma they are going through (Winship, 2015: 744). Caring presence improves mutual respect among patients and nurses, trust, self-respect and honesty (Du Plessis, 2016b: 50). Caring presence can be used by leaders in health care institutions such as nursing managers to promote professional growth, empower staff, foster career development, improve job satisfaction among members of staff and achieve high quality care (Peng *et al*., 2015). Caring presence can also be used to achieve spiritual means and healing (Du Plessis, 2016b: 47; Pfeiffer *et al*., 2014: 2893; Ramezani *et al.*, 2014: 211).

Patients also benefit when nurses demonstrate caring presence. A good example of a patients' perception with regard to such caring attitude is provided in a meta-synthesis description of literature about adult patients' satisfaction with nursing care across the world as follows: "They could speak to you more respectfully. They did not treat you as though you were some kind of a funny-patient. You had a name. You had a personality, you had needs and you had wants. The district nurse has known my family for decades and understands my situation…She sees me as a human being" (Chawani, 2009:69).

However, there is concern that South African nurses do not always demonstrate caring presence. Rude and impatient behaviour has negative and disastrous outcomes such as lack of trust from the patient, loss of dignity and value, embarrassment, lack of competency from staff, bad ethical conduct and even in the death of patients (Lachman, 2012: 112; Oosthuisen, 2012: 53). The following illustration by Hosken (2009: 1) is a typical example of such negative behaviour:

> *"I was ready to die. I had made peace with my God and was ready to go." These are the emotional words of Pretoria pensioner Fanie Jansen van Vuuren, 58, who described the ordeal he allegedly suffered at the hands of Steve Biko Academic Hospital nursing staff as "hell on Earth". "If it had not been for the Pretoria News, I would have died," he said. Maritz's (Jansen's partner) daughter contacted the Pretoria News out of desperation after her mother broke down in tears in front of her on Wednesday night while describing how Jansen van Vuuren had been lying in his own faeces for nearly three days. He was in hospital for follow-up operations after his colon was removed late last year because of cancer. The operation left Jansen van Vuuren in pain with nurses apparently neglecting him when it came to cleaning and dressing his wounds. The situation became so bad that excrement leaked from his open wounds, spilling out on to his bed and the floor of his room in the surgery ward. "He repeatedly called nurses, but no one came. They just ignored him and when he stood up to get help, his wounds opened up and the stuff poured out on the floor. Even after this happened, no one came to help. "It is not fair. No one, rich or poor, should be treated like this."*

Consequently, the South African Department of Health has called for better quality care for patients. This can be achieved through improving elements of good care such as caring presence in order to foster South African's poor health (NDOH, 2011a; NDOH, 2011b). Moreover, literature stresses the importance of caring presence as a core element for quality care (Bright, 2013: 16). Nurses should be encouraged to acknowledge and implement a caring attitude, such as caring presence, uninterruptedly to achieve better quality care in South Africa (NDOH, 2011a: 8).

1.3 Problem statement

From the above background discussion, it is apparent that caring presence is essential for the improvement of quality care (Canzan *et al*., 2014: 738; Harrison, 2009: 3) and that it can and should be cultivated in nurses (Tokpah &Middleton, 2013: 91). Bright (2013: 95) maintains that challenges encountered by nurses in their personal life and in the working environment cause anguish, affect their caring presence and lead to mediocrity in terms of care. Furthermore, in another study on caring in the geriatric context by Canzan *et al*. (2014 737), the skills, ability to work, knowledge and values of nurses were found to be crucial elements in achieving caring presence and delivering quality care.

Furthermore, Packard *et al.* (2008: 96) found that role modeling presence and 'being with' in teaching and learning is transformational. Poynton (2011: 3) points out that caring presence can be taught when teaching holistic nursing, psychological aspects of nursing, the nurse-patient relationship, quality control and patient satisfaction. De Natale and Klevay (2013:125) discuss their experience using Parse's theory on human becoming to guide students in teaching and learning, namely; to enact free-flowing attentiveness with the other in active stillness and how this approach helps students to understand that being present is foundational in honoring quality of

life and respecting others' choices. Another example of research on how to cultivate caring presence is that of McCollum and Gehart (2010:347), who suggest a curriculum that makes use of journaling, in-class meditation exercises and mindfulness practice such as walking, prayer, breathing and reflection.

Prior to this study, no synthesis of literature had been available on cultivating caring presence. Such a synthesis will be very helpful in order to develop strategies for the cultivation of caring presence and to identify gaps. This will guide nurses and nurse managers/leaders on how to develop caring presence in nurses, hence the rationale for conducting this study. It is important to research more on strategies to foster caring presence in order to understand and promote its application in nursing (Bright, 2013: 24, Canzan *et al*, 2014: 733; Du Plessis, 2016b: 52; Winship, 2015: 745) and to promote quality health care in health care institutions and communities at large (Trajkovski *et al*., 2013: 98; Bright, 2013: 18).

1.4 Research question

From the above problem statement, the following research question was formulated:

What strategies are available on how caring presence can be cultivated in nurses?

1.5 Purpose of the study

The purpose of this study was to:

- Critically review available research-based literature on strategies to cultivate caring presence in nurses; and
- Synthesise research-based literature on how caring presence is cultivated in nurses.

1.6 Paradigmatic perspective

A paradigmatic perspective is an assumption one considers based on learned and lived experiences (Tackett, 1997:1). In this study, the paradigmatic perspective entails meta-theoretical, theoretical and methodological assumptions as discussed below.

1.6.1 Meta-theoretical assumptions

Meta-theoretical assumptions are the researcher's own beliefs and worldview. The researcher's assumptions on central concepts in nursing, namely; person, nursing, the environment, health and illnesses/diseases are relevant for this discussion.

1.6.1.1 Person

The researcher's belief is that a person is created by God who made him or her in His image. In Genesis 1:27 (Holy Bible: New King James Version, 2013: 2), it is written that "God created man in His own image, in His image and His likeness He created him; male and female He created them." Thus, a person has three dimensions, namely, Spirit, Soul and Body (Holy Bible: New King James Version, 2013: 1441) and each person is unique and, consequently, his/her own characteristics may differ from others. According to the researcher, this entails that being created in God's image, a person has to be treated as a unique being, with respect, consideration and dignity.

In this study, a person is used to refer to patients and nurses, created by God and consequently, their right to respect and dignity should be carefully considered. Additionally, they are viewed holistically within a caring environment, taking all aspects of the person such as his/her background, environment and values into consideration (Geyer *et al*., 2011: 21).

If a person is referred to as a "holistic being", it means that the entire system pertaining to the specific person is taken into consideration rather than focusing on some parts, such as the physical, mental, social and spiritual welfare of the person (Olorunleke Igunnuoda, 2015:7). The researcher believes that before taking any decision or action while caring for a patient, he/she must be aware and, where possible, always involve the patient's relatives or members of the family since they usually share the same values and are part of his or her life. The researcher also understands from empirical experience that the patient's family and his/her community play a crucial role in the patient's care and wellbeing. Caring presence is a meaningful approach to providing such holistic, respectful care.

1.6.1.2 Nursing

The researcher agrees with the definition of nursing as defined by the American Nursing Association (ANA 2016: 1) which states that nursing is "a career in which nurses have the responsibility to give comprehensive care and sympathising with the sufferer". This includes recognising when death is near and conveying that information to families. Nurses should collaborate with other members of the health care team to ensure optimal symptom management and to provide support for the patient and family. "Nursing is broadly all activities performed by nurses and is concerned with restoration or maintenance of individual and community health holistically with consideration to the physical, psychological, emotional, spiritual and social demands of that specific individual" (Shamian, 2014: 867). The researcher, therefore, considers nursing to be a science and an art of caring, of which caring presence forms an integral part.

The application of nursing to this study pertains to being with the patient as a nurse and providing him/her with a supportive environment for health, comfort and shared humanness, and connectedness. Caring for patient as a nurse entails following a holistic approach, seeing a patient as a whole and even beyond their disease process in order to achieve the promotion of health, the prevention of illness and to help those patients at the point of death to die peacefully and with dignity.

1.6.1.3 Health

According to the researcher, health is the state of being mentally, physically and emotionally well, which is best achieved by meeting the needs for the body, soul and spirit. Additionally, the researcher concurs with the following definition of the World Health Organisation (WHO, 2011: 2) that "Health is a state of complete physical, mental and social wellbeing and not only the absence of infirmity and illness". Thus, in this study, it was crucial for the researcher to find research-based literature on caring presence in order to promote caring presence among nurses, to facilitate health.

1.6.1.4 The environment

An environment is the totality of surrounding conditions or the area in which something or a person lives. In this study, the environment refers to a person's environment. Both the internal and external environment of patients will be considered in this research. The external environment is the physical environment and comprises the things a person is exposed to from the existence of the person within an environment such as where the person lives, works and does physical activities. The internal environment provides adjustment to adapt to the external environment and comprises the body, the mind and the spirit. The components of the internal environment must be in equilibrium in order for a person to attain his/her optimal healing (Samueli Institute, 2013:11). Therefore, an environment is an important determinant of health and health care workers and nurses have to practice caring presence to provide the patient with a therapeutic environment, taking into account, the patient's physical, spiritual and social factors and using the best available resources in order to meet the patient's needs in order to achieve his/her optimal level of health.

1.6.1.5 Illness/disease

The researcher considers illness as the deterioration of health, whether physically or mentally. A person is ill when he or she is no longer able to do what he or she can normally do, whether physically or mentally. The way people perceive and deal with things in their environment has an impact on their health and can determine whether a person can become ill or not and at which level can this illness affect them. Social stressors, for example, can make a person mentally and even physically ill. Usually, people's coping mechanism with regard to social stressors differ, thus

making each person a unique identity that has to be treated uniquely during care. In this study, therefore, each individual affected by illness must be cared for, through caring presence, as a unique identity and with regard to the specific condition they are presenting with.

1.6.2 Theoretical assumptions

Theoretical assumptions are knowledge and facts that can be proved and are testable (Brink *et al*., 2013: 68). The theoretical assumptions of this study comprise the central theoretical assumption as well as the theoretical clarification of concepts relevant to this study. The rationale for conducting this study is summed up in the central theoretical assumption.

1.6.2.1 Central theoretical assumption

No synthesised information could be found on practices with regard to the cultivation of caring presence. The cultivation of caring presence is crucial in quality care since it is profitable to both the health care worker and the patient (Du Plessis, 2016b: 49). It is an inter-subjective process which is unique, holistic, sensitive, and intimate, and the nurse displaying caring presence is able to adapt to specific contexts (Bright, 2013; Du Plessis, 2016a). Although research has been conducted on caring presence, no systematic review regarding the cultivation of caring presence in nurses has been done to inform nursing practice. Research on the cultivation of caring presence among nurses is essential to counter the existing poor-quality healthcare in South Africa. Thus, the results of this systematic review will allow a better understanding of the phenomenon and provide a synthesis of the best available literature on the cultivation of caring presence

1.6.2.2 Concepts relevant to this study

1.6.2.2.1 Caring presence

As described by Bright (2013:17), caring presence is a reciprocal behaviour between the nurse and the patient, the focal point being the patient and, is achieved through paying attention to their needs and being wholly committed intentionally for healing purposes.

1.6.2.2.2 Cultivate

The researcher concurs with the definition of cultivate as defined by the Oxford Dictionary (2016) as follows: “socialisation through training and education to develop one’s mind or manner. It also means to foster the growth of something”. In this study, ‘cultivate’ refers to developing caring presence in nurses in order to enable them to enact caring presence, leading to an improvement in their own wellbeing, as well as the wellbeing of patients, and to better quality of care.

1.6.2.2.3 Nurses

According to AHNA (2015:6), “a nurse is a person responsible for doing practices in the sphere of the nursing profession which entails using a holistic caring process of assessing the needs of the individual, doing a therapeutic care plan, an implementation and evaluation of the outcome, taking into consideration the physical, psychological, social, emotional and spiritual wellbeing of the individual and with the aim of healing the whole individual.

1.6.2.2.4 Strategies

According to the oxford dictionary (2016), strategy is a general plan or set of plan intended to achieve a goal especially over a long period of time.

1.6.3 Methodological assumptions

The research model in accordance with the theory for health promotion in nursing (Botes, 2002:12) was adopted in this systematic review. In this model, the research process focuses on a holistic view and the fundamental concern is on the promotion of health. In this model, nursing actions are separated into three interrelated levels, namely; nursing practice, the theory of nursing and research methodology (nursing science) and the paradigmatic perspective (Botes, 2002: 9). Research relates to all these levels and are guided by all three of these levels.

The first level is the practice of nursing. It is mainly empirical and comprises all fields of nursing practice in order to achieve health promotion for the patient. The nurse is involved to interact with the patient, applying knowledge and skills grounded on nursing practice. The interpretation of the patient with regard to the practice or service offered by the nurse is then analysed and, if found correct, is considered in future as the knowledge base of the profession. In this study, knowledge generated at this level and published as research-based literature, was considered in the systematic review.

The second level involves nursing science and research methodology. This level is generated through research and brings forth theory for a better understanding of the nursing practice. The result is that researchers generate theory related to practice from research and knowledge generated is applied by the nursing practitioner. In this study, nursing science and relevant research methodology guided the systematic review, to provide a synthesis on how caring presence can be cultivated, that can be used by nurses in different settings.

The third level, the paradigmatic perspective of nursing, entails convictions that are meta-theoretical, theoretical and methodological in nature and that are aligned with one another. In this study, the researcher used a research method that is in line with her meta-theoretical and theoretical assumptions. The meta-theoretical assumptions are based on the researcher's Christian and holistic worldview (as stated in 1.6.1).

1.7 Research design and method

An explorative and descriptive research design (CRD, 2009:226) was adopted in this study, following the steps of a systematic review outlined in Table 1.1.

Table 1-1: Steps of the systematic review process (as adapted from the Academy of Nutrition and Diabetics (AND) Manual, 2016: 6)

STEPS	BRIEF EXPLANATION OF ACTIONS TAKEN
Step 1:	Formulation of a focused review question of interest using the PICOS format (Population, Intervention, Comparison, Outcome and Study design)
Step 2	Systematically gathering and classifying literature using a search strategy to find literature to answer the research question relevant to the study and selection of studies to be included.
Step 3	Conduct a method-specific critical appraisal for each study report: Instruments such as CASP, EA and JHNEBP were used to critically appraise studies
Step 4	Summarising of evidence: this entails extraction, analysis and synthesis of data.
Step 5	Drafting the conclusions: this step was used to answer the research question, state the strengths and weaknesses of existing literature and provide a conclusion for the study.

The design and steps of this systematic review are discussed in detail in Chapter 2.

1.8 Measures to ensure rigour

According to Mallet *et al.* (2012:447), if the review lacks methodological rigour, it will not yield consistency and truthfulness in the results. The use of an objective, clear and strict approach of the entire procedure which met the inclusion and exclusion criteria in the systematic review is thus, essential in order to ensure that the study is unbiased (Mallet *et al*., 2012:446). Rigour was attained by developing and using a fixed protocol/procedure for the systematic review. This systematic process, and recording of the execution of the process, using tools such as the evidence worksheet flow chart and tables (see appendices A to G), helped to ensure rigour.

During the review process, inclusion and exclusion criteria were used to select studies in order to prevent investigator bias. These criteria were developed in line with the purpose of the study and the research question. The researcher consulted a subject librarian in order to ensure that all relevant studies regarding the cultivation of caring presence were identified and included (Kitchenham, 2004:7). Grey literature sources were critically appraised for quality and, included in order to ascertain a high level of sensitivity and depth.

Furthermore, during the critical appraisal step, an assessment was done to determine the quality, strength and weaknesses of studies. All studies which met the inclusion criteria were reviewed and assessed for quality and later, those considered were synthesised. This process also assisted in determining the efficacy and contribution of the study to quality care (CRD, 2009: 33).

To avoid inconsistency and promote increased validity, the researcher critically analysed, evaluated and interpreted the studies concerned. An independent reviewer also assisted at different stages such as during the selection of the studies, during critical appraisal and during data synthesis (CRD, 2009:34).

In order to ensure that only high-quality studies were included in the review, the researcher ensured that the full text of each study could be found and a list of the studies excluded as well as the rationale for exclusion were kept to prevent selection bias (Kitchenham, 2004:10).

1.9 Ethical considerations

The researcher was guided by the principles of ethics in health research as discussed by the Department of Health (DoH, 2015), as well as by the principles of ethics in conducting a systematic review (Vergnes *et al.*, 2010, Wagner & Wiffen, 2011).

1.9.1 Relevance and value

Since this study is relevant to the wellbeing of both nurses and patients, it is ethically warranted.

1.9.2 Scientific integrity

The researcher verified the originality of studies to be considered before consideration in the study (see Table 3.4.1) (Vergnes *et al.*, 2010: 773). Plagiarism was avoided by ensuring full acknowledgement of the authors of the studies considered. Furthermore, transparency was ensured by acknowledging all contributors in the systematic review (see section 1.12.8), by declaring any conflict of interest (see 1.12.9) and by means of accurate data extraction (Wagner & Wiffen, 2011: 133).

1.9.3 Role-player engagement

Before embarking on the systematic review, a search strategy was determined in consultation with an independent reviewer and a subject librarian and their roles determined. The researcher extracted data, two expert supervisors as well as an independent expert, reviewed the entire process of the systematic review to ensure rigour.

1.9.4 Fair selection of evidence

During data extraction, the principle of fair selection of studies was done (see Tables 3.4, 3.5 and 3.6). Studies on strategies to cultivate caring presence were also considered in this study.

1.9.5 Fair balance of risk and benefits

Since this study is a systematic review, no risk was involved as no human beings were directly involved as participants and no consent from participants was required (Greeff, 2016: 198). The authors of the studies considered were acknowledged in order to avoid plagiarism. Participants in the original studies were protected by ensuring that ethical principles were followed in the original studies, for instance, noting whether an independent committee provided permission for the study to be conducted and whether informed consents were obtained, noting the qualifications of the authors as well as the benefit-risk ratio of the studies (Vergnes *et al.*, 2010: 773). Furthermore, ethical principles were adhered to such as maintaining honesty and integrity throughout the systematic review and in the accuracy of the report. The benefit of this systematic review is that it provides reliable information on the cultivation of caring presence in nurses, to be used by role players such as nurse educators and nursing managers to cultivate caring presence in nurses. It also provides valuable information on cultivating caring presence, which could guide future research.

1.9.6 Ongoing respect for participants, including privacy and confidentiality

No human participant was directly involved in this study. Different studies were included in this systematic review. Nevertheless, honesty was maintained throughout the study by giving credit to specific authors and specific material used in the text when necessary. Falsification and plagiarism were avoided and full bibliographic information included in the list of references. Furthermore, the North-West University's policy on plagiarism and intellectual property was adhered to. The databases and sources of information used were handled with respect as well as the fundamental ethical principles of protecting scientific knowledge used.

1.9.7 Researcher competence and expertise

The researcher has the required qualification to conduct this study. Additionally, the two supervisors and the independent reviewer are experts in research and two of them are expert in this methodology. The researcher also participated in Ethics training held in April 2016 at the North-West University (NWU), Potchefstroom Campus.

1.9.8 Monitoring the research

In order to meet the ethical principles pertaining to this systematic review, the researcher ensured that the study was adequately, strictly and methodologically done, while clearly acknowledging sources of information with respect and integrity and communicated the outcomes with exactitude (Brink *et al*., 2013: 32). The guidelines and ethical principles of the Scientific Committee of INSINQ research Focus Area were adhered to as well as consultations with both supervisors for advice in order to ensure that the quality of the research conforms to the standards required. The researcher also ensured that information from approved databases obtained from the Internet and manually retrieved was critically assessed for reliability and validity through the critical appraisal step in the systematic review.

Additionally, the researcher ensured that scientific honesty was preserved by acknowledging the authors of the different studies used in text referencing and provided a list of references at the end of the study. Before undertaking the study, the research proposal for the study was submitted to the Scientific Committee of the INSINQ Research Focus Area and the Health Research Ethics Committee of the Faculty of Health Sciences, North-West University (reference number: NWU-00343-16-A1) to ascertain scientific integrity and ethical clearance (see Appendix F). Furthermore, the researcher kept a detailed record of the review and communicated the research findings accurately and in an unbiased manner for auditing purposes. An independent reviewer was involved in the systematic review process, and the study submitted for internal and external examination. Bi-annual reports on the progress made by the researcher were submitted to the Faculty of Health Sciences, and an annual report of the study submitted to the Health Research Ethics Committee.

1.9.9 Conflict of interest

According to Greeff (2016:197), a conflict of interest is “where a person’s individual interests or responsibilities have the potential to influence the carrying out of his or her institutional role or professional obligations in research”. The researcher declares that she has no such conflict of interest. As a safety measure, the research proposal was submitted to the scientific committee for review in order to get feedback before conducting the study (Greeff, 2016:118).

1.10 Dissemination of the findings

In order to provide general information regarding the findings of this study, the researcher targeted a relevant audience, namely; nurses, health care institutions, stakeholders, ethical review committees, policy makers and health science researchers.

Thus, the following channels will be used to disseminate the findings of the study:

- A manuscript will be submitted to a peer-reviewed journal;
- Presentations at relevant workshops, seminars and conferences where the above-mentioned stakeholders are present, such as annual research days, training opportunities and conferences on caring presence and quality in nursing; and
- The researcher also intends to further the study by enrolling PhD studies and to focus on the implementation and evaluation of practices to cultivate caring presence in nurses.

1.11 Structure of the study

The study is divided as follows:

Chapter 1: Overview of the study

Chapter 2: Research methodology

Chapter 3: Analysis and presentation of findings

Chapter 4: Conclusions, limitations of the study and recommendations

1.12 Summary of chapter

This chapter has provided an overview of the study, the introduction, the background and the problem statement. The research question was raised followed by the purpose of the study in response to the question asked. The paradigmatic perspective was discussed, the research method is grounded in the five steps of the systematic review briefly outlined in Table 1.1, followed by a discussion on how rigour was maintained, as well as ethical considerations. The structure of the study was also provided. It has been established in this Chapter that a systematic review will add value to the scientific body of knowledge with regard to research in health sciences and nursing science in particular, by providing a better understanding of the cultivation of caring presence, its importance in caring for patients and in the nursing profession. The next chapter is the research methodology.

CHAPTER 2:
RESEARCH METHOD

2

2.1 Introduction

In this chapter, the research design and methodology used in conducting this study are discussed. A systematic review was adopted in this study, allowing the research to focus and include a wide range of scientific information on how caring presence is cultivated in nurses. A systematic review is a scientific process of gathering literature to synthesise good information on a specific clinical practice (JBI, 2015: 4). Thus, the methodology adopted in this systematic review is explained in detail, according to the five specific steps pertaining to this study as follows:

- Formulating a focused review question (step 1);
- Gathering and classifying the evidence (step 2);
- Conducting a critical appraisal (step 3);
- Summarising of evidence (step 4); and
- Drafting the conclusion (step 5).

2.2 Research design

An explorative and descriptive research design was adopted in this study (CRD, 2009:226). This enabled the researcher to critically review and synthesise available research-based literature on how caring presence is cultivated in nurses (CRD, 2009:48). A systematic review was used within this design, focusing on and providing scientific literature (CRD, 2009: V) on how caring presence is cultivated among nurses. A systematic review aims at integrating summaries of literature available about a particular issue in an attempt to limit bias in order to answer the existing research question (CRD, 2009: V). Conducting a systematic review for this study will contribute to the body of knowledge with regard to cultivating caring presence (Burns & Grove, 2011:24).

The application of the steps in this study is discussed below.

2.3 Research methodology

2.3.1 Formulation of a focussed review question (step 1)

According to AND (2016:7), a systematic review should start with a review question in order to identify relevant studies. Thus, in this study, the review question guided the researcher to approach the study in a focussed and systematic manner. A systematic review question should consist of the following components: a population of interest (P); an intervention (I) which can also be seen as a procedure or approach; a comparison intervention (C) when applicable; and the outcomes and study design (S). This is known as the PICOS format (AND, 2016:19; CRD, 2009:160). The PICOS format is, therefore, relevant to ask a good question and identify key words necessary in gathering data. In this systematic review, the review question focused on finding available evidence on the cultivation of caring presence and elements used in the PICOS format (AND, 2016:19).

Table 2-1: Components of the focussed review question taking into consideration the acronym PICOS

COMPONENTS OF THE ACRONYM	COMPONENTS OF THE FOCUSSED REVIEW QUESTION
Population	Nurses
Intervention	Strategies to cultivate caring presence
Comparison intervention	Not applicable (N/A)
Outcome	Nurses enacting caring presence; Wellbeing of Nurses and improved wellbeing of patients
Study design	All types of study designs, including randomised control trials, clinical studies, observational studies, cohort and case-control studies and qualitative research

The review question was as follows: What strategies lead to the cultivation of caring presence in nurses in order for them to enact caring presence, improve their wellbeing and, to consequently, improve the wellbeing of patients?

2.3.2 Gathering and classifying the evidence (step 2)

After the researcher decided on the review question to be used, she then proceeded with finding the best research-based literature available to answer the review question (AND, 2016: 22). Therefore, EPPI programme was used to sift the literature. These studies were chosen based on

inclusion and exclusion criteria (Brink *et al*., 2013: 131). In this step, the researcher used databases, manual searches of research evidence and grey literature. Inclusion and exclusion criteria to select evidence related to the review question, and elements related to the review question were gathered and classified, abstracts and citations were reviewed in order to identify studies that met the criteria to answering the review question (AND, 2016: 22).

2.3.2.1 Inclusion criteria

Brink *et al*. (2013: 131) define inclusion criteria as features required for an element to be constituent of the target population. Therefore, the inclusion criteria for this study were as follows:

- Studies about nurses implementing caring presence;
- Studies about strategies, interventions or best practices to cultivate caring presence in nursing;
- Studies whose outcomes included nurses enacting caring presence and contributing to the wellbeing of patients as well as nurses;
- Time frame: During data collection, relevant studies on caring presence, up to the 2016, were included to maximise the number of eligible studies and to ensure the inclusion of most current interventions till the year 2016 to promote the cultivation of caring presence in nursing;
- Qualitative, quantitative, mixed methods and clinical trials studies were included, as well as grey literature such as conference abstracts; and
- All studies on caring presence in nursing (for non- English literature, authors of the articles were contacted).

2.3.2.2 Exclusion criteria

Exclusion criteria are features that can lead to the exclusion of an element from the target population (Brink *et al*., 2013: 131). The exclusion criteria for this study were as follows:

- Studies that do not address the review question;
- Primary studies in foreign languages (non- English articles) without an available English version / translation after consultation with the primary authors were excluded; and
- Duplicate studies to avoid repetition and promote exactitude regarding the results.

For analysis of evidence, only studies meeting the relevant criteria were considered. The outcome of this step is a detailed list of included and excluded studies and the rationale which served as an entry point to the next step (AND, 2016: 23).

2.3.2.3 Role of an expert librarian

An expert librarian was consulted at Ferdinand Postma Library, North-West University, Potchefstroom Campus to assist with studies that could not be retrieved by the researcher.

2.3.2.4 Identification of key words

The researcher found key words that had a bearing on the outcomes and intervention. “Caring presence” is the main word with regard to intervention. In this case, in order to achieve the well-being of nurses and patients, caring presence must be cultivated and enacted among nurses. After consultation with an independent reviewer, the researcher used additional keywords to find relevant studies. The following specific key words were used electronically to search for reviews: “caring presence and nurs”; “nursing presence and nurs”; “healing presence and nurs”; “therapeutic presence and nurs”; “being with and nurs” (‘nurs’ refers to mean nurse(s) and or nursing).

2.3.2.5 Sources of data and search

2.3.2.5.1 Databases

Currently, there are 20 databases for nursing on the NWU search site. After conferring with an independent reviewer and the liberian, the researcher located relevant studies using the following comprehensive, diverse and multidisciplinary nursing journals and databases of articles: EBSCOhost: PubMed Central; Academic Search Premier; Africa Wide Information; Applied Science and Technology Source; CINAHL; CINAHL With Full Text; E-Journal; ERIC; Health Source - Consumer Edition; Health sources: Nursing/Academic Edition; Master File Premier; MEDLINE; Open Dissertations; PsycArticles; PsycInfo; Scorpus; and Web of Science.

The researcher accessed the above databases through relevant key words in order to obtain relevant articles. Each database has its unique characteristic and while retrieving articles, duplicate articles were found, however, articles that did not provide relevant information about the cultivation of caring presence were discarded.

In addition, grey literature such as conference proceedings, report booklets and higher degree dissertations were searched using specialised search engines, relevant databases (such as Google Scholar) and websites.

2.3.2.5.2 Manual search

Manual searches were done by consulting journals that could not be accessed electronically. Hand searches of tables of contents were done as well as reference lists of key papers and where only the abstract was available, researchers were contacted to get the full report. Hence, a subject librarian was contacted for guidance during the review and to give suggestions on how to identify studies that were missed during the search on databases.

2.3.2.5.3 EPPI

The EPPI (Evidence for Policy and Practice Information) programme was used for the management of references and stages of the review (CRD, 2009: 21). After the search for the identification of possible studies, the first step with regard to the selection of relevant sample to the review question was done with the assistance of the above inclusion and exclusion criteria. Thereafter, the title and information in the abstract were carefully analysed to see if a decision to include or exclude the study could be made, if not, the full text was considered. Decisions made on inclusion and exclusion of studies were documented on a PRISMA flow chart (see flow chart 2.1). After selection of the sample, a critical appraisal was done to ensure only high quality studies were included in the review.

2.3.3 Conducting a critical appraisal (step 3)

According to OPHLA (2014: 4), critical appraisal is the procedure whereby research is cautiously and consistently analysed and evaluated to estimate its trustworthiness and its application. Through critical appraisal, the researcher asked questions about studies consulted in the previous steps. The methodologies, data collection and methods of data analysis used were carefully examined and evaluated as well as their outcomes in order to determine their potential influence or their applicability in clinical practice and future research on the cultivation of caring presence. The purpose of this was to identify the best available research studies to synthesise good quality literature with regard to cultivating caring presence in nurses.

As the last step of the sampling procedure, critical appraisal has to evaluate the best available evidence with exactitude. In this step, relevant and applicable studies in the cultivation of caring presence in nurses were critically reviewed by the researcher and the independent reviewer (AND, 2016: 41).

In order to achieve this, three actions were considered using different instruments as follows:

2.3.3.1 Abstracting key information to a data extraction template (DET) (action 1)

A data extraction table was drafted on studies found to be of high quality in the previous step. The table contained information about each study, about the findings in general and specifically, about the findings directly relevant to the systematic review. Information on the author, date of publication, the results, limitations of the study and the significance of the study for the review was included in the table (AND, 2016: 62).

Each research article was carefully read in order to determine the quality of methodology used as well as the validity of the outcomes. A summary of major findings pertaining to each research study was abstracted to the evidence worksheet (AND, 2016: 45).

2.3.3.2 Completion of the worksheet and quality rating (action 2)

The researcher carefully examined each article to find crucial details with regard to the methodology and design and its application to the study. Later, an overall rating of the strength of the evidence of each primary study was done using a quality criteria checklist relevant to the specific design of the study (AND, 2016: 45) (see appendices A-E).

2.3.3.3 Compilation of all checklists into a single table (action 3)

In this last step of the critical appraisal, all checklists pertaining to each study are gathered into a single table using a side-by-side comparison of different domains of each study (AND, 2016: 59). This list indicates which studies were rated as high quality studies and included as best evidence, and which were rated as not meeting the relevant quality criteria for inclusion (see 2.3.2.1) and were excluded. Thus, only articles with the best quality were used in step 4.

2.3.4 Summarising the evidence (step 4)

This phase consists of two parts, namely; extraction of data and data synthesis (AND, 2016: 62).

2.3.4.1 Data synthesis (thematic synthesis)

Data synthesis is the process of summarising the results of the data extraction step (CRD, 2009: 76). After extraction of data from the relevant studies, a synthesis was done through thematic synthesis to identify, analyse and describe themes related to data (AND, 2016: 66). This was done independently then the two supervisors as well as the independents reviewer together with the reviewer reached the consensus.

The results obtained from data extraction were synthesised in such a way that they were able to answer the review question.

2.3.5 Conclusions, limitations and recommendations (step 5)

2.3.5.1 Conclusions

After completion of step 4, a conclusion was drawn. According to AND (2016: 68), a conclusion must be clearly stated and strictly grounded on relevant evidence reviewed. It should point out the significance for health care and be precise to avoid misapprehension. A conclusion needs to be clear, simple and straight to the point (AND, 2016: 68). A conclusion should clearly state what the relevant answer to the review question is. It should further state whether there is agreement or disagreement within key information in the worksheets regarding the question asked.

Botma *et al*. (2015:75) state that conclusions should be distinctly connected/linked to the introduction and the purpose of the study. Therefore, subjects and themes identified from the previous steps as well as the purpose of the study guided the researcher in drawing conclusions for this study.

2.3.5.2 Limitations of the study

The limitations of the study are discussed in Chapter 4.

2.3.5.3 Recommendations

Recommendations for practice are suggested from the specific findings and the conclusions (AND, 2016: 105). This systematic review provides nurses and health care practitioners with information on strategies that could assist them to cultivate caring presence in order to improve the quality of care given to patients.

2.4 Data management and storage

Data was extracted by carefully reading each study, taking into consideration the inclusion and exclusion criteria as mentioned in sections 2.3.2.1 and 2.3.2.2 respectively. Data was stored using data extraction worksheets. The researcher, the two supervisors and the independent reviewer verified the data for confirmation before undertaking the next step.

2.5 Summary of chapter

This chapter has provided the methodology used in conducting this systematic review, namely; how the review question was formulated, how findings from relevant high quality studies were collected and classified, how critical appraisal was done and how the evidence was summarised. The next chapter focuses on the analysis and presentation of the findings of the study.

CHAPTER 3:
ANALYSIS AND PRESENTATION OF FINDINGS

3

3.1 Introduction

In this chapter, an overview of the realisation of the study conducted according to the first four steps of this systematic review is provided. These steps are as follows: step 1) formulation of the focussed review question; step 2) systematic gathering and classifying evidence using strategies that can answer the review question; step 3) conducting a critical appraisal for each report; and, step 4) extraction, analysis and synthesis of data to summarise the evidence. Step 5, which entails stating the strengths and weaknesses of the findings/evidence is discussed in Chapter 4 of this study.

As led by the research question and the purpose of the study (see Table 3.1), the steps of the systematic review are discussed below.

Table 3-1: Research question and purpose of the study

Research question	Purpose of the study
What strategies are available on how caring presence can be cultivated in nurses?	• To critically review available research-based literature on strategies to cultivate caring presence in nurses; and • To synthesise research-based literature on how caring presence is cultivated in nurses.

3.2 Realisation of step 1: the review question

The review question was used as formulated during the planning of the research (see section 2.3.1), namely: What strategies lead to the cultivation of caring presence among nurses for them to enact caring presence, improve their wellbeing and, to consequently, improve the wellbeing of patients?

3.3 Step 2: systematic gathering and classification of evidence

In step 2, relevant studies were identified by the researcher, taking into consideration, the specific inclusion as well as exclusion criteria as formulated during the planning phase (see sections 2.3.2.1 and 2.3.2.2). The choice of keywords was appropriate to find relevant literature (see

section 2.3.2.4), namely; “caring presence and nurs”, “nursing presence and nurs”, “healing presence and nurs”, “therapeutic presence and nurs”, “being with and nurs” (for nurse(s) and or nursing). Relevant studies were obtained using the following databases (see Table 3.2) as they covered the most relevant and major databases with regard to the topic, nationally and internationally.

Table 3-2: Sources of literature used in the search strategy

Database/programme	Domain and type of literature included
PubMed Central	International journal articles on health sciences
EBSCOhost: Academic Search Premier Africa Wide Information Applied Science and Technology Sources CINAHL CINAHL With Full Text E-Journals ERIC Health Sources - Consumer Edition Health Sources: Nursing/Academic Edition Master File Premier MEDLINE Open Dissertations PsycArticles PsycInfo	International journal articles, theses and dissertations on health sciences
Scopus	International journal articles on health sciences
Web of Science	International journal articles on health Sciences
Manual search	Manual search of relevant articles that could not be found electronically

After collection of all articles, the EPPI programme was used to sift the literature. The first step that was taken after all the articles were loaded in this programme was to exclude duplicates, thereafter, all titles and abstracts were carefully read and taking into consideration the inclusion as well as the exclusion criteria, were either included or excluded. In the next step, all articles without abstracts were sent to the expert librarian, together with the selected relevant articles in order to get the full text. A few articles could not be obtained. The specific articles that could not be obtained are in table 3.6.

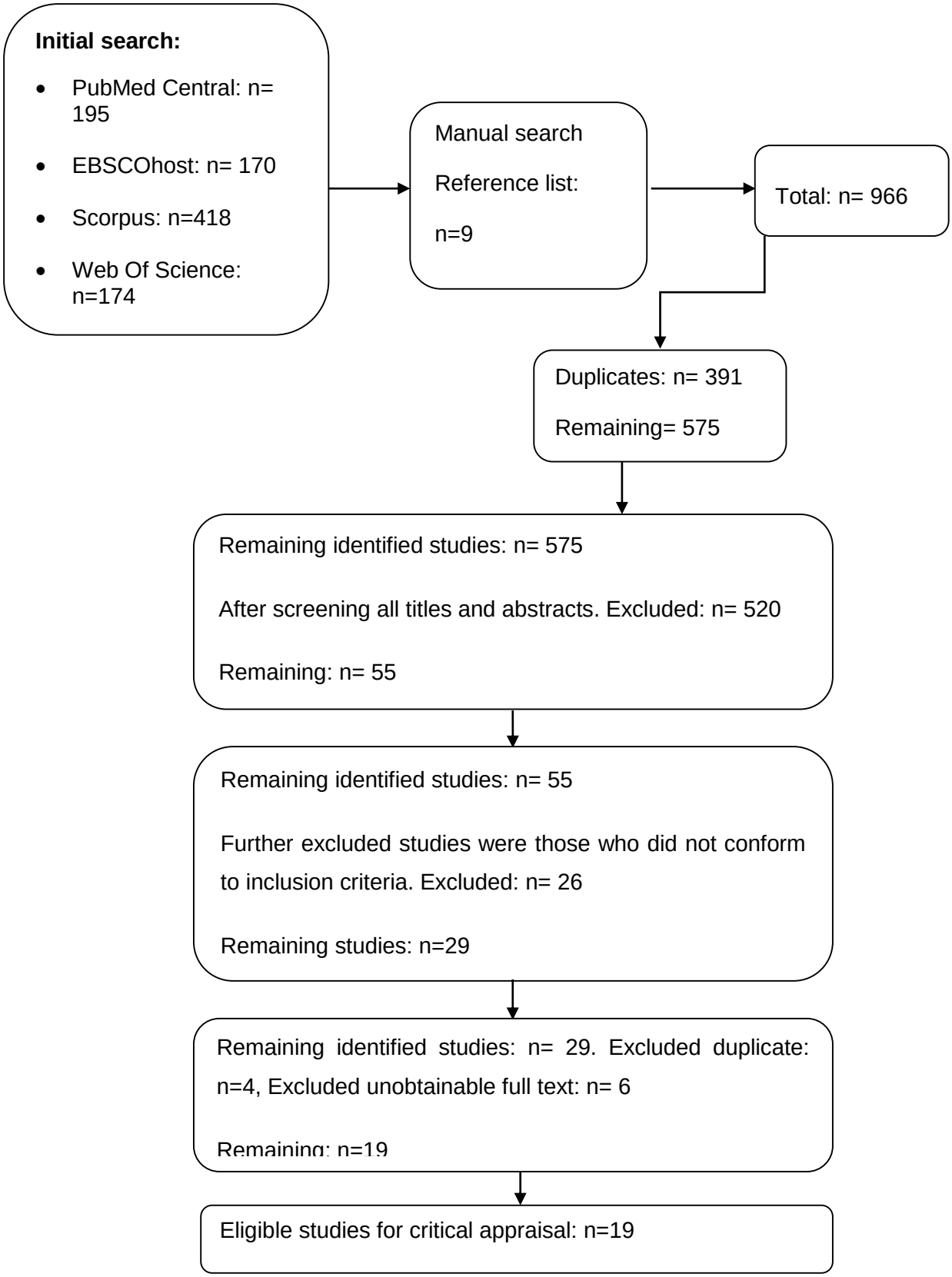
Table 3-3: Summary of results of search and excluded documents due to duplication

Databases	Initial search	Duplicates
PubMed Central	195	81
EBSCOhost:	170	46
Scopus	418	172
Web Of Science	174	92
References	9	00
Total	**966**	**391**

The documents were retrieved using the above databases and selected keywords as mentioned earlier. Thus, after the initial search, all titles as well as abstracts were screened for possible inclusion and exclusion. Studies that met the inclusion criteria after reading the abstracts were selected, thereafter, the full papers were carefully screened for critical appraisal and to determine whether they answered the review question (CRD, 2009:13).

Throughout the process, record keeping was done to ensure rigour and for audit purposes. From the initial search, that is, 966 documents electronically searched, 9 found in the references, 391 documents were excluded as they were duplicates. After screening all titles and abstracts of the remaining 575 documents, a total of 55 documents were retained for full text.

Flow chart 3.1 provides details of the search. Tables 3.4 and 3.5 provides a list of articles excluded after the initial number of 55 articles were identified, and the reasons for their exclusion.



Flow chart 3-1: Realisation of the search strategy and findings

Table 3-4: Excluded studies with rationale for exclusion (excluded 27 studies)

No	Authors and journals	Title	Design	Reason for exclusion
1	Akansel, N. *et al.* 2011. *The journal of clinical nursing*, 22:1818-1826	Mokken scaling of the caring dimensions inventory	Descriptive study design	Does not address the review question. No enactment of caring presence demonstrated or described.
2	An *et al*. 2009. *Australian Journal of Advanced nursing*, 26 (3)	The effect of a nursing programme on reducing stress in older adults in two Korean nursing homes	Quasi-experimental study	Does not address the review question. But rather focuses on the reduction of stress in older adults using mainly physical presence.
3	Barker, M. 1996. *British journal of nursing (Mark Allen publishing),* 2006 (1134-1138).	Should there be a nursing presence in the operating theatre?	Case report	Does not support the review question.
4	Bishop, A.H & Scudder, J.R. 1997. *Issues in law and medicine*, (13):236-236	Nursing Ethics: therapeutic caring presence	Book	Excluded because it is not a research report
5	Boucher, M.A. 1998 American Journal of nursing (AJN). 98(2)	Delegation Alert!: How to delegate effectively while maintaining your nursing presence	Not stated	It focuses on delegation rather than on cultivation of caring presence.
6	Caserta, J.E. 1992. *Home health care nurse,* 10(3)	A nursing presence	Not stated	Does not address the review question
7	Cavalieri, R.J. 1998. *American Journal of Nursing*. pp. 60, 62-63.	Nursing presence in osteoporosis research	Not stated	Does not address the review question
8	Clark, C.S. 2003. *International Journal for Human Caring*. 7(3)	The transpersonal caring moment evolution of high ordered beings	Cross-sectional survey	Does not focus on the review question
9	Clarke, W. 2013. *Journal of psychiatric and mental health nursing*, 20 (455-465).	Ordinary decency: a way of being with sick people	Randomised control trials	Does not address the review question. Relies rather on ethical behaviour of some categories of nurses.
10	Crawford, J. 2010. *American holistic nurse association*, 30(4):16-17	Nursing presence and evidence-based research	Not stated	Excluded because it does not address the review question. It focuses more on the concept of nursing presence and the research.
11	Curley, M.A.Q. 1997. *Journal of psychiatric nursing*, 12(4)	Mutuality: An expression of nursing presence	Explorative study	Excluded because it focuses more on nurse-parent relationship. No emphasis on the cultivation of caring presence.
12	D'alessio, E. 2010. *Nursing management*, 2010:16-18	Enhancing nursing's presence	Experimental design	Excluded because it emphasises nursing care and patient satisfaction. It does not address the review question.
13	Doona, M.E. *et al*. 1999. *Journal of holistic nursing*, 17(1) :54-70	Nursing presence. As real as a milky way bar	Hermeneutic design	Excluded because it focuses more on the concept presence rather than on the cultivation of caring presence.

No	Authors and journals	Title	Design	Reason for exclusion
14	Dwyer, A.F. 1969. *Journal of psychiatric nursing and mental health services*, 1969:176-180.	Therapy of being-with: re-entrance to existence	Narrative study	Excluded because it does not address the review question.
15	Godkin, J. 2004. *Journal of health care management*, 2001:258-267	Caring behaviours among nurses: Fostering a conversation of gestures.	Not stated	Excluded because it does not address the review question
16	Hancock, C & Hudspeth, R.S. 2014 *Journal of nursing administration quarterly Journal of Nursing standard*, 38(4):356-358	Using philanthropy to enhance nursing presence: the cleveland Clinic experience	Case control study	Excluded because it does not address the review question. It focuses on the existence of nursing care
17	Hansbrough, W. 2011. University of San Diego. Thesis	Examining nursing presence in the acute care setting as an indicator of patient satisfaction with nursing care	Mixed method	Excluded because it does not address the review question. It rather focuses on the investigation of caring presence on hospitalised adults.
18	Henry, N. I. 2007. *Current reviews for academic libraries*, 2007:661-661	Healing presence: the presence of nursing	Review	Excluded because the article is a book review and does not address the review question
19	Herth, K. 1990. *Journal of advanced nursing*, 1990: 1250-1259	Fostering hope in terminally ill people	Qualitative explorative study	Excluded because it does not address the review question
20	Kaplowitz, J.A & Kerlen, S. 1991. *Journal of Christian nursing*, 1991:12-15	Community health advisors: a caring presence	Qualitative	Excluded because it does not address the review question
22	Ketchem S. 2016. *Nursing for women's health*, 20(2): 126-128.	"Nurses' Professional Caring Presence and Power to Affect Change". Study	Cohort	Relies on the image of nurses in the society. it does not therefore, speaks about the cultivation of caring presence
23	Nelson, S. 2009. *Creative nursing*, (15): 2002-205	Healing presence: a conversation with Shelli Nelson, RN, BS	Interview	Excluded because it does not address the review question. Focuses on working experiences of a nurse
24	Shamian, J. 2015. *International nursing review*, (62):435-436	Strong nursing presence is vital to global health	Not stated	Excluded because it does not address the review question
25	Stern, L. 2002, *American journal of nursing*, 202(12):13	Nursing presence	Not stated	Excluded because it does not address the review question
26	Yagasaki, K & Komatsu, H. 2013. *Clinical journal of oncology nursing*, 17(5):512-516	The need for a nursing presence in oral chemotherapy	Qualitative study: grounded theory	Excluded because it does not address the review question
27	Zencakova, J. 2005. *Nursing standard (royal college of nursing, Great Britain*), 19(45):29	Being with a patient as he or she dies is a unique experience	Not stated	Excluded as it does not address the review question

Table 3-5: Duplicate studies (n=4)

No	Authors and journals	Title	Design	Reason for exclusion
1	Andrus, V. 2010. *The American Holistic Nurse Association*. 2010(18-20).	Therapeutic presence: Bringing comfort to our patients.	Case report	A duplicate
3	Bishop, A.H & Scudder, J.R. 1997. *Issues in law & medicine*, (13):236-236	Nursing Ethics: therapeutic caring presence	Not a research report	A duplicate
2	Covington, H. 2002. University of Colorado (thesis)	Caring presence: Journey towards a mutual goal.	Qualitative study.	A duplicate
4	Sutterfield, R. 2002. *American journal of nursing*, 202(12):13.	Nursing presence	Not stated	A duplicate

The following table (Table 3.6) presents a list of documents that were unavailable.

Table 3-6: Unobtainable documents (n=6)

No	Authors and journals	Titles
1	Angel, G. 1989. *The Pennsylvania nurse*, 44(1)	Nursing presence and potential in alternative delivery systems
2	Celich, K.L & Crossetti, M.G. 2004. *Revista Gaucha de enfermagem / EENFUFRGS*, 25(3) :377-385	Being with the carer: a dimension of the caring process
3	Ferreira, S. 2013. *Krankenpflege. Soins infirmiers*, 108(6):68-70	When “being with” replaces “doing with”
4	Godkin, J & Godkin, L. 2004. *Health care management review*, 29(3):258-267	Caring behaviours among nurses: Fostering a conversation of gestures
5	Rinker, S. 1992. *NLN publications*, (15-2465):221-239	A caring presence: confederate nursing practice
6	Steffen, L. 2011. *Creative nursing*, 17(4):52-52	Healing presence: the essence of nursing

3.4 Step 3: Performing critical appraisal

In this step, the quality of the different types of studies was determined as follows: each article was cautiously examined to evaluate its quality, strengths and weaknesses (CRD, 2009:3). Another purpose of the critical appraisal was to determine the studies' contribution to answer the review question (CRD, 2009:33). All the eligible studies were critically appraised for methodology and quality. The Johns Hopkins Nursing Evidence-Based Practice (JHNEBP) tools were used to appraise literature reviews, case reports and meta-syntheses (see Appendices B and C). The JHNEBP instruments were used because they appraise the strength, level and quality of the literature based on the research evidence, guided by critical questions (JHNEBP, 2017). The Johanna Briggs Institute (JBI) checklists (see Appendix D) were used for text and opinion and some case reports. The Critical Appraisal Skills Programme (CASP) checklist for qualitative studies (see Appendix A) was used for qualitative studies. The CASP instrument was chosen for qualitative studies because of its accessibility and appropriateness to review such studies (CASP, 2018).

In short, the JHNEBP tool for literature reviews comprise the following five questions:

- Is the subject matter to be reviewed clearly stated?
- Is literature relevant and up-to-date (most sources are within the past five years or classic)?
- Of the literature reviewed, is there a meaningful analysis of the conclusions across the articles included in the review?
- Are gaps in the literature identified? and
- Are recommendations made for future practice or study?

Case reports were evaluated using the JHNEBP tool for appraising case reports, using the following four questions:

- Is the purpose of the case report clearly stated?
- Is the case report clearly presented?
- Are the findings of the case report supported by relevant theory or research? and
- Are the recommendations clearly stated and linked to the findings?

In order to appraise the meta-analysis study, the JHNEBP tool for systematic reviews (with or without meta-analysis) was used, consisting of eleven questions as follows:

- Were the variables of interest clearly identified?
- Was the research comprehensive and reproducible
    - Key search terms stated?
    - Multiple databases searched and identified?
    - Inclusion and exclusion criteria stated?
- Was there a flow diagram that included the number of studies eliminated at each level of review?
- Were details of included studies presented (design, sample, methods, results, outcomes, strengths and limitations)?
- Were methods for appraising the strength of evidence (level and quality) described?
- Were conclusions based on results:
    - Were results interpreted?
    - Conclusions followed logically from the interpretation and systematic review question? and
- Did the systematic review include a section addressing limitations and how they were addressed?
- The Johanna Briggs Institute (JBI) (2017) critical appraisal tools for text and opinion were used to assess the methodological quality of the study and to ascertain the magnitude of addressing possibility of biased design, conduct and analysis. Thus, the followings six question were used:
    - Is the source of the opinion clearly identified?
    - Does the source of the opinion have a bearing in the field of expertise?
    - Are the interests of the relevant population the central focus of the opinion?

- Is the stated position the result of an analytical process, and is there logic in the opinion expressed?
- Is there reference to the extant literature? and
- Is any incongruence with the literature/sources logically defended?

- To critically appraise some of the case reports, the JBI checklists for case report were used and consisted of the following eight questions:
  - Were patient's demographic characteristics clearly described?
  - Was the patient's history clearly described and presented as a timeline?
  - Was the current clinical condition of the patient on presentation clearly described?
  - Were the diagnostic tests or assessment methods and results clearly described?
  - Was the intervention(s) or treatment procedure(s) clearly described?
  - Was the post-intervention clinical condition clearly described?
  - Were adverse events (harms) or unanticipated events identified and described? and
  - Does the case report provide takeaway lessons?
- The CASP checklist for qualitative studies was used for qualitative research and consisted of the following 10 questions:
  - Was there any clear statement of the aim of the study?
  - Was the qualitative methodology appropriate?
  - Was the research design appropriate to address the aim of the research?
  - Was the recruitment strategy appropriate to the aim of the research?
  - Was the data collected in a way that addressed the research issue?
  - Was the relationship between the researcher and the participants adequately considered?
  - Were ethical issues taken into consideration?

- Was the data analysis sufficiently rigorous?
- Was there a clear statement of findings? and
- How valuable was the research?

Marks were allocated using the number of questions the tool or checklist consisted of. For example, for the JHNEBP, consisting of five questions, marks were allocated out of five for this specific tool. If the answer to a specific question was labelled “no”, then it was marked as minus one mark.

For all studies, the Evidence Appraisal manual was followed for grading of the studies using the following words and symbols for grading level (AND, 2016:43) (see Appendix E):

- Words for describing: high, medium/neutral and low and
- AND quality rating: (+) = good quality, (Ø) = neutral, and (-) = low quality.

Table 3.7 shows the quality rating system, based on the above-mentioned tools, used by the researcher and the independent reviewer.

Table 3-7: Quality rating for quality of articles (adapted from JHNEBP, 2017, JBI, 2017, CASP, 2018 and AND, 2016)

Quality rating	JHNEBP	CASP score quality rating	AND	JBI
A. High quality	≥5/6 or ≥7/8	≥8/10	(+)	≥5/6
B. Good / medium/neutral quality	3/6 to 4/6 or 4/8 to 6/8	≥5/10 to <8/10	(Ø)	3/6 to 4/6
C. Low quality or major flaws	1/6 to 2/6 or 1/8 to 3/8	≥1/10 to <5/10	(-)	1/6 to 2/6

After the critical appraisal, all studies included were considered the final sample for summarising the evidence. A total of 17 studies were finally included. Table 3.8 presents the critical appraisal.

Table 3-8: Critical appraisal

Authors, year, titles and journals	Types of study designs and settings	Research method / Approach	Rigour and outcome of critical appraisal
Anderson, J.H. 2007. Nursing presence in a community heart failure programme. *The nurse practitioner*, 32(10):14-21.	Case report Setting: a regional medical centre, Boise, Idaho.	Sample: Using a series of 3 cases observed in a regional medical centre, the author describes the concept of nursing presence and how it can have an impact on a patient's outcomes in home-based, advanced practice nurse-directed programme for patients with heart failure. Data collection: Case reports Data analysis: not clearly stated	Instrument used: JHNBP for non-research evidence appraisal tool, case report. JHNBP score: 4/4 AND Quality rating: high (+) Decision: included
Andrus, V. 2010. Therapeutic presence: Bringing comfort to our patients. *The American Holistic Nurse Association*. 2010(18-20).	Text and opinion. Setting: not stated	Give examples of 2 nurses who reported on the case of patients they were nursing after some time, after they implemented presence.	Instrument used: JBI Critical Appraisal Tool for text and opinion papers JBI score: 2/6 AND quality rating: low (-) Decision: excluded
Coffman, F. 2007. Healing presence ceremony in nursing education. *International Journal for Human Caring*, 11(4):52-56.	Case report Setting: Nevada State University	A healing presence ceremony is used at a college of nursing to help nursing students develop themselves as caring practitioners.	Instrument used: JHNBP for non-research evidence appraisal tool, case report. JHNBP score: 4/4 AND Quality rating: High (+) Decision: included
Covington, H. 2002. Caring presence: Journey towards a mutual goal. University of Colorado (thesis)	Qualitative study: explorative descriptive. Setting: Community in the rocky mountain region of the Western United states.	13 women and two men between the ages of 21 and 65 (all whites) with the diagnosis of chronic illness. 4 females and 1 male nurse practitioners who were taking care of the above patients were chosen using purposive sampling. Nurses and patients	Instrument: CASP, qualitative study tool. CASP score: 10/10 AND Quality rating: high (+)

Authors, year, titles and journals	Types of study designs and settings	Research method / Approach	Rigour and outcome of critical appraisal
		were interviewed to get their description of caring presence during care.	Decision: included
Delashmutt, M.B. 2007. Students' experience of nursing presence with poor mothers. *The association of women's health, obstetric and neonatal nurses*, 36(2):183-189.	Case report. Setting: faith-based crisis centre for the area poor and homeless	Sample: A group of 188 senior level student (BSN) nurses' clinical experience with women in poverty. Data collection: a questionnaire was used prior to their first clinical day in 2000 to explore their basic knowledge about poverty (more especially poor mothers), and after their last clinical day in 2004, another questionnaire was filled by each one of them for the same reason. Data analysis: not clear	Instrument used: JBI, critical appraisal checklist for case reports. JBI score: 8/8 AND Quality rating: high (+) Decision: included
Du Plessis, E. 2016a. Caring presence in practice: facilitating an appreciative discourse in nursing. *International nursing review*, 63(3):377-380	Qualitative research Settings: social media namely, a Facebook page and newspaper report	Sample: nurses on a Facebook page, and formal media in which nurses are appreciated for their efforts (all-inclusive sampling). Data collection: nurses were invited to write narratives on caring presence. Additionally, news report about acknowledgement and appreciation of nurses using literature search. Data collection: narratives, full text newspaper, SA Media, Sabinet on SAepublications. Data analysis: deductive content analysis to analyse narratives and news reports in relation to the definition of caring presence and types of caring presence.	Instrument used: CASP Study had a clear aim and an appropriate method was used to invite participants to share their views on the topic and to collect available media reports. All participants received the same interview questions or the same topic. The author's conclusion and recommendations were clearly stated. The study can be applied to the local population. CASP score: 10/10 AND Quality rating: high (+) Decision: included

Authors, year, titles and journals	Types of study designs and settings	Research method / Approach	Rigour and outcome of critical appraisal
Du Plessis, E. 2016b. Presence: a step closer to spiritual care in nursing. *Holistic nursing practice*, 30(1):47-53.	Text and opinion Setting: not applicable	This article discusses how presence may be an accessible first step for nurses towards spiritual care. The nature, consequences and cultivation of presence are discussed.	Instrument used: JBI Critical Appraisal Tool for text and opinion papers JBI score: 6/6 AND Quality rating: high (+) Decision: included
Duis-Nittsche, E.R. 2002. A study of nursing presence. University of Texas Medical branch. Thesis	Qualitative descriptive study. Setting: inpatients acute care settings	7 nurses and 7 patients who were nursed by the same nurses each were interviewed about their knowledge and experiences of nursing presence. Purposive sampling was used to select participants.	Instrument: CASP, qualitative study tool. CASP: 10/10 AND Quality rating: high (+) Decision: included
Fahlberg, B & Roush, T. 2016. Mindful presence: 'being with' in our nursing care. *Nursing 2016*, 46(3):14-15.	Text and opinion Setting: not clearly stated	Sample: one patient Data collection: interview Data analysis: not clear A report is given about a patient named "Tom" who has been a cancer patient. His case is used as an example and illustration of communication and caring presence to students and nurses.	Instrument used: JBI critical appraisal tool for text and opinion papers JBI score: 3/6 AND quality rating: medium (Ø) Decision: included
Finfgeld-Connett, D. 2006. Meta-synthesis of presence in nursing. *Journal of advanced nursing*, 55(6):708-714	Meta-synthesis Setting: not applicable	Literature search was systematically done on the concept 'presence' and its enactment in nursing.	Instrument used: JHNEBP, appraisal for systematic review (with or without Meta-Analysis). JHNEBP score: 11/11 AND Quality rating: high (+) Decision: included

Authors, year, titles and journals	Types of study designs and settings	Research method / Approach	Rigour and outcome of critical appraisal
Godkin, J & Godkin, L. 2004. Caring behaviours among nurses fostering a conversation of gestures. *Health care manage rev*, 29(3):256-267.	Discussion paper Setting: not applicable	A discussion on caring behaviours among nurses in order to suggest means through which caring presence can be discovered and taught.	Instrument used: JBI critical appraisal tool for text and opinion papers JBI score: 6/6 AND Quality rating: high (+) Decision: included
Godkin, J. 2001. Healing presence *Journal of holistic nursing: official journal of the American Holistic Nurses' Association*, 19(1): 5-21.	Literature review Setting: not applicable	Reviewing many articles on caring presence to understand the phenomenon and to reach the aim of greater satisfaction for both nurse and patients.	Instrument used: JHNEBP for non-research evidence appraisal, literature review JHNBP score: 5/5 AND Quality rating: high (+) Decision: included
Hooper, D. 2013. The caring presence of nursing: a qualitative focus. *Journal of perianesthesi*a nursing, 28(5):255-256	Text and opinion Setting: perianaesthesia	Sample: not clear, Data collection: not clear Data analysis: not clear A report is given about a qualitative research on four studies that examine the lived experiences of patients across the surgical continuum and nursing presence and care.	Instrument used: JBI critical appraisal tool for text and opinion papers JBI score: 5/6 AND quality rating: high (+) Decision: included
Iseminger *et al*. 2009. Healing during existential moments: the "art" of nursing presence. *Nursing.theclinic.com,* 44(4):447-459.	Literature review Setting: not applicable	This article discusses barriers to nursing presence and ways to overcome such barriers. The discussion is supported by relevant scientific literature and reference is made to cases to illustrate central ideas. In conclusion, a Transformative Nursing Presence model is suggested.	Instrument used: John Hopkins Evidence-based practice (JHNEBP) for non-research evidence appraisal, literature review JHNEBP score: 5/5 AND Quality rating: high (+) Decision: Included
Koenig, J. Therapeutic nursing and the "beginner's mind"	Text and opinion	The study uses the case of a patient she cared for, who was in pain and burst into	Instrument used: JBI Critical Appraisal Tool for text and opinion papers

Authors, year, titles and journals	Types of study designs and settings	Research method / Approach	Rigour and outcome of critical appraisal
Holistic nursing and acute care, 2002:6-7	Setting: not stated	tears to explain her belief and way of enactment of caring presence for a patient facing such situation.	JBI score: 2/6 AND quality rating: low (-) Decision: excluded
McMahon M.A & Christopher, K.A. 2011. Towards a mid-range theory of nursing presence. *Nursing forum*, 46(2):71-82.	Literature review. Setting: not applicable	An extensive literature review was conducted to synthesise relevant literature and develop a mid-range theory aimed at facilitating the implementation of presence in clinical settings.	Instrument used: JHNEBP for non-research evidence appraisal, literature review JHNEBP score: 4.5/5- literature used were relevant but were mostly not up-to-date. AND Quality rating: high (+) Decision: included
Osterman, P.L.C *et al*. 2010. An exploratory study of nurses' presence in daily care on an oncology unit. *Nursing forum*, 45(3):197-205	Qualitative descriptive study. Setting: 275-bed non-profit community hospital in New England with 30-35 bed oncology unit	Sample: 10 nurses (5 females and 5 males; all Caucasians from 40 years old). 10 patients (5 females and 5 males; all Caucasians). Data collection: data was collected in 3 phases over a period of 6 months, and mainly through participant observation. Data analysis: Observational notes from nurses as well as interviews with individuals and groups about their experiences during morning care.	Instrument used: CASP for qualitative studies The research question was clearly stated. Inclusion criteria were clearly stated. Study protocol was clearly described. The sampling method and population were clearly stated. Overall, the study had a good plan, execution and was well reported, with a good rigour. The study cannot be generalised to the local population. CASP score: 9/10 AND Quality rating: high (+) Decision: included
Pederson, C. 1993. Presence as a nursing intervention with hospitalised children. *Journal of mental-child nursing*, 1993:75-81	Literature Review Setting: not applicable	Using literature on nursing presence, a discussion was done on the importance of nursing presence with children, and information on ways in which nurses can operationalise and evaluate presence discussed.	Instrument used: JHNEBP for non-research evidence appraisal, literature review JHNEBP score: 4.5/5. most of the literature was not up-to-date

Authors, year, titles and journals	Types of study designs and settings	Research method / Approach	Rigour and outcome of critical appraisal
			AND quality rating: high (+) Decision: included
Snyder *et al*, M *et a*l. 2000. Use of presence in the critical care unit. *AACN Clinical issues,* 11(1):27-33,	Literature review Setting: not applicable	Literature used to discuss the importance of caring presence in critical care units. An elaboration of the importance of caring presence is given as well as techniques nurses could use in critical care unit in implementing caring presence.	Instrument used: JHNEBP for non-research evidence appraisal, literature review JHNEBP score: 4.5/5 AND quality rating: high (+) Decision: included

3.5 Step 4: summarising of evidence

This phase is made up of two parts, namely extraction of data and data synthesis (AND, 2016:62).

3.5.1 Data extraction

A data extraction table was drafted on the studies found to be of high quality in the previous step. The table contain information about each study, about the findings in general and specifically about the findings directly relevant to the systematic review. Information on the author, date of publication, the results, limitations of the study and the study's significance for the review was included in the table (AND, 2016:62).

3.5.2 Data synthesis (synthesis)

Data synthesis is the process of summarising the results of the data extraction step (CRD, 2009:76). After extraction of data from the relevant studies, a synthesis was done by means of thematic synthesis to identify, analyse and describe the themes related to data (AND, 2016:66).

The results from the data extraction were synthesized in such a way that they were able to answer the review question.

3.6 Step 5: extraction, analysis and synthesis of data

Out of the 19 studies that were critically appraised, 17 were finally retained for inclusion and synthesis as they were considered to be of good methodological quality as indicated in Table 3.8. An explanation of the characteristics of the studies is provided below, followed by discussions on data extraction and synthesis, as well as discussions on the findings.

3.6.1 Characteristics of studies considered (n=17)

Studies that qualified as adequate for inclusion in this study had different designs. Five studies were literature reviews, three were texts and opinions, three were case reports, four were qualitative studies, and one was meta-synthesis while one was a discussion paper.

3.6.1.1 Literature review (LR) (n=5)

Five studies were identified as literature reviews. The JHNEBP tool for non-research and the AND manual were used to appraise the studies. The first literature review was that of Iseminger *et al*. (2009) on “healing during existential moments: the “art” of nursing presence”. After critical appraisal, the study was rated high (+) quality level according to AND and received a score of 5/5 according to the JHNEBP score. The second systematic review was done by McMahon and Christopher (2011) and the title of the study was: “Towards a mid-range theory of nursing presence”. It was critically appraised and was given a score of 4.5/5 using the JHNEBP instrument and given a high (+) quality rating in accordance with the AND quality rating scale. The third literature review considered was that of Godkin (2001) entitled: “Healing presence”. After critical appraisal, a score of 5/5 was assigned in accordance with the JHNEBP tool and was rated high (+) quality according to the AND quality rating scale. The fourth literature review considered was that of Pederson (1993) entitled: ”Presence as a nursing intervention with hospitalised children”. The JHNEBP score was 4.5/5 and the EA quality rating was high (+). The firth literature review focused on the use of presence in a critical care unit by Snyder *et al.* (2000). The study was scored 4.5/5 in accordance with the JHNEBP score and the EA quality rating was high (+).

3.6.1.2 Texts and opinions (n=3)

Three texts and opinions papers were identified. The JBI Critical Appraisal Tool for texts and opinions papers was used to appraise these papers. The first text and opinion paper was that of Du Plessis (2016b) entitled; “Presence: a step closer to spiritual care in nursing”. The JBI score was 6/6 and the AND quality rating was high (+). The second text and opinion paper was that of Hooper (2013) entitled: “The caring presence of nursing: a qualitative focus”. The JBI score was 5/6 and the quality rating scale according to AND was high (+). The third text and opinion paper

was entitled: “Mindful presence: ‘being with’ in our nursing care” by Fahlberg and Roush (2016). The JBI score was 3/6 and was rated medium according to the AND rating scale.

3.6.1.3 Case reports (n=3)

Three case reports were identified. Two instruments were used to critically appraise these papers, namely; the JHNBP for non-research evidence appraisal tool, case reports and the JBI critical appraisal checklist for case reports. The first case report was that of Anderson (2007) entitled: “Nursing presence in a community heart failure programme”. The instrument used was the JHNBP for non-research evidence appraisal tool, case report. The JHNBP score was 4/4 and the AND rating scale was high (+). The second case report was the “Student’s experience of nursing presence with poor mothers” by Delashmutt (2007). The instrument used was the JBI critical appraisal checklist for case reports with a score of 8/8 and rated high (+) according to the AND manual. The third case report was a study by Coffman (2007) entitled: “Healing presence ceremony in nursing education”. The JHNBP for non-research evidence appraisal tool, case report was the most appropriate to appraise this paper with a score of 4/4; and the AND manual was also used and rated high (+).

3.6.1.4 Qualitative studies (n=4)

Four qualitative studies were considered and critically appraised. The CASP for qualitative studies and the AND manual were used to critically appraise the studies. The first study identified was that of Osterman *et al.* (2010), which explored nurses’ presence in daily care in an oncology unit. The CASP score given was 9/10 and the AND Quality rating was high (+). The second qualitative study was that of Du Plessis (2016b) entitled: “Caring presence in practice: facilitating an appreciative discourse in nursing”. The CASP score was 10/10 and the AND quality rating scale was high (+). The third qualitative study was that of Covington (2002) on “Caring presence: Journey towards a mutual goal”. Using CASP, a score of 10/10 was given and a high (+) rating given using AND. The fourth and last qualitative study was the one that focused on nursing presence by Duiss-Nitsche (2002). After the critical appraisal, the CASP score was given: 10/10 and the AND quality rating was high (+).

3.6.1.5 Meta-synthesis (n=1)

One meta-synthesis by Finfgeld-Connett (2006) entitled: “Meta-synthesis of presence in nursing” was identified. The instrument used to critically appraise this paper was the JHNEBP appraisal tool for systematic reviews (with or without meta-analysis). The JHNEBP score was 11/11 while the AND quality rating scale was high (+).

3.6.1.6 Discussion paper (n=1)

One discussion paper by Godkin and Godkin (2004) entitled: “Caring behaviours among nurses fostering a conversation of gestures” was considered in the study. The instrument used to critically appraise this paper was the JBI critical appraisal tool for text and opinion papers. The JBI score was 6/6 and was rated high (+) in accordance with the AND quality rating scale.

3.6.2 Designing a data extraction tool

In the course of data extraction, all studies that had medium or high quality ratings were considered. A data extraction tool, namely a table, was designed to process data from each study, to ensure accuracy and to make sure all relevant information was collected from each study. This was also done to easily synthesise the studies (AND, 2016:41). Headings of the table comprised the following: references (author’s name, year, title of the study, journal); focus of the study; findings of the sudy and findings relevant to the current study. Thus, after the critical appraisal, 17 studies were retained as the final sample and extraction for each study was done using a table as illustrated in Table 3.9.

All the evidence extracted was graded and grounded on the strength of their evidence in accordance with the AND Manual (2016:71) (see appendix E):

- Grade I: good/strong
- Grade II: fair
- Grade III: limited/weak
- Grade IV: expert opinion only
- Grade V: grade not assignable

Table 3-9: Data extraction of studies considered eligible for synthesis (n=17)

Reference	Focus of the study	Findings of the study	Findings relevant to this study and the cultivation of caring presence
Anderson, J.H. 2007. Nursing presence in a community heart failure programme. *The nurse practitioner*, 32(10):14-21.	The aim of this study was to describe the concept of nursing presence and its positive influence on patient outcomes in a home-based, advanced nurse-directed programmes for patients with heart failure.	A series of 3 cases were observed in a regional medical centre as nurses enacted caring presence towards patients under their care. Nursing presence can be progressively used to promote positive self-care behaviours in patients and their loved ones who are usually frustrated due to the long-term illness of the patient. Therapeutic presence became the heart of intervention for Community Case Management (CCM) Programme.	The findings of this study suggest the means through which nursing presence can be enacted by nurses assisting the elderly who are suffering from long-term illnesses. The advantages of nursing presence in community case management were highlighted. Thus, caring presence can be achieved through the following: listening; authenticity; understanding; commitment; reassurance; openness; touch; confidence; silence; humour; compassion, vigilance, sharing, non-abandonment; competence; self-awareness; trust; respect; affirming; coaching; continuity; and conscience. Evidence grading: Grade I (good)
Coffman, F. 2007. Healing presence ceremony in nursing education. *International Journal for Human Caring,* 11(4):52-56.	The aim of this study was to find a means of developing a nursing programme to assist student nurses to create a healing-caring consciousness.	The healing ceremony is a powerful tool to help students to be knowledgeable and acquire skills to practise caring presence.	The findings from this study demonstrate that the meaning of caring presence should be explored in the nursing content and in the teaching-learning process as the nursing programme develops. The following can be used to foster caring presence: being insightful, open to one's uniqueness, avoid prejudices and brokenness. Other steps for being present include having the intention to be a healing presence,

Reference	Focus of the study	Findings of the study	Findings relevant to this study and the cultivation of caring presence
			arrange space for it, respect the one under your care, offer what you have to give, receive the person as they are, and be holistic and balanced. Evidence Grading: Grade II (fair)
Covington, H. 2002. Caring presence: Journey towards a mutual goal. University of Colorado (thesis)	The aim of this study was to describe de experience of caring presence within the context of a shared nurse practitioner-patient relationship over time from the viewpoint of the nurse and the patient.	Placing presence in the context of caring clarifies many things for the patient and the nurse. For instance, the nurse can differentiate between caring and presence. The patients on the other side, can be aware of whether the health care giver is enacting caring presence or not as they get used to the phenomenon.	Caring presence has implications in the therapeutic care of patients, in nursing education, in nursing practice, in nursing research to improve patient outcomes, and to meet the needs of both patients and nurses. Caring presence is fostered through: the joining of two individuals' spirits; physical connection (e.g.: hug, smile, touch); unconditional acceptance; empathy; making the patient feels reassured and connected to the nurse; spiritual bonding; interrelatedness; feeling of exchange of energy; feeling of a force beyond self when absorbed wholly and in harmony as energy flows from one person to another. Evidence grading: Grade I (good)
Delashmutt, M.B. 2007. Student's experience of nursing presence with poor mothers. *The association of women's health, obstetric and neonatal nurses*, 36(2):183-189	The aim of this study was to develop and implement an undergraduate clinical course for nursing students, the focus of which was the effect of poverty on mental, physical and spiritual health.	Students' insight about poverty had grown. Nursing support has a healing power. Physical closeness and bedside presence is a spiritual connection that existed during the process of caring for the poor mothers.	The findings from this study show that being willing to give oneself fully in a relationship empowers the patient and promotes health. Therefore, the following are necessary to foster presence: physical closeness; communication; listening to and hearing; processing;

Reference	Focus of the study	Findings of the study	Findings relevant to this study and the cultivation of caring presence
			feeling physically, mentally and spiritually what the patient says; and be willing to give oneself fully. Evidence grading: Grade I (good)
Du Plessis, E. 2016a. Caring presence in practice: facilitating an appreciative discourse in nursing. *International nursing review*, 63(3):377-380	The aim of this study was to describe an appreciation of caring presence practised by nurses in South Africa and to facilitate an appreciative discourse in nursing and a return to caring value and attitudes.	Even though it was apparent that nurses practise caring presence in South Africa, further research is needed. Nursing education should include caring presence as a phenomenon in nursing and caring presence should be cultivated by means of platforms such as social media. The findings from this study confirm that there are different types of presence enacted by a nurse such as physical and partial presence, full presence and transcendental presence. It also shows that even though some nurses are fully aware of the concept of caring presence, they are not always willing to share about it.	The author of this article suggests the following can be implemented in fostering caring presence: being there physically; going beyond the scientific data; knowing what will work and when to act; and giving self wholly. Evidence grading: Grade I (good)
Du Plessis, E. 2016b. Presence: a step closer to spiritual care in nursing. *Holistic nurs prac*, 30(1):47-53	The aim of this study was to discuss spiritual care and presence and presence as a first step for spiritual care.	Nurses find it difficult to give spiritual care to patients of different beliefs, and therefore, spiritual care in nursing is neglected. However, presence as a core element of spiritual care can, therefore, be implemented as a first step to encourage nurses to eventually give	The findings from this study provide insights into the concept of caring presence in nursing and how caring presence can be enacted and cultivated in nursing using examples from different studies. Thus, the author suggests that nursing presence can be cultivated through reflection on own nursing

Reference	Focus of the study	Findings of the study	Findings relevant to this study and the cultivation of caring presence
		the spiritual care needed by the patient under their care. <u>Particular interventions</u>: • A nurse enacting presence has qualities such as choosing to be vulnerable while being with the patient, respect the individual differences, must have unconditional positive regard, have critical thinking skills; • Caring presence has some advantages that must be knowledgeable by the nurse such as deep contact between the care giver and the patient, creation of a healing environment, it contributes to the patient's safety and security, it reduces stress, enhances resilience, leadership and holistic care.	experiences in a non-judgemental manner in order to foster "being with and enhance human connection, caring presence can be taught when educating about many subjects using literature, films, field trips to purposefully activate emotional responses, beliefs, choices and personal values, which will be reflected upon. Presence can also be developed through transformative experience by exposing nurses to settings where they can observe, be aware and advocate for people. Another means to foster presence is to accentuate traditional nursing arts such as holding hands, being with the patients, sitting, talking to patients and doing physical touching. Students should be made aware of the concept 'presence' by nurses and educators who should also encourage them to put into practice Evidence grading: Grade I (good)
Duis-Nittsche, E.R. 2002. A study of nursing presence. University of Texas Medical branch. Thesis.	The purpose of this study was to describe the nature, the experience of nursing presence within nurse-patient relationships	Patients agree that transpersonal relationship and the healing environment is what they need and want. The nurses think as they demonstrate caring presence with their patients, it facilitates the healing process and satisfaction for both the patients and them (nurses) as their	The findings from this study show that both nurses and the patients state the importance of knowing the patient, having a closer relationship through bonding and, therefore, demonstrating caring presence. Thus, caring presence can be cultivated through attention,

Reference	Focus of the study	Findings of the study	Findings relevant to this study and the cultivation of caring presence
		health care giver. Therefore, nursing presence as a phenomenon can be described by both the nurse and the patient.	connection and engagement between the nurse and the patient, knowing the patient, responding to their needs, having positive attitude towards patients, bonding with the patient and their own and encouraging them, considering the patient as a human being, knowing the patient physically, emotionally and spiritually, it entails being intuitive about the patient's recovery, good communication and explaining to the patient about his or her condition, listening, being compassionate, connection, recognition of cultural, religious and personal beliefs of the patient, being patient, using humour effectively, making eye contact, physical touch, hugs and other direct contacts, the nurse ensures that particular events concerning patients such as birthday are taken into consideration, keeping in contact with patients when transferred to others wards by calling or visiting. Evidence grading: Grade I (good)
Fahlberg, B & Roush, T. 2016. Mindful presence: being with in our nursing care. *Nursing 2016*, 46(3):14-15.	The aim of this study was to give a report on a patient as he shared about his view and experience regarding caring presence with nurses	Nurses as people who care for patients have long-term effect on them, their condition and their family. Patients see nurses from their physical attitudes whether towards them or not such as the way they walk, talk, address them, to the way	The importance of mindfulness and its positive consequence for caring presence such as paying more attention to the patients and the family by learning who they are as people and what their principles are, sitting down with the patient in

Reference	Focus of the study	Findings of the study	Findings relevant to this study and the cultivation of caring presence
		nurses analyse and do things in their environment. In this study, mindfulness is spoken about and suggested as a way nurses can be present with the patients under their care in order to give them better care. In this way, nurses will have an increased awareness, be more attentive and, pay more attention and with sympathy to patients under their care.	instances such as having an actively dying patient, slowing down when approaching patient and watch own body language, being focussed, show empathy. Evidence grading: Grade III (limited)
Finfgeld-Connett, D. 2006. Meta-synthesis of presence in nursing. *Journal of advanced nursing*, 55(6):708-714.	The aim of this study was to report a meta-synthesis of the concept of presence using nursing literature.	Presence is enacted in moments, over days, weeks or even years and, its qualities are interpersonal sensitivity, and being holistically oriented. Presence is a process with many antecedents such as patient's needs, openness and the nurse's willingness, his/her personal profession and maturity as well as a contributory working environment. Its attributes are characterised by aspects such as holism, intimacy and vulnerability. The expected outcome of presence is increased mental and physical wellbeing for the patient and enhanced mental well-being for nurses enacting presence.	The findings of this study provide a clear insight into the concept of presence. It gives positive experience and how to implement presence in the working environment as well as the reason for implementing it both for the nurses and for the patients. Therefore, it is not possible to have a good nursing presence when the patient does not have the need and capacity and openness for it. Thus, presence can be cultivated through identifying the needs of patients, openness, nurse's willingness, personal and professional maturity, and moral underpinnings, having a conducive work environment, sensitivity, holism, intimacy, vulnerability and uniqueness. Evidence grading: Grade I (good)

Reference	Focus of the study	Findings of the study	Findings relevant to this study and the cultivation of caring presence
Godkin, J. & Godkin, L. 2004. Caring behaviours among nurses fostering a conversation of gesture. *Health care manage rev*, 29(3):256-267.	The aim of this study was to suggest ways through which nursing presence can be discovered and taught. Thus, its purpose is to encourage caring behaviour in nursing	Caring behaviours can ease the development of nursing presence in many dimensions such as uniqueness through communication, respect, aid, comfort and empathy. Caring behaviours can also be developed by connecting with the patient's experience and by sensing patient's needs. The author of this article also suggests that more models of caring should be available in nursing to increase flexibility in clinical practice. It suggests Neurolinguistic Programming (NLP), which entails creating a description of the process that can be used and polished to finally create a service based on that description. This is done by creating habits, thus, nursing presence can be analysed and transmitted from generation to generation or to others. He, therefore, suggests that presence is cultivated through bedside presence, clinical presence and healing presence	The findings of this study suggest ways to teach nursing presence and also how to convey it to others in nursing practice. Thus, it suggests caring presence can be cultivated through uniqueness, connecting with the patient's experience, sensing, communication, respect, going beyond the scientific data, knowing what will work and when to act and being with the patient. Evidence grading: Grade I (good)
Godkin, J. 2001. Healing presence, *Journal of holistic*, 19(1): 5-21	The article suggests a three-stage, hierarchical model in presence, resulting in healing presence	A three-stage model culminating in healing presence is used to understand the nurse-patient relationship, the model comprises three stages namely: • Bedside presence in which the nurse connects with the patient's experience and being aware of	In this study, a model called hierarchy of healing presence is used to explain how healing presence can be enacted in different areas of care in nursing. It gives the advantages for the nurse as well as the patient when using such model of care which is a holistic care and the need of nurse-

Reference	Focus of the study	Findings of the study	Findings relevant to this study and the cultivation of caring presence
		his/her own uniqueness and that of the patient; • Clinical presence which entails going beyond scientific data by being aware of the forms of human response and, sensing by perceiving signals sent by the patient and being able to interpret them; and • Healing presence which comprises being present, knowing what will work and when to act.	patient dyad. Thus, caring presence can be enacted through uniqueness, connecting with the patient's experience, sensing, going beyond the scientific data, knowing what will work and when to act and being with the patient. Evidence grading: Grade I (good)
Hooper, D. 2013. The caring presence of nursing: a qualitative focus. *Journal of perianesthesia nursing*, 28(5):255-	The aim of this study was to describe the patient's experience of presence while undergoing a surgical procedure in the paranaesthesia setting.	The study implies that presence is more than just being at the bedside of the patient.	The techniques that can be used to foster caring presence are as follows: being actively and intentionally engaged with the patient; be one with the patient; step outside of just doing your job; use eye contact; actively listening; and be fully engaged. Grading level: Grade III (limited)
Iseminger *et al*. 2009. Healing during existential moments: the "art" of nursing presence. *Nursing clinic of North America,* 44(4):447-459.	The aim of this study was to actualise the concept of nursing presence and to facilitate its use by nurses and meet the needs of holistic care of patients. From actual and perceived barriers to nursing presence and nursing student	The following interventions are necessary to improve presence by nurses: awareness; empathic appreciation; appreciative abandonment; being respectful and listening; having skilled communication; having a selective focussing; availability; awe; openness; flexibility; supportive	The findings of this study shows that nurses who cared for patients with a transcendent practice, being aware, empathic, listening, being respectful towards patients, had a good skill of communication, were opened, flexible and had an enhanced nursing presence during their care.

Reference	Focus of the study	Findings of the study	Findings relevant to this study and the cultivation of caring presence
	barriers to nursing presence, through transcendent practices, to enhanced nursing presence.	milieu; having the ability to embrace another's situation; being aligned with the organisational mission.	Evidence grading: Grade II (fair)
McMahon M.A & Christopher, K.A. 2011. Towards a mid-range theory of nursing presence. *Nursing forum*, 46(2):71-82	The aim of this study was to come up with a mid-range theory of nursing presence to assist nursing students understand presence and gain skills necessary for applying presence to facilitate the incorporation of the humanistic aspect of patient care in the undergraduate curriculum of student nurses.	Nursing presence depends on five elements as follows: • Individual nurse characteristics such as professional maturity, moral maturity, relational skill maturity and personal maturity; • The patient's characteristics, which include the patient's openness, the relationship with the nurse, his/her level of weakness during illness/wellness state and the history of nursing presence; • The nurse-patient dyad characteristics, which include gender, age, culture, belief or spirituality and history of nurse-patient relationship; • Some environmental factors such as the environmental atmosphere of the healthcare delivery setting, time restraint for staff members, and increasing use of technology in clinical setting; • The practice consideration: this depends on the decision and priorities of the patient's need for	The findings of this study reveal that nurses should be taught about the concept and skills of presence from the Baccalaureate programme. Skills learned in nursing presence are the following: identification and utilisation of the nurse's sensitive points in order to facilitate presence, how to foster professional maturity among nurses, increased ability to identify types of presence and how to apply them, learning to anticipate the patient's needs, offering self, identifying patient's vulnerability and threats and how to implement presence in this case, develop reflective skills in nursing in order to determine how nursing presence can be applied in specific cases. Thus, skills related to nursing presence should continuously be applied and taught for better patient care in clinical settings. Evidence grading: Grade II (fair)

Reference	Focus of the study	Findings of the study	Findings relevant to this study and the cultivation of caring presence
		presence as determined by the nurse.	
Osterman, P.L.C. *et al*. 2010. An exploratory study of nurses' presence in daily care on an oncology unit. *Nursing forum*, 45(3):197-205	The aim of this study was to explore the use of presence among nurses in an oncology unit. Also, the limitation of understanding of nursing presence and how it can be implemented by nurses was addressed in the study.	Presence was engrafted in the nurse's attitude and approach during morning care. The patient's attitude seems to direct the way nurses enact presence. Thus, three types of presence were identified in the process: physical presence (for example eye contact); partial presence; and full presence.	The findings show that nurses may enact presence depending on their patient's attitude. It also shows that patients rely more on their nurses when they feel cared for. Means to enact presence identified in the study were as follows: creativity; humour; thoughtful manner towards patients; observing readiness and openness of patients; emotional support; being playful; reflective thinking; and active dialogue among nurses about the concept of presence. Evidence grading. Grade I (good)
Pederson, C. 1993. Presence as a nursing intervention with hospitalised children. *Journal of mental-child nursing*, 1993:75-81	Using literature on nursing presence, a discussion was done on the importance of nursing presence with children, and information on ways in which nurses can operationalise and evaluate presence.	• Presence is characterised by openness, availability and being wholly at the disposal of another being • Presence is the connection between people with different people. A nurse practising presence views a patient as a person and not an object. Some expressions of nursing presence are communication (dialogue), empathy, using self as an	Nurses should develop skills and be willing to practise caring presence towards children and their parents and/relatives. Thus, presence can be fostered through the following: openness, availability and being wholly at the disposal of another; view a patient as a person and not as an object, communication (dialogue), empathy, using self as an intervention instrument for the sake of patient's care. Presence should not merely be physical but being in connection with each other, using eye

Reference	Focus of the study	Findings of the study	Findings relevant to this study and the cultivation of caring presence
		intervention instrument for the sake of a patient's care. Presence should not merely be physical but being in connection with each other, using eye contact, friendly body language, a tender tone of voice Another aspect of nursing presence is parental presence when the nurse encourages parents to be by the children's side constantly as they can, more especially when going through situations such as surgical operation. Nurses display caring presence here by being there physically and giving emotional support to both parents and their child.	contact, friendly body language, a tender tone of voice, encourage parents to be by the children's side constantly as they can, more especially when going through situations such as surgical operation, being there physically and giving emotional support to both parents and their child. Nurses need to be in touch with self in order to do caring presence with their patients, having self-awareness, be committed to assist others and having the necessary skills for their duties as a carer, thus, must acquire, when necessary, relevant skills. Evidence grading: grade I (good)
Snyder *et al*. 2000. Use of presence in the critical care unit. *AACN Clinical issues*, 11(1):27-33.	Literature used to discuss the importance of caring presence in critical care units. An elaboration of the importance of caring presence is given as well as techniques used by nurses in critical care unit in implementing caring presence.	People should be feel the presence and not be objects to each other. The following techniques can be used by nurses in the critical care unit: • Use "centering" (being in the meditative mood) before getting into contact with the patient. For example, take a pause and do some reflection before entering the room, focus on the patient by repeating their name.	Caring presence is manifested by being competent, attentive, concerned and being available both physically and beyond with the patient and family. The following techniques can, thus, be used to foster presence: use "centering" (being in the meditative mood) before getting into contact with the patient; take a pause and do some reflection before entering the room; focus on the patient by repeating their name; eye contact, touch as appropriate to

Reference	Focus of the study	Findings of the study	Findings relevant to this study and the cultivation of caring presence
		Another technique is eye contact, touch as appropriate to make. As nurse pause before entering the room, take many slow breaths. Do not rely much on technologies to care for patients, so show humanity	make. As a nurse pauses before entering the room, take many slow breaths, do not rely much on technologies to care for patients, so show humanity. Evidence grading: grade I (good)

3.6.3 Synthesis of findings

Using thematic analysis, the findings from each of the 17 studies were compared and synthesised, for similarities and divergences (CRD, 2009:228). Appendix G provides an overview of the data synthesis process. Thus, from the extracted data (Tables 3.8 and 3.9), different themes and sub-themes were identified as strategies through which caring presence can be cultivated in nursing. Many themes and subthemes were identified. Furthermore, due to similarities, some were grouped into themes and some as sub-themes. Five main themes with or without sub-themes emerged, as shown in Table 3.10. These themes and sub-themes are discussed in the following section.

Table 3-10: Themes and sub-themes identified

No	Themes	Sub-themes
1	The cultivation of caring presence in nursing through critical thinking skills and awareness.	1.1. The cultivating caring presence using active listening skills; 1.2. The cultivation of caring presence through being authentic and realistic; and 1.3. The cultivation of caring presence through patient assistance in decision-making.
2	The cultivation of caring presence through holistic care	2.1 Cultivating caring presence through humour, being playful and other skills to relieve patient's stress and anxiety; 2.2. Cultivating caring presence through physical, spiritual and emotional/psychological enhancement; 2.3. Cultivating caring presence through the use of self as an intervention instrument; 2.4. The cultivation of caring presence through mindfulness and meditation techniques; 2.5. Cultivating caring presence through a therapeutic environment; 2.6. Cultivating caring presence through focusing more on human means of care and less on technological means; and 2.7. Cultivating caring presence by considering particular events and people related to patients such as birthdays and family members.
3	The cultivation of caring presence in nursing through awareness of the concept 'presence' and different types of presence.	3.1. Cultivating caring presence through the knowledge of physical and partial presence; 3.2. The cultivation of caring presence through the knowledge of full presence; and 3.3. The cultivation of caring presence through the knowledge of transcendent connectedness.
4	The cultivation of caring presence through fostering personal and professional growth.	
5	The cultivation of caring presence through reflection.	

3.6.3.1 The cultivation of caring presence in nursing through critical thinking skills and awareness

3.6.3.1.1 Cultivating caring presence using active listening skills

Nurses should be made aware, encouraged and trained to use critical thinking skills in caring for patients. This is important to examine the patient's experience for care (Iseminger *et al*, 2009:447-459; Anderson 2007:14-21; Hooper, 2013:255-256).

3.6.3.1.2 Cultivating caring presence through being authentic and realistic

To be authentic and realistic, the nurse must demonstrate compassion, competence, confidence, be conscious and committed. According to Anderson (2007:14-21), in a therapeutic relationship between the nurse and the patient, the nurse's presence should be authentic. Thus, the nurse's level of confidence to attend to the patient's needs may contribute to the integration of presence as a therapeutic intervention for both the patient and even related ones. Therefore, the nurse must be able to demonstrate confidence in attending to the needs of the patient. Osterman (2010:197-205) states that nurses must be more conscious of the role of presence in their interaction with the patient under their care. Consciousness is a way of showing authenticity and awareness in nursing presence. Pederson (1993:75-81) stresses that nurses should be committed to assist others and have the necessary skills for their duties as a carer. They must, therefore, seek to acquire, when necessary, relevant skills in caring presence. According to Hooper (2013:255-256), nurses should be fully committed because patients need them to enact presence, however they can.

3.6.3.1.3 Cultivating caring presence through assistance to patient's in decision-making

The nurse must assist the patient in making decisions that could affect their condition. For example, according to Iseminger *et al*. (2009:447-459), the nurse must consider helping the patient to be enhanced spiritually, emotionally and not only physically. Another example given by Anderson (2007:14-21) is that patients, relatives and caregivers of the patient should be assisted in taking or giving the patient's prescribed treatment as a way of caring presence.

3.6.3.2 The cultivation of caring presence through holistic care

Holistic care, which entails the mind, the body, the spirit, the emotions and the environment of the patient, is beneficial for caring presence (Iseminger *et al.*, 2009:447-459; McMahon & Christopher, 2011:71-82; Hooper, 2013:255-256; Coffman, 2007:52-56; Covington, 2002; Duis-Nittsche, 2002; Godkin, 2001:5-21; Snyder *et al.,* 2000:27-33). Nurses should receive the person (patient) as they are, be holistic and balanced. They should, therefore, be taught about the aim

of holistic care in connection to caring presence (Coffman, 2007:52-56). Recognising and be considerate of the patient's religious belief, cultural beliefs, special events such as birthdates, contribute to good caring presence (Duis-Nittsche, 2002). The findings obtained by Snyder *et al.* (2000:27-33) revealed that treating patients as human beings and not an object, not relying on technology to care but rather considering being humanness, taking into consideration the whole being, leads to positive results, thus bringing a level of satisfaction to both the patient and the nurse. According to Godkin (2001:5-21), being clinically present, going beyond scientific data by being aware of the forms of human response should be encouraged as well as sensing by perceiving signals sent by the patient and being able to interpret them.

3.6.3.2.1 Cultivating caring presence through humour, being playful and other skills to relieve patient's stress and anxiety

According to Iseminger *et al*. (2009:447-459), humour is an intervention related to caring presence and is part of the nursing intervention classification (NIC), which is part of the practices recognised as beneficial to good nursing practice in general. Nurses should, therefore, use humour as an intervention in caring presence. Anderson (2007:14-21) argues that humour is part of the therapeutic presence not only offered to the patient but to the relatives as well as intervention in nursing care. Additionally, Osterman (2010:197-205) stresses how important and helpful humour is in teaching a patient as it also enhances good comprehension, thus making learning easier for the patient. Furthermore, Duis-Nittsche (2002) explains that humour can be used to facilitate interpersonal communication between the nurse and the patient in interviewing the patient (for example, about their progress), teaching and communication in general with the patient.

3.6.3.2.2 Cultivating caring presence through physical, spiritual and emotional/psychological enhancement

According to Iseminger *et al.* (2009:447-459), taking care of the physical, spiritual and emotional needs of the patient is the gist of clinical nursing practice and, therefore, essential in nursing presence. For example, women in labour usually describe nursing presence during the time of their labour being there physically, touching and talking to them, encouraging them emotionally and spiritually through prayers and meditation as well. Fahlberg and Roush (2016:14-15) conducted a study on nursing presence and found that there is a connection and exchange of human experience through therapeutic touch (physical), compassion, spiritual exploration, psychological and psychosocial means, which entails all these three levels of enhancement. According to Godkin (2001:5-21), patients use the term 'caring presence' to describe nurses and those who pay attention to them physically and emotionally, making them feel valued and important. He also emphasises that working on the physical, emotional and psychological life of

patients makes it easier to connect with the patient's experience, which is essential in caring presence. Studies by Delashmutt (2007:183-189); Covington (2002:1-199); Duis-Nittsche (2002:1-244) also revealed that when nurses make themselves available physically, emotionally as well as spiritually to their patients, the essence of presence can be holistically achieved in a way.

3.6.3.2.3 Cultivating caring presence through the use of self as an intervention instrument

According to McMahon and Christopher (2011:71-82), when the nurse fully gives self during presence, it encourages the patient to do the same, leading to deep patient-nurse engagement. Additionally, Finfgeld-Connett (2006:708-714) state that in presence, it is essential to use oneself as an intervention instrument in caring. Delashmutt (2007:183-189) used an example of a student who wrote the following statement: "we achieve nursing presence by giving our whole self to the patient…if we are missing an aspect of our personality, how can we then be totally giving yourself?" This statement concurs with giving oneself fully in caring presence as we care for the patient. Furthermore, Du Plessis (2016a:377-380) provides a definition of presence as purposefully focusing on the patient and paying attention to their needs while fully offering self to be with the patient and aiming at healing. Coffman (2007:52-56) also provides a definition of presence as "a mode of being available or opened in a situation with the wholeness of one's unique individual being, a gift of the self and which can only be given freely". Additionally, Hooper (2013:255-256) states that patients undergoing procedures, such as surgical procedures, need nurses to be fully committed and patients need their enactment of presence.

3.6.3.2.4 The cultivation of caring presence through mindfulness and meditation techniques

According to Fahlberg and Roush (2016:14-15), "mindfulness in nursing is a transformative process in which one develops an increasing ability to experience being present with awareness, acceptance and attention". Fahlberg and Roush (2016:14-15) thus, consider mindfulness as treating the patient with awareness, acceptance and attention, and requires that the nurse purposefully pays attention to the moment, to be actively engaged, be non-judgemental, empathic (putting yourself in their shoes). It also requires calmness, taking a deep breath and relaxation, appropriate body language, be focused while eliminating distraction, sit down with patients and family sometimes to show how important they are. For instance, a nurse can chose to be with a patient at a quiet moment when the patient is in deep thought because of his or her situation. Just to be there, touching the patient and simply chatting with him/her, can be a good way of implementing mindfulness technique in presence. Furthermore, Du Plessis (2016b:47-53) gives some examples of ways to enhance mindfulness as a way of cultivating presence among staff members. The author maintains it should begin from the people enacting presence, and

thereafter, be implemented with patients. Some techniques given are as follows: walking; prayer; breathing centering; and reflection. Du Plessis (2016b:47-53) further stresses that awareness, attention and acceptance should be developed. Emphasis should be placed on the development of mindfulness at work and in nursing education ceremonies. According to Snyder *et al.* (2000:27-33), nurses should be taught meditative mood or "centering". This technique needs to start before getting into contact with the patient to gain more focus on the person or the patient and his/her situation, thus cultivating caring presence through a therapeutic environment

According to McMahon and Christopher (2011:71-82), the environment is one of the crucial factors during nurse-patient dyad or interaction and consequently, has an impact on the quality of presence. These environmental factors comprises the physical setting and the professional tone of the workplace, proper staffing (for example, having an appropriate number of workers with good relationship among them will promote collaborative working relationships), a supportive nursing management, the culture of the unit, whether it considers relational aspect or not, will have an effect on presence. Another factor is the allocated time to the nurse to perform certain duties and the increasing use of technology. Similarly, Du Plessis (2016b:47-53) and Finfgeld-Connett (2006:708-714) suggest a number of aspects to be considered in the working environment in order to enhance presence. These factors are: management that support employees and strive to make nurses to work cooperatively; supportive members of staff; utilising technology wisely; and consideration of psychological and spiritual concerns.

3.6.3.2.5 Cultivating caring presence through focusing on human means of care and less on technology

According to Godkin (2001:5-21); Coffman (2007:52-56); Duis-Nittsche (2002:1-244) and Snyder *et al.* (2000:27-33), the concept 'nursing presence' has its meaning in the humanistic nursing theory. Therefore, when implementing caring presence, the patient should be considered as a human being that he/she is. The nurse should be available for the patient and use humanistic means, going beyond scientific data to care for the patient. For example, the use of technology should be really limited and should not interfere with taking the whole of the patient into consideration. The nurse should care and show empathy, taking into consideration, time to attend to their needs.

3.6.3.2.6 Cultivating caring presence through consideration of particular events and people related to the patient

Furthermore, particular events and people related to the patient should be considered. For example, Fahlberg and Roush (2016:14-15) stress the importance of considering members of the

family to assist in relieving anxiety and stress as it is often the case, more especially when the patient is also having tough times. Tips such as good facial expressions (friendly and easily approachable), tone of voice, and body language should be done carefully and with consideration to help relieve the patient and relatives. Furthermore, Pederson (1993:75-81) maintains it is important to use parental presence by encouraging parents to be by the children's side as constantly as they can, more especially when going through situations such as surgical operation. Nurses display caring presence here by being there physically and giving emotional support to both parents and their children. In considering particular events pertaining to the patient, Duis-Nittsche (2002) states that nurses should ensure that particular events concerning patients such as birthdays be taken into consideration. Also, keeping in contact with patients when transferred to other wards, by calling or visiting, is another way of practising caring presence.

3.6.3.3 The cultivation of caring presence through awareness of the concept of presence and types of presence

3.6.3.3.1 Cultivating caring presence through knowledge of physical and partial presence

This type of presence entails merely being close to the patient mostly physically, not the full being is present. In this type of presence, the nurse can be present as they are in a room and or close to the patient with their physical body, but not fully present because one can be present physically, but the mind is absent though; it can give some comfort to the patient (Plessis, 2016:377-380). Some studies refer to this type of presence as bedside presence, as the nurse is physically present at the bedside of the patient (Delashmutt, 2007:183-189; Godkin, 2001:5-21). Godkin (2001:5-21) considers bedside presence as an opportunity that the nurse must grasp to connect with the patient's experience and being aware of his/her own uniqueness and that of the patient. The author believes, in this way, patient satisfaction will be met and increased healing potential in nurse-patient dyad will be achieved.

3.6.3.3.2 Cultivating caring presence through the knowledge of full presence

Anderson (2007:14-21) states that presence, as a therapeutic intervention, needs a nurse who has a considerable level of maturity, level of experience, confidence and conscience. Thus, a nurse must go beyond physical presence. Full presence, according to Du Plessis (2016a:377-380), is unique and entails empathy, caring and innovation (creativity). The findings obtained by Godkin and Godkin (2004:256-267) suggest that full presence entails caring behaviour and can ease the development of nursing presence in many dimensions by practising skills such as uniqueness through communication, respect, aid, comfort and empathy and by sensing the needs of patients. The author considers communication as a key means to attaining full nursing presence. Finfgeld-Connett (2006:708-714) stresses that the expected outcome of presence is

increased mental and physical wellbeing for the patient (full presence) and enhanced mental well-being for nurses enacting presence.

3.6.3.3.3 Cultivating caring presence through transcendent connectedness

According to Covington (2002), presence is journeying towards the mutual goal for both the nurse and the patient to be fully connected to each other, and this entails transcending connectedness as the nurse and the patient are joined physically (e.g. hug, smile, touch) and in spirit. Transcending connectedness also entails unconditional acceptance, empathy, making the patient feel reassured and connected to the nurse. Transcendent connectedness also entails metaphysical experience, which happens when both parties are absorbed in the moment, are spiritually bonded, interrelated and there is an exchange of energy. This, therefore, results in a feeling of a force beyond self when fully committed as energy flows from one person to another. Transcendental presence is, therefore, spiritual in nature and arouses positive feelings of connection and happiness (Du Plessis, 2016a:377-380). Du Plessis (2016a:377-380) argues that it is the most powerful means of restoration to wholeness after a trauma to an individual.

3.6.3.4 The cultivation of caring presence through fostering personal and professional growth

Personal and professional growth is essential in caring presence as it takes the nurse from one point to another, gaining knowledge and professional maturity. Thus, nurses should be encouraged to grow using means such as learning from their superior at their place of work. For example, at a place of work, nurses who are interested in knowledge about caring presence, can learn from the clinical nurse specialist (CNS). Therefore, the CNS can pay attention as he/she observes the interaction of the subordinate nurse with the patient and give advice or role model (being a good example). Subordinates can all work under the guidance of the CNS and, progressively, gain knowledge and growth (Iseminger *et al*., 2009:447-459). According to McMahon and Christopher (2011:71-82) and Finfgeld-Connett (2006:708-714), professional maturity and growth are very essential in caring presence. The nurse with professional maturity is the one with the capacity to determine the physical, psychological and therapeutic level of presence to be implemented in a specific case. Finally, Anderson (2007:14-21) states that personal and professional growth can be achieved through reflection on past experiences, thus developing new strategies for future encounters. Nurses need to be authentic, committed, conscious and sensitive towards the needs of patients.

3.6.3.5 The cultivation of caring presence through reflection

Nurses should use their own thinking to reflect on their own vulnerability with the patient as an individual (Osterman, 2010:197-205). The level of vulnerability of a nurse, as the one caring for the sufferer and their awareness, can contribute to caring presence. This is because nurses must be opened to any situation they are facing during care, some environmental factors (e.g. working condition), cultural differences and factors such as the age and race should, therefore, not interfere with the care, rather, the nurse can use it as a mean to effectively do caring presence as he/she expresses acceptance towards the patient (McMahon & Christopher, 2011:71-82). According to Du Plessis (2016b:47-53), nurses should be encouraged to choose to be vulnerable with the patient, to respect differences, have unconditional positive regards and, therefore, reflect on intimacy with a patient as a way to connect with that particular patient.

3.7 Summary of chapter

The chapter focused on data analysis and the presentation of the findings of the systematic review. A detailed explanation was given of how data was collected and classified, the realisation of the search strategy, papers excluded in the study as well as the reason for their exclusion. A description of the critical appraisal was also provided. In answering the review question, a summary and synthesis of the findings were provided. The next chapter (Chapter 4) focuses on the conclusions, limitations of the study and recommendations for the cultivation of caring presence, nursing practice, education and nursing research.

CHAPTER 4
CONCLUSIONS, LIMITATIONS AND RECOMMENDATIONS

4

4.1 Introduction

This chapter provides conclusions regarding the cultivation of nursing presence in nursing. These conclusion statements, together with the findings, as discussed in Chapter 3, provide a synthesis of high quality literature on how caring presence can be cultivated among nurses. The rigour and limitations pertaining to this study are also discussed as well as recommendations for nursing practice, nursing education and nursing research.

4.2 Conclusions

The research question stated in Chapter 1 was: “What strategies are available on how caring presence can be cultivated in nurses?” During the systematic review, it was evident that there is limited information on the cultivation of caring presence and, therefore, more research is needed regarding this topic. However, in answering the research question, conclusions could be formulated from the synthesised findings. Therefore, the conclusions included recommendation on how to practice caring presence, the means through which caring presence can be enhanced and its implication for health.

4.2.1 Conclusion statement 1

Existentialism (considering the thinking, acting and the feeling of a person) and the spirituality of the individual are relevant in caring presence. It is, therefore important to use techniques in helping the patient to be enhanced spiritually, emotionally and not only physically in enacting caring presence. In addition, caring presence can also be fostered through nursing education by teaching nursing students and the nursing staff.

4.2.2 Conclusion statement 2

Educating nursing students and exposing them to the clinical practice of presence is effective in cultivating caring presence among nurses from an early stage in their career. Therefore, since nursing presence can be a challenge for nursing students and nursing educators, introducing a mid-range theory of nursing presence will be of assistance in nursing education where nursing presence needs to be cultivated (McMahon & Christopher, 2011:71-82). Thus, the mid-range theory entails using literature on presence to analyse how different techniques and types of

presence used in clinical settings by nurses such as features of individual nurses, patients, shared features between the nurse and the patient (nurse-patient-dyad), the environment and the aim as well as the determination of the nurse in enacting presence and achieving satisfactory results for both the patient and the nurse can bring about many beneficial outcomes for patients. Presence should, thus be considered at the clinical setting and also by student nurses in training.

4.2.3 Conclusion statement 3

Mindfulness and meditation are essential in enacting presence (mindful presence). Mindfulness entails awareness, acceptance and attention and requires the nurse to purposefully pay attention to the moment, active engagement, be non-judgemental and empathic (putting yourself in their shoes). It also requires calmness, taking a deep breath and relaxation, appropriate body language, be focused while eliminating distraction, sit down with patients and family sometimes, to show how important they are. In addition to techniques of caring such as holistic care, reciprocity, sincerity, attentive listening, intimacy, therapeutic touch, spirituality, empathy, recognition of patient's psychological, psychosocial and physical needs and recognition of patient's family, mindfulness is necessary as it contributes to change for the nurse and the patient and goes beyond simple presence.

4.2.4 Conclusion statement 4

Using reflection on intimacy, choosing to be vulnerable when with the patient, respecting the patient as an individual with differences, having unconditional positive regard, critical thinking skills and mindfulness in nursing are all essential in enacting caring presence as they are ways to connect to the patient and facilitate good achievement in nursing care.

4.2.5 Conclusion statement 5

The findings revealed that nursing presence has dimensions that are effective in caring presence such as the uniqueness of the nurse and how he or she connects with the patient's experience, having the ability to sense what is wrong or right with the patient without him/her talking yet and going beyond scientific data by being able to discern the form of human responses. Therefore, applying principles such as the hierarchy of healing presence (a model), is essential and entails bedside presence, clinical presence and healing presence respectively. All these aspects of caring can inspire nurses and give them a positive feeling in providing caring presence, as when implemented, the patient as well as the healer are both changed.

4.2.6 Conclusion statement 6

Attributes of caring presence such as holism, intimacy, vulnerability, sensitivity, uniqueness, own enhanced mental well-being, own willingness, personal and professional maturity and a conducive work environment, when properly applied, contribute to the wellbeing of patients and nurses. Furthermore nurses need to be more familiar with the term ‘presence’ in order to easily enact presence.

4.2.7 Conclusion statement 7

Caring behaviour can facilitate the development of nursing presence in many dimensions by practising skills such as uniqueness through communication, respect, aid, comfort and empathy. Another skill is connecting with the patient’s experience through communication, respect and providing information. The third skill here is sensing using aid, communication and empathy. Caring behaviour can also be developed by connecting with the patient’s experiences and by sensing the needs of the patient. Communication is a key means to attaining nursing presence. Models of caring should be available in nursing to increase flexibility in clinical practice. Finally, nursing presence can be analysed and transmitted from generation to generation or to others.

4.2.8 Conclusion statement 8

Presence, as a therapeutic intervention, needs a nurse who has a considerable level of maturity, level of experience and confidence. Therefore, presence entails a non-judgemental attitude from the nurse. It also entails therapeutic presence through compassion, support through active listening, touch, humour, continuity of care and alleviation of grief. The nurse needs to be self-aware, open, flexible, ready and willing to accept other situations. Therefore, a nurse needs a great sense of commitment, be conscious and have a high communication skill in enacting presence. Finally, presence is an inherent part of nursing as it helps in building trusting relationships, accomplish medical stability and a method of preventing crisis if implemented by nurses.

4.2.9 Conclusion statement 9

The type of enactment used by nurses in caring presence depends mostly on the readiness and openness of their patients. Since patients rely on nurses for communication most of the time, that active dialogue among nurses is also important in enacting presence. Aspects such as reflective thinking, being consciously aware, communication, openness, emotional support of patient, having a good attitude and being playful (humour), sometimes, are necessary in enacting presence. Being willing to give oneself fully in a relationship, empowers patients and promote

health. Hence, the nurse enacting presence needs the following for optimum patient care: a reciprocal communion between patient and self, which goes beyond just physical needs of the patient; physical closeness through bedside presence; uniqueness of the nurse through the art of nursing action and be a good listener. All in all, the nurse must be physically, mentally and spiritually present. Therefore, using a patient's situation such as poverty to make nurses or nursing students get a better understanding of presence is effective. Finally, being willing to give oneself fully in a relationship, empowers the patient and physical, spiritual and clinical outcome.

4.2.10 Conclusion statement 10

Presence can be divided into three components as follows: physical and partial presence, which entails merely being close to the patient (not the full being is present at the moment); full presence, which is unique and entails empathy, caring and innovation (creativity); and transcendental presence, which is spiritual in nature and arouse positive feelings of connection and happiness. The researchers argues it is the most powerful means of restoration to wholeness after a trauma to an individual. Thus, the need for research on the topic. Media platforms should also be used to encourage nurses to share stories of caring presence and transformational change in the promotion of good quality care and improvement of well-being.

4.2.11 Conclusion statement 11

Having an attitude of care and practising caring presence should be encouraged among students in nursing programmes and be taught at school. Therefore, steps towards realising a healing presence begin with oneself as the carer, by being honest, insightful, and open to one's uniqueness, humanness, prejudices, brokenness and wholeness. Other steps for being present include having the intention to be a healing presence, arrange space for such presence, respect the one under your care, offer what you have to give, receive the person as he or she is and be holistic and balanced. In conclusion, nursing presence can be taught not only in clinical settings and with patients but also in the community and in schools using people of such community as they share their experiences of what they think presence is.

4.2.12 Conclusion statement 12

As a journeying towards the mutual goal for both the nurse and the patient, presence has three components as follows. The first component is mutual trust in which trust must be established between the two parties. The second component being transcending connectedness, which entails the joining of two individuals' spirits, physical connection (e.g.: hug, smile, touch); transcending connectedness also entails unconditional acceptance, empathy, making the patient feel reassured and connected to the nurse. The third component is metaphysical experience,

which happens when the parties are absorbed in the moment. This last one entails spiritual bonding, interrelatedness, feeling of exchange of energy, and feeling of a force beyond self when absorbed wholly and in harmony as energy flows from one person to another. Thus, in clinical settings, using experience between nurse and patients, over time, presence can be distinguished as a journey towards a mutual goal as the above-mentioned characteristics of caring are reflected.

4.2.13 Conclusion statement 13

Nursing presence goes beyond just being physically present and rendering technical care. It entails attention, connection and engagement between the nurse and the patient. Presence also entails knowing the patient, responding to his or her needs, having a positive attitude towards a patient. It also involves bonding with patients? And encouraging them. Presence also involves considering the patient as a human being, knowing the patient physically, emotionally and spiritually, it entails being intuitive about if the patient is recovering or not. It involves a good interaction between the nurse and the patient and, explaining to the patient about his or her condition, listening, being compassionate and in connection. It also entails recognition of cultural, religious and personal beliefs of the patient, being patient, using humour effectively and making eye contact. It further entails physical touch, hugs and others direct contact. That particular events concerning a patient such as birthdays, are taken into consideration. Thus, when successfully applied, nursing presence has the potential to bring a sense of satisfaction and fulfilment to both the patient and the nurse.

4.2.14 Conclusion statement 14

Presence is characterised by openness, availability and being wholly at the disposal of another being. A nurse should be conscious that presence is the connection between two different people. A nurse practising presence views a patient as a person and not an object. Some expressions of nursing presence are dialogue, empathy, using self as an intervention instrument for the sake of a patient's care. Another aspect of nursing presence is parental presence, when the nurse encourages parents to be by the side of the children as constantly as they can, more especially, when going through serious or critical situations such as surgical operation. A nurse should display caring presence in this case by being there physically and giving emotional support to both parents and their children. Nurses need to be in touch with self in order to provide caring presence with their patient, having self-awareness, be committed to assist others and having the necessary skills for their duties as a carer. Thus, the nurse must acquire, when necessary, relevant skills. Hence, presence is a critical element of nursing care in all settings.

4.2.15 Conclusion statement 15

People should provide presence and not act as objects to one another. Therefore, the following techniques should be used: “centring” (being in the meditative mood) before getting into contact with the patient, for example, take a pause and do some reflection before entering the room, focus on the patient by repeating their name; eye contact, touch as appropriate to make; a nurse should pause before entering the room and take as many slow breaths as possible; the nurse should not rely much on technologies to care for patients and must show humanity. Additionally, nurses can cultivate their presence abilities by using observation skills to learn from those enacting presence more efficiently, nurses can also require feedback from patients, including children with whom they have enacted presence to make corrections when needed, thus making a difference.

4.3 Evaluation of rigour

The guidelines as suggested by Whittemore and Knafl (2005:546-553) were used to evaluate the rigour of this study. The evaluation was done based on the problem identification, the literature search, the data evaluation, the data synthesis and the presentation stages.

4.3.1 Problem identification stage

In this systematic review, the problem was identified accompanied by a clear review question and a purpose of the review based on preliminary exploration. Afterwards, the concept of concern and the appropriate method for the systematic review were determined (Whittemore &Knafl, 2005: 548).

4.3.2 Literature search stage

A well-defined literature search strategy was followed. All relevant literature was collected through relevant databases after identifying the most appropriate key words. Manual searches were also done using reference lists. All these searches were conducted based on the purpose of the review and in collaboration with the research supervisors and an independent reviewer. All electronic reviews were stored using the EPPI reviewer and the first stage of sifting was done using the same software, excluding duplicated reviews and thereafter, excluding or including using titles and abstracts. Subsequently, an experienced librarian at the Ferdinand Postma Library, North-West University, Potchefstroom Campus was contacted to obtain the relevant studies. Thus, all the search processes were carefully documented step by step as indicated in Chapters 2 and 3.

4.3.3 Data evaluation stage

The critical appraisal was done as explained in Chapters 2 and 3 of this study. Data from literature relevant for this study was analysed to ensure that high quality data was included (AND, 2016:27). Standard checklists were used to allocate marks/scores for each relevant study to ascertain relevance and the quality of the studies (AND, 2016:49). Hence, only studies meeting the relevant criteria and with good or high scores were retained. Studies that were of poor quality, were excluded and the rationale provided as to why they were excluded. The entire procedure was reviewed by the supervisor and the co-supervisor, who are well experienced in the field to ensure rigour. Furthermore, the entire process was carefully documented to ensure transparency (AND, 2016:59).

4.3.4 Data synthesis stage

During data synthesis, findings that were relevant to answering the review question were identified. These findings were grouped to form themes and sub-themes (see Table 3.9). A rigorous and transparent process was followed during the data synthesis stage, as documented in Chapter 2 and 3.

4.3.5 Presentation

The conclusions, limitations of the study and recommendations for future research are discussed in this Chapter (Chapter 4). Finally, the results of the study will be submitted to a peer-reviewed journal for publication.

4.4 Limitations of the study

The following limitations were identified in the course of the study:

- This systematic review was done as a Master's mini-dissertation and, therefore, was not conducted in a team. However, all the processes were conducted under the supervision of two experienced people in the field, namely; the supervisor and the co-supervisor, an independent reviewer as well as an experienced librarian;

- Electronic databases used for this study were only those subscribed to by the North-West University. This, therefore, constituted a limitation because other databases could be found apart from those used in this study. However, to overcome this challenge, a search was done using other sources such as grey literature and electronic databases;

- Some authors were contacted through email to request studies that could not be found, however, these authors did not respond to the request;
- Even though the choice of keywords was highly considered, it could be possible that some information was missed;
- The abstracts and the full texts of some publications were not always easily obtainable, an explanation has been provided in the study; and
- Studies considered for this systematic review were both neutral and of high quality, which could affect the generalisation of the study to the wider population.
- The data were collected up until the year 2016 as the search was initiated in the year 2016. The researcher is aware that there may be more recent literatures available for the year 2017-2018.

4.5 Recommendations

In the field of nursing, there is a need to cultivate caring presence. However, many are not aware or know very little about the enactment of caring presence. Therefore, the following recommendations are made for nursing practice, nursing education and research, based on the findings and conclusions of this study.

4.5.1 Recommendations for nursing practice

- Nursing leaders (such as nursing managers) and nurses in general, should be more aware and keep up to date with the best available evidence on how caring presence could be cultivated in nursing to improve nursing practice and the satisfaction of patients, by reading recent research on the practice of caring presence.
- Nurses should be trained to implement techniques such as mindfulness and meditation, which are highly connected to caring presence.
- Guidelines and protocols on the best available evidence to cultivate / enact caring presence should be made available in nursing practice. Such guidelines should be based on the themes and sub-themes that emerged in this study (see Table 3.10). The findings and conclusions of this systematic review should be considered when formulating such guidelines.
- Healthcare institutions should organise workshops to train nurses on the enactment of caring presence.

- Social media should be used by the leadership in nursing to sensitise nurses on topics such as caring presence and mindfulness in nursing.

4.5.2 Recommendation for nursing education

- The current and available evidence on how caring presence can be cultivated in nursing could be included in the nursing curriculum to educate, inform, equip nurses of all categories, including registered nurses, registered midwives, enrolled midwives, enrolled nurses and enrolled nursing assistants in order to effectively and efficiently deliver the best nursing care to the community.

4.5.3 Recommendations for nursing research

- There is lack of nursing specific research on the enactment of caring presence. Therefore, further research should be done on the cultivation and enactment of caring presence.
- Research is needed to identify and elaborate on techniques used in caring presence.
- More research is needed on the best practice in cultivating caring presence in specific settings such as in hospitals, mental health care institutions, in day clinics and in health centres.
- Further research on caring presence is needed to create awareness with regard to the enactment of caring presence and its importance in nursing care.
- Further research is needed on topics such as mindfulness, spirituality in nursing that contribute to the enactment of caring presence by nurses.

4.6 Summary of chapter

This systematic review answered the question raised in this review. Literature with regard to how caring presence is cultivated in nursing was identified and explained in the study (see Table 3.9 and discussions in Chapters 3 and 4). Nevertheless, several means through which caring presence can be cultivated in clinical settings and in nursing education were identified such as the cultivation of caring presence through the following means: critical thinking skills and awareness, holistic care, awareness of the concept of presence and types of presence, fostering personal and professional growth and, the cultivation of caring presence through reflection. However, there was no specific evidence available to demonstrate how caring presence can be cultivated in nursing. The studies were qualitative in nature, text and opinion, literature reviews, case reports, discussions and a meta-synthesis, thus, further research is needed on the specific strategies to cultivate the practice and enactment of caring presence in nursing.

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APPENDIX A: CASP CHECKLIST

CASP
Critical Appraisal Skills Programme

Section A: Are the results valid?		
1. Was there a clear statement of the aims of the research?	Yes ☐ Can't Tell ☐ No ☐	HINT: Consider • what was the goal of the research • why it was thought important • its relevance
Comments:		
2. Is a qualitative methodology appropriate?	Yes ☐ Can't Tell ☐ No ☐	HINT: Consider • If the research seeks to interpret or illuminate the actions and/or subjective experiences of research participants • Is qualitative research the tight methodology for addressing the research goal
Comments:		
Is it worth continuing?		
3. Was the research design appropriate to address the aims of the research?	Yes ☐ Can't Tell ☐ No ☐	HINT: Consider • if the researcher has justified the research design (e.g. have they discussed how they decided which method to use)
Comments:		

CASP
Critical Appraisal Skills Programme

4. Was the recruitment strategy appropriate to the aims of the research?

Yes ☐
Can't Tell ☐
No ☐

HINT: Consider
- If the researcher has explained how the participants were selected
- If they explained why the participants they selected were the most appropriate to provide access to the type of knowledge sought by the study
- If there are any discussions around recruitment (e.g. why some people chose not to take part)

Comments:

5. Was the data collected in a way that addressed the research issue?

Yes ☐
Can't Tell ☐
No ☐

HINT: Consider
- If the setting for the data collection was justified
- If it is clear how data were collected (e.g. focus group, semi-structured interview etc.)
- If the researcher has justified the methods chosen
- If the researcher has made the methods explicit (e.g. for interview method, is there an indication of how interviews are conducted, or did they use a topic guide)
- If methods were modified during the study. If so, has the researcher explained how and why
- If the form of data is clear (e.g. tape recordings, video material, notes etc.)
- If the researcher has discussed saturation of data

Comments:

6. Has the relationship between researcher and participants been adequately considered?

Yes ☐
Can't Tell ☐
No ☐

HINT: Consider

- If the researcher critically examined their own role, potential bias and influence during (a) formulation of the research questions (b) data collection, including sample recruitment and choice of location
- How the researcher responded to events during the study and whether they considered the implications of any changes in the research design

Comments:

Section B: What are the results?

7. Have ethical issues been taken into consideration?

Yes ☐
Can't Tell ☐
No ☐

HINT: Consider

- If there are sufficient details of how the research was explained to participants for the reader to assess whether ethical standards were maintained
- If the researcher has discussed issues raised by the study (e.g. issues around informed consent or confidentiality or how they have handled the effects of the study on the participants during and after the study)
- If approval has been sought from the ethics committee

Comments:

CASP
Critical Appraisal Skills Programme

Section C: Will the results help locally?

10. How valuable is the research?

HINT: Consider

- If the researcher discusses the contribution the study makes to existing knowledge or understanding (e.g. do they consider the findings in relation to current practice or policy, or relevant research-based literature
- If they identify new areas where research is necessary
- If the researchers have discussed whether or how the findings can be transferred to other populations or considered other ways the research may be used

Comments:

APPENDIX B: JHNEBP TOOLS FOR APPRASIAL OF LITERATURE REVIEWS, CASE REPORTS AND EXPERT OPINIONS

Johns Hopkins Nursing Evidence-Based Practice

Appendix F
Non-Research Evidence Appraisal

Evidence level and quality rating:	
Article title:	Number:
Author(s):	Publication date:
Journal:	
Setting:	Sample (composition and size):
Does this evidence address my EBP question? ☐ Yes ☐ No- *Do not proceed with appraisal of this evidence*	

❑ **Clinical Practice Guidelines LEVEL IV** Systematically developed recommendations from nationally recognized experts based on research evidence or expert consensus panel ❑ **Consensus or Position Statement LEVEL IV** Systematically developed recommendations, based on research and nationally recognized expert opinion, that guide members of a professional organization in decision-making for an issue of concern		
▪ Are the types of evidence included identified?	☐ Yes	☐ No
▪ Were appropriate stakeholders involved in the development of recommendations?	☐ Yes	☐ No
▪ Are groups to which recommendations apply and do not apply clearly stated?	☐ Yes	☐ No
▪ Have potential biases been eliminated?	☐ Yes	☐ No
▪ Does each recommendation have an identified level of evidence stated?	☐ Yes	☐ No
▪ Are recommendations clear?	☐ Yes	☐ No
Findings That Help Answer the EBP Question		
Complete the corresponding quality rating section.		

Appendix F
Non-Research Evidence Appraisal

❑ **Literature review LEVEL V** Summary of selected published literature including scientific and nonscientific such as reports of organizational experience and opinions of experts ❑ **Integrative review LEVEL V** Summary of research evidence and theoretical literature; analyzes, compares themes, notes gaps in the selected literature		
• Is subject matter to be reviewed clearly stated?	☐ Yes	☐ No
• Is literature relevant and up-to-date (most sources are within the past five years or classic)?	☐ Yes	☐ No
• Of the literature reviewed, is there a meaningful analysis of the conclusions across the articles included in the review?	☐ Yes	☐ No
• Are gaps in the literature identified?	☐ Yes	☐ No
• Are recommendations made for future practice or study?	☐ Yes	☐ No
Findings That Help Answer the EBP Question		
Complete the corresponding quality rating section.		

❑ **Expert opinion LEVEL V** Opinion of one or more individuals based on clinical expertise		
• Has the individual published or presented on the topic?	☐ Yes	☐ No
• Is the author's opinion based on scientific evidence?	☐ Yes	☐ No
• Is the author's opinion clearly stated?	☐ Yes	☐ No
• Are potential biases acknowledged?	☐ Yes	☐ No
Findings That Help Answer the EBP Question		
Complete the corresponding quality rating section.		

Appendix F
Non-Research Evidence Appraisal

Organizational Experience

- ☐ Quality improvement LEVEL V
  Cyclical method to examine workflows, processes, or systems with a specific organization
- ☐ Financial evaluation LEVEL V
  Economic evaluation that applies analytic techniques to identify, measure, and compare the cost and outcomes of two or more alternative programs or interventions
- ☐ Program evaluation LEVEL V
  Systematic assessment of the processes and/or outcomes of a program; can involve both quaNtitative and quaLitative methods

Setting:	Sample Size/Composition:		
• Was the aim of the project clearly stated?	❑ Yes	❑ No	
• Was the method fully described?	❑ Yes	❑ No	
• Were process or outcome measures identified?	❑ Yes	❑ No	
• Were results fully described?	❑ Yes	❑ No	
• Was interpretation clear and appropriate?	❑ Yes	❑ No	
• Are components of cost/benefit or cost effectiveness analysis described?	❑ Yes	❑ No	❑ N/A
Findings That Help Answer the EBP Question			

Complete the corresponding quality rating section.

Appendix F
Non-Research Evidence Appraisal

Quality Rating for Clinical Practice Guidelines, Consensus, or Position Statements **(Level IV)**
A High quality Material officially sponsored by a professional, public, or private organization or a government agency; documentation of a systematic literature search strategy; consistent results with sufficient numbers of well-designed studies; criteria-based evaluation of overall scientific strength and quality of included studies and definitive conclusions; national expertise clearly evident; developed or revised within the past five years.
B Good quality Material officially sponsored by a professional, public, or private organization or a government agency; reasonably thorough and appropriate systematic literature search strategy; reasonably consistent results, sufficient numbers of well-designed studies; evaluation of strengths and limitations of included studies with fairly definitive conclusions; national expertise clearly evident; developed or revised within the past five years.
C Low quality or major flaw Material not sponsored by an official organization or agency; undefined, poorly defined, or limited literature search strategy; no evaluation of strengths and limitations of included studies; insufficient evidence with inconsistent results; conclusions cannot be drawn; not revised within the past five years.
Quality Rating for Organizational Experience **(Level V)**
A High quality Clear aims and objectives; consistent results across multiple settings; formal quality improvement or financial evaluation methods used; definitive conclusions; consistent recommendations with thorough reference to scientific evidence.
B Good quality Clear aims and objectives; formal quality improvement or financial evaluation methods used; consistent results in a single setting; reasonably consistent recommendations with some reference to scientific evidence.
C Low quality or major flaws Unclear or missing aims and objectives; inconsistent results; poorly defined quality; improvement/financial analysis method; recommendations cannot be made.
Quality Rating for Case Report, Integrative Review, Literature Review, Expert Opinion, Community Standard, Clinician Experience, Consumer Preference **(Level V)**
A High quality Expertise is clearly evident, draws definitive conclusions, and provides scientific rationale; thought leader in the field.
B Good quality Expertise appears to be credible, draws fairly definitive conclusions, and provides logical argument for opinions.
C Low quality or major flaws Expertise is not discernable or is dubious; conclusions cannot be drawn.

Appendix F
Non-Research Evidence Appraisal

☐ **Case report LEVEL V** In-depth look at a person or group or another social unit		
▪ Is the purpose of the case report clearly stated?	❑ Yes	❑ No
▪ Is the case report clearly presented?	❑ Yes	❑ No
▪ Are the findings of the case report supported by relevant theory or research?	❑ Yes	❑ No
▪ Are the recommendations clearly stated and linked to the findings?	❑ Yes	❑ No
Findings That Help Answer the EBP Question		
Complete the corresponding quality rating.		

Community standard, clinician experience, or consumer preference LEVEL V ❑ **Community standard:** Current practice for comparable settings in the community ❑ **Clinician experience:** Knowledge gained through practice experience ❑ **Consumer preference:** Knowledge gained through life experience			
Information Source(s)		Number of Sources	
• Source of information has credible experience	❑ Yes	❑ No	❑ N/A
• Opinions are clearly stated	❑ Yes	❑ No	❑ N/A
• Evidence obtained is consistent	❑ Yes	❑ No	❑ N/A
Findings That Help You Answer the EBP Question			
Complete the corresponding quality rating section.			

APPENDIX C: JHNEBP RESEARCH EVIDENCE APPRAISAL TOOL FOR SYSTEMATIC REVIEWS (WITH OR WITHOUT META-ANALYSIS)

Johns Hopkins Nursing Evidence-Based Practice

Appendix E

Research Evidence Appraisal Tool

Appraisal of Systematic Review (With or Without Meta-Analysis)		
Were the variables of interest clearly identified?	☐ Yes	☐ No
Was the search comprehensive and reproducible? • Key search terms stated	☐ Yes	☐ No
• Multiple databases searched and identified	☐ Yes	☐ No
• Inclusion and exclusion criteria stated	☐ Yes	☐ No
Was there a flow diagram that included the number of studies eliminated at each level of review?	☐ Yes	☐ No
Were details of included studies presented (design, sample, methods, results, outcomes, strengths, and limitations)?	☐ Yes	☐ No
Were methods for appraising the strength of evidence (level and quality) described?	☐ Yes	☐ No
Were conclusions based on results?	☐ Yes	☐ No
• Results were interpreted	☐ Yes	☐ No
• Conclusions flowed logically from the interpretation and systematic review question	☐ Yes	☐ No
Did the systematic review include a section addressing limitations **and** how they were addressed?	☐ Yes	☐ No
Complete the **Quality Rating for QuaNtitative Studies** section (below)		

Quality Rating for QuaNtitative Studies

Circle the appropriate quality rating below:

A High quality: Consistent, generalizable results; sufficient sample size for the study design; adequate control; definitive conclusions; consistent recommendations based on comprehensive literature review that includes thorough reference to scientific evidence.

B Good quality: Reasonably consistent results; sufficient sample size for the study design; some control, and fairly definitive conclusions; reasonably consistent recommendations based on fairly comprehensive literature review that includes some reference to scientific evidence.

C Low quality or major flaws: Little evidence with inconsistent results; insufficient sample size for the study design; conclusions cannot be drawn.

APPENDIX D: JBI-CRITICAL APPRAISAL CHECKLIST FOR CASE REPORTS AND JBI CHECKLIST FOR TEXT AND OPINION

Go to start of banner

Appendix 4 Critical appraisal checklist for case reports

Skip to end of metadata
Go to start of metadata

JBI Critical Appraisal Checklist for Case Reports

Reviewer_____Date_____

Author _____Year_____Record Number _____

	Yes	No	Unclear	Not applicable
1. Were patient's demographic characteristics clearly described?	□	□	□	□
1. Was the patient's history clearly described and presented as a timeline?	□	□	□	□
1. Was the current clinical condition of the patient on presentation clearly described?	□	□	□	□
1. Were diagnostic tests or assessment methods and the results clearly described?	□	□	□	□
1. Was the intervention(s) or treatment procedure(s) clearly described?	□	□	□	□
1. Was the post-intervention clinical condition clearly described?	□	□	□	□
1. Were adverse events (harms) or unanticipated events identified and described?	□	□	□	□
1. Does the case report provide takeaway lessons?	□	□	□	□

Overall appraisal: Include □ Exclude □ Seek further info □

Comments (Including reason for exclusion)

_____

_____

_____

Explanation of case reports critical appraisal

How to cite: Moola S, Munn Z, Tufanaru C, Aromataris E, Sears K, Sfetcu R, Currie M, Qureshi R, Mattis P, Lisy K, Mu P-F. Chapter 7: Systematic reviews of etiology and risk. In: Aromataris E, Munn Z (Editors). *Joanna Briggs Institute Reviewer's Manual.* The Joanna Briggs Institute, 2017. Available from https://reviewersmanual.joannabriggs.org/

Case Reports Critical Appraisal Tool

Answers: Yes, No, Unclear or Not/Applicable

1. Were patient's demographic characteristics clearly described?

Does the case report clearly describe patient's age, sex, race, medical history, diagnosis, prognosis, previous treatments, past and current diagnostic test results, and medications? The setting and context may also be described.

2. Was the patient's history clearly described and presented as a timeline?

A good case report will clearly describe the history of the patient, their medical, family and psychosocial history including relevant genetic information, as well as relevant past interventions and their outcomes. (CARE Checklist 2013)

3. Was the current clinical condition of the patient on presentation clearly described?

The current clinical condition of the patient should be described in detail including the uniqueness of the condition/disease, symptoms, frequency and severity. The case report should also be able to present whether differential diagnoses was considered.

4. Were diagnostic tests or methods and the results clearly described?

A reader of the case report should be provided sufficient information to understand how the patient was assessed. It is important that all appropriate tests are ordered to confirm a diagnosis and therefore the case report should provide a clear description of various diagnostic tests used (whether a gold standard or alternative diagnostic tests). Photographs or illustrations of diagnostic procedures, radiographs, or treatment procedures are usually presented when appropriate to convey a clear message to readers.

5. Was the intervention(s) or treatment procedure(s) clearly described?

It is important to clearly describe treatment or intervention procedures as other clinicians will be reading the paper and therefore may enable clear understanding of the treatment protocol. The report should describe the treatment/intervention protocol in detail; for e.g. in pharmacological management of dental anxiety - the type of drug, route of administration, drug dosage and frequency, and any side effects.

6. Was the post-intervention clinical condition clearly described?

A good case report should clearly describe the clinical condition post-intervention in terms of the presence or lack thereof symptoms. The outcomes of management/treatment when presented as images or figures would help in conveying the information to the reader/clinician.

7. Were adverse events (harms) or unanticipated events identified and described?

With any treatment/intervention/drug, there are bound to be some adverse events and in some cases, they may be severe. It is important that adverse events are clearly documented and described, particularly when a new or unique condition is being treated or when a new drug or treatment is used. In addition, unanticipated events, if any that may yield new or useful information should be identified and clearly described.

8. Does the case report provide takeaway lessons?

Case reports should summarize key lessons learned from a case in terms of the background of the condition/disease and clinical

practice guidance for clinicians when presented with similar cases.

References:

Gagnier JJ, Kienle G, Altman DG, Moher D, Sox H, Riley D, CARE Group. The CARE Guidelines: Consensus-Based Clinical Case Reporting Guideline Development. Headache: The Journal of Head and Face Pain, 2013;53(10):1541-1547.

Overview
Content Tools

THE JOANNA BRIGGS INSTITUTE
Better evidence. Better outcomes.

The Joanna Briggs Institute Critical Appraisal tools
for use in JBI Systematic Reviews

Checklist for Text and Opinion

http://joannabriggs.org/research/critical-appraisal-tools.html

www.joannabriggs.org

THE JOANNA BRIGGS INSTITUTE

The Joanna Briggs Institute

Introduction

The Joanna Briggs Institute (JBI) is an international, membership based research and development organization within the Faculty of Health Sciences at the University of Adelaide. The Institute specializes in promoting and supporting evidence-based healthcare by providing access to resources for professionals in nursing, midwifery, medicine, and allied health. With over 80 collaborating centres and entities, servicing over 90 countries, the Institute is a recognized global leader in evidence-based healthcare.

JBI Systematic Reviews

The core of evidence synthesis is the systematic review of literature of a particular intervention, condition or issue. The systematic review is essentially an analysis of the available literature (that is, evidence) and a judgment of the effectiveness or otherwise of a practice, involving a series of complex steps. The JBI takes a particular view on what counts as evidence and the methods utilized to synthesize those different types of evidence. In line with this broader view of evidence, the Institute has developed theories, methodologies and rigorous processes for the critical appraisal and synthesis of these diverse forms of evidence in order to aid in clinical decision-making in health care. There now exists JBI guidance for conducting reviews of effectiveness research, qualitative research, prevalence/incidence, etiology/risk, economic evaluations, text/opinion, diagnostic test accuracy, mixed-methods, umbrella reviews and scoping reviews. Further information regarding JBI systematic reviews can be found in the JBI Reviewer's Manual on our website.

JBI Critical Appraisal Tools

All systematic reviews incorporate a process of critique or appraisal of the research evidence. The purpose of this appraisal is to assess the methodological quality of a study and to determine the extent to which a study has addressed the possibility of bias in its design, conduct and analysis. All papers selected for inclusion in the systematic review (that is – those that meet the inclusion criteria described in the protocol) need to be subjected to rigorous appraisal by two critical appraisers. The results of this appraisal can then be used to inform synthesis and interpretation of the results of the study. JBI Critical appraisal tools have been developed by the JBI and collaborators and approved by the JBI Scientific Committee following extensive peer review. Although designed for use in systematic reviews, JBI critical appraisal tools can also be used when creating Critically Appraised Topics (CAT), in journal clubs and as an educational tool.

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Explanation of Text and Expert Opinion critical appraisal tool

How to cite: McArthur A, Klugarova J, Yan H, Florescu S. Innovations in the systematic review of text and opinion. Int J Evid Based Healthc. 2015;13(3):188–195.

Answers: Yes, No, Unclear or Not/Applicable

1. **Is the source of the opinion clearly identified?**

   Is there a named author? Unnamed editorial pieces in journals or newspapers, or magazines give broader licence for comment, however authorship should be identifiable.

2. **Does the source of opinion have standing in the field of expertise?**

   The qualifications, current appointment and current affiliations with specific groups need to be stated in the publication and the reviewer needs to be satisfied that the author(s) has some standing within the field.

3. **Are the interests of the relevant population the central focus of the opinion?**

   The aim of this question is to establish the author's purpose in writing the paper by considering the intended audience. If the review topic is related to a clinical intervention, or aspect of health care delivery, a focus on health outcomes will be pertinent to the review. However, if for example the review is focused on addressing an issue of inter-professional behaviour or power relations, a focus on the relevant groups is desired and applicable. Therefore this question should be answered in context with the purpose of the review.

4. **Is the stated position the result of an analytical process, and is there logic in the opinion expressed?**

   In order to establish the clarity or otherwise of the rationale or basis for the opinion, give consideration to the direction of the main lines of argument. Questions to pose of each textual paper include: What are the main points in the conclusions or recommendations? What arguments does the author use to support the main points? Is the argument logical? Have important terms been clearly defined? Do the arguments support the main points?

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JBI Critical Appraisal Checklist for Text and Opinion Papers

Reviewer_____Date_____

Author _____Year_____Record Number _____

	Yes	No	Unclear	Not applicable
1. Is the source of the opinion clearly identified?	☐	☐	☐	☐
2. Does the source of opinion have standing in the field of expertise?	☐	☐	☐	☐
3. Are the interests of the relevant population the central focus of the opinion?	☐	☐	☐	☐
4. Is the stated position the result of an analytical process, and is there logic in the opinion expressed?	☐	☐	☐	☐
5. Is there reference to the extant literature?	☐	☐	☐	☐
6. Is any incongruence with the literature/sources logically defended?	☐	☐	☐	☐

Overall appraisal: Include ☐ Exclude ☐ Seek further info ☐

Comments (Including reason for exclusion)

_____

_____

_____

5. **Is there reference to the extant literature?**

   If there is reference to the extant literature, is it a non-biased, inclusive representation, or is it a non-critical description of content specifically supportive of the line of argument being put forward? These considerations will highlight the robustness of how cited literature was managed.

6. **Is any incongruence with the literature/sources logically defended?**

   Is there any reference provided in the text to ascertain if the opinion expressed has wider support? Consider also if the author demonstrated awareness of alternate or dominant opinions in the literature and provided an informed defence of their position as it relates to other or similar discourses.

APPENDIX E: EA CHECKLISTS FOR WORKSHEETS AND GRADING OF EVIDENCE

Tips for Completing Primary Research and Review Article *Worksheets*

Below, we provide two *Evidence Worksheets* templates—one for primary research and the other for review articles—that include tips for filling in the appropriate information. You can find these in Table 3.0 and Table 3.1. Download blank copies of the *Evidence Worksheet* from the Methodology section of the EAL (www.andeal.org).

Table 3.0 What to Abstract from Primary Research

Citation:	List the complete bibliographical citation
Study Design:	Name of the study design. Refer to algorithm (Figure 2.3)
Class:	(A, B, C, D) Based on classes of evidence reports (Table 2.3)
Quality Rating:	(+, Ø, -) Based on quality criteria checklist for primary research
Research Purpose:	Research question being investigated in study
Inclusion Criteria:	Requirement for study eligibility
Exclusion Criteria:	Items that disqualify an individual from participation in study.
Description of Study Protocol:	What happened in the study Describe interventions, regimens, risk factors, or procedures studied; when outcomes were measured; how intervening factors were managed.
Data Collection Summary:	Outcome(s) and other indicators Important variables and methods of measurement Was blinding used?

Description of Actual Data Sample:	Relevant descriptors of sample and comparison of groups at baseline Note loss of subjects (withdrawals, dropout, response rate, etc.)
Summary of Results:	Key Findings Abstract results including quantitative data and statistics. Be specific. Often tables are created in this section. (Include statistical significance – P values, confidence intervals, relative risk, odds ratios, likelihood ratio, number needed to treat, if available)
Author Conclusion:	As stated by the author in body of report
Reviewer Comments:	*Note strengths and limitations of the study. Identify concerns that affect study validity and generalizability (Always italicize)*
Funding Source	Who provided the funding for this study?

Table 3.1 What to Abstract from Review Article

Citation:	List the complete bibliographical citation
Study Design:	Type of review (systematic, narrative, meta-analysis)
Class:	(M, R, X) Based on classes of evidence reports
Quality Rating:	(+, Ø, -) Based on quality criteria checklist for reviews
Research Purpose:	Question being addressed in the research
Inclusion Criteria:	Criteria for article inclusion
Exclusion Criteria:	Why articles were excluded from review.
Description of Study Protocol:	Search procedures Was study quality assessed? Type of interventions and outcomes investigated, populations included
Data Collection Summary:	What type of information was abstracted from articles? How was it combined? What analytic methods were used, if any?
Description of Actual Data Sample:	# of articles included # of articles identified Number and type of studies reviewed Sample size of studies, and characteristics of the study participants

Grade the Strength of the Evidence Supporting the Conclusion Statement

The expert panel reviews all the documents produced during the evidence analysis process and reaches a consensus on the strength of the evidence supporting the conclusion statement.

Before the expert panel grading session, expert panel members will review all the materials listed in the previous section. The expert workgroup members ensure that the information from the research article is abstracted accurately on the worksheets.

In some expert workgroups all of the members are responsible for reviewing all of the articles and worksheets. Other expert workgroups have found it useful to divide the task by assigning one or two of the research articles to each member to read.

During the grading session, expert panel members should ask the following questions:

- Does the preliminary Evidence Summary accurately capture all the key information contained in the *Evidence Worksheet*s regarding the question?
- Does the draft Conclusion Statement accurately and clearly sum up the evidence as it pertains to dietetic practice?

The expert panel may accept the preliminary evidence summary, make only minor changes, or completely rewrite this material. Once the expert panel is satisfied with the Evidence Summary and Conclusion Statement, they will assign a grade. The expert panel should review the *Academy's Grade Definitions* and the Conclusion Grading Table (Table 5.0) to make sure they understand the criteria for the different grades. These tools will assist the work group in their deliberations regarding the strength of the evidence.

Grade Definitions: Strength of the Evidence for a Conclusion

Statement

Grade I: Good—The evidence consists of results from studies of strong design for answering the question addressed. The results are both clinically important and consistent with minor exceptions at most. The results are free of serious doubts about generalizability, bias, and flaws in research design. Studies with negative results have sufficiently large sample sizes to have adequate statistical power.

Grade II: Fair—The evidence consists of results from studies of strong design answering the question addressed, but there is uncertainty attached to the conclusion because of inconsistencies among the results from different studies or because of doubts about generalizability, bias, research design flaws, or adequacy of sample size. Alternatively, the evidence consists solely of results from weaker designs for the questions addressed, but the results have been confirmed in separate studies and are consistent with minor exceptions at most.

Grade III: Limited—The evidence consists of results from a limited number of studies of weak design for answering the questions addressed. Evidence from studies of strong design is either unavailable because no studies of strong design have been done or because the studies that have been done are inconclusive due to lack of generalizability, bias, design flaws, or inadequate sample sizes.

Grade IV: Expert Opinion Only—The support of the conclusion consists solely of the statement of informed medical commentators based on their clinical experience, unsubstantiated by the results of any research studies.

Grade V: Not Assignable*— There is no evidence available that directly supports or refutes the conclusion.

Adapted by the Academy of Nutrition and Dietetics from: Greer N, Mosser G, Logan G, Wagstrom Halaas G. A practical approach to evidence grading. Jt Comm. J Qual Improv. 2000; 26:700-712.

*The addition of Grade V was adopted in September 2004. As the systematic reviews were accomplished by the Work Groups and the trained Evidence Analysts, situations occurred where none of the original four grades were applicable resulting in the designation of "not assignable." The designation of Grade V was added to capture the 'not assignable" category. Of note, ICSI also reviewed and modified their grading system and in November 2003 they adopted a "not assignable" grade.

Table 5.0 Conclusion Grading Table					
Strength of Evidence Elements	**Grades**				
	I **Good/Strong**	**II** **Fair**	**III** **Limited/Weak**	**IV** **Expert Opinion Only**	V **Grade Not Assignable**
Quality • Scientific rigor/validity • Considers design and execution	Studies of strong design for question Free from design flaws, bias and execution problems	Studies of strong design for question with minor methodological concerns, OR Only studies of weaker study design for question	Studies of weak design for answering the question OR Inconclusive findings due to design flaws, bias or execution problems	No studies available Conclusion based on usual practice, expert consensus, clinical experience, opinion, or extrapolation from basic research	No evidence that pertains to question being addressed
Consistency Of findings across studies	Findings generally consistent in direction and size of effect or degree of association, and statistical significance with minor exceptions at most	Inconsistency among results of studies with strong design, OR Consistency with minor exceptions across studies of weaker design	Unexplained inconsistency among results from different studies OR single study unconfirmed by other studies	Conclusion supported solely by statements of informed nutrition or medical commentators	NA
Quantity • Number of studies • Number of subjects in studies	One to several good quality studies Large number of subjects studied Studies with negative results have sufficiently large sample size for adequate statistical power	Several studies by independent investigators Doubts about adequacy of sample size to avoid Type I and Type II error	Limited number of studies Low number of subjects studied and/or inadequate sample size within studies	Unsubstantiated by published research studies	Relevant studies have not been done
Clinical impact • Importance of studied outcomes • Magnitude of effect	Studied outcome relates directly to the question Size of effect is clinically meaningful Significant (statistical) difference is large	Some doubt about the statistical or clinical significance of the effect	Studied outcome is an intermediate outcome or surrogate for the true outcome of interest OR Size of effect is small or lacks statistical and/or clinical significance	Objective data unavailable	Indicates area for future research
Generalizability To population of interest	Studied population, intervention and outcomes are free from serious doubts about generalizability	Minor doubts about generalizability	Serious doubts about generalizability due to narrow or different study population, intervention or outcomes studied	Generalizability limited to scope of experience	NA

APPENDIX F: ETHICAL APPROVAL LETTER

NORTH-WEST UNIVERSITY
YUNIBESITI YA BOKONE-BOPHIRIMA
NOORDWES-UNIVERSITEIT

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Faks: (018) 299-4910
Web: http://www.nwu.ac.za

Institutional Research Ethics Regulatory Committee
Tel: +27 18 299 4849
Email : Ethics@nwu.ac.za

ETHICS APPROVAL CERTIFICATE OF STUDY

Based on approval by **Health Research Ethics Committee (HREC)** on **23/11/2016** after being reviewed at the meeting held on **20/10/2016**, the North-West University Institutional Research Ethics Regulatory Committee (NWU-IRERC) hereby **approves** your study as indicated below. This implies that the NWU-IRERC grants its permission that provided the special conditions specified below are met and pending any other authorisation that may be necessary, the study may be initiated, using the ethics number below.

Study title: **The cultivation of caring presence in nurses: a systematic review.**

Study Leader/Supervisor: **Prof E du Plessis**
Student: **CO Noutchie**

Ethics number:

N	W	U	-	0	0	3	4	3	-	1	6	-	A	1
Institution				Study Number						Year			Status	

Status: S= Submission; R = Re-Submission; P = Provisional Authorisation; A = Authorisation

Application Type: Single study

Commencement date: 2016-11-23 **Risk:** **Minimal**

Continuation of the study is dependent on receipt of the annual (or as otherwise stipulated) monitoring report and the concomitant issuing of a letter of continuation up to a maximum period of three years.

Special conditions of the approval (if applicable):

- Translation of the informed consent document to the languages applicable to the study participants should be submitted to the HREC (if applicable).
- Any research at governmental or private institutions, permission must still be obtained from relevant authorities and provided to the HREC. Ethics approval is required BEFORE approval can be obtained from these authorities.

General conditions:

While this ethics approval is subject to all declarations, undertakings and agreements incorporated and signed in the application form, please note the following:

- *The study leader (principle investigator) must report in the prescribed format to the NWU-IRERC via HREC:*
  - *annually (or as otherwise requested) on the monitoring of the study, and upon completion of the study*
  - *without any delay in case of any adverse event or incident (or any matter that interrupts sound ethical principles) during the course of the study.*
- *Annually a number of studies may be randomly selected for an external audit.*
- *The approval applies strictly to the proposal as stipulated in the application form. Would any changes to the proposal be deemed necessary during the course of the study, the study leader must apply for approval of these amendments at the HREC, prior to implementation. Would there be deviated from the study proposal without the necessary approval of such amendments, the ethics approval is immediately and automatically forfeited.*
- *The date of approval indicates the first date that the study may be started.*
- *In the interest of ethical responsibility the NWU-IRERC and HREC retains the right to:*
  - *request access to any information or data at any time during the course or after completion of the study;*
  - *to ask further questions, seek additional information, require further modification or monitor the conduct of your research or the informed consent process.*
  - *withdraw or postpone approval if:*
    - *any unethical principles or practices of the study are revealed or suspected,*
    - *it becomes apparent that any relevant information was withheld from the HREC or that information has been false or misrepresented,*
    - *the required amendments, annual (or otherwise stipulated) report and reporting of adverse events or incidents was not done in a timely manner and accurately,*
    - *new institutional rules, national legislation or international conventions deem it necessary.*
- *HREC can be contacted for further information or any report templates via Ethics-HRECApply@nwu.ac.za or 018 299 1206.*

The IRERC would like to remain at your service as scientist and researcher, and wishes you well with your study. Please do not hesitate to contact the IRERC or HREC for any further enquiries or requests for assistance.

Yours sincerely

Prof Linda du Plessis
Chair NWU Institutional Research Ethics Regulatory Committee (IRERC)

APPENDIX G: OVERVIEW OF DATA SYNTHESIS PROCESS

Finding	Summary of findings	Topics identified from the findings	Topics grouped together	Themes: Caring presence can be cultivated through:
Iseminger *et al*. 2009	The following interventions are necessary to improve presence by nurses. The author states intervention that can be put in place by nurses and the health system for nurses to enact caring presence such as the Nursing Intervention Classification to assist with actively listening to the patient, anticipatory guidance of the patient, tips to reduce anxiety, decision-making support, humour and having an enhanced self-efficacy. Additionally, the Nursing Outcome Classification (NOC) such as ensuring patient's satisfaction and acceptance of his/health status. The nurse must also consider helping the patient to be enhanced spiritually, emotionally and not only physically. Overall, this study revealed that even though there are barriers to implementing caring presence, it is not impossible to implement it. Nurses must make their work more meaningful and go through personal transformation and positivity knowing that it will help achieve optimal healing (Iseminger *et al*, 2009: 447-459).	actively listening to the patient, anticipatory guidance of the patient, tips to reduce anxiety, decision-making support, humour having an enhanced self-efficacy ensuring patient's satisfaction acceptance of his/health status consider helping the patient to be enhanced spiritually, emotionally and not only physically more meaningful and go through personal transformation and positivity knowing that it will help achieve optimal healing	actively listening to the patient (1) active listening (8) active listening (17)	Encouraging active listening
			anticipatory guidance of the patient (1) learning to anticipate the needs of patients (2) being focussed and knowing what will work (3) be knowledgeable about what to do and what will work in specific situations (4) critical thinking skills (1), (3) being clinically present, which entails going beyond scientific data by being aware of the forms of human response and (4) sensing (6) sensing by perceiving signals sent by the patient and being able to interpret them (4) sensing (6), (7) going beyond scientific data (7), (11) reflective thinking and creativity (9) Processing (10) Knowing what will work and when to act (7), (10)	Encourage nurses/train nurses/make them aware of critical thinking skills in order that they can be aware of the meaning of the patient's responses, and look beyond clinical data, so that they can anticipate the needs of the patient

Finding	Summary of findings	Topics identified from the findings	Topics grouped together	Themes: Caring presence can be cultivated through:
			Insightful (12) Pay attention (14)	
			tips to reduce anxiety (1)	Encourage nurses/train nurses/make them aware to assist the patient to reduce anxiety
			decision-making support (1)	Encourage nurses/train nurses/make them aware to assist patients in decision-making
			Humour (1) Humour (8) Being playful (9) Using humour effectively (14)	Encourage nurses/train nurses/make them aware to use their humour to relieve stress and anxiety
			having an enhanced self-efficacy (1) more meaningful and go through personal transformation and positivity knowing that it will help achieve optimal healing (1) foster professional maturity in nurses (2) personal and professional maturity (6)	Fostering personal growth and professional maturity in nurses

Finding	Summary of findings	Topics identified from the findings	Topics grouped together	Themes: Caring presence can be cultivated through:
			ensuring patient's satisfaction (1) individual characteristics of the nurse, characteristics of the patient, the nurse-patient dyad characteristics, environmental factors, and the practice consideration as the nurse prioritises the patient's needs (2) respect individual differences(3) have unconditional positive regard (3) develop reflective skills in nursing (2) have unconditional positive regards (4) have respect for the patient (7) having understanding and respect the patient (8) have reflective thinking (9) avoid prejudice and brokenness (12) respect the one under your care (12) have unconditional acceptance (13) have positive attitude towards patients (14) reflect before entering a patient's room (16)	Preparing nurses to explore and reflect on the unique needs of the patient, from the viewpoint of the patient.

Finding	Summary of findings	Topics identified from the findings	Topics grouped together	Themes: Caring presence can be cultivated through:
			holism (5) consider helping the patient to be enhanced spiritually, emotionally and not only physically (1) Offering oneself (2) Slowing down when approaching the patient and watch own body language (3) Being with the patient (7) being present physically and psychologically (4) Being aware of his/her own uniqueness and that of the patient. (4) intimacy with patient (5), (6) bedside presence (4) emotional support (9) compassionate, committed (8) physical closeness, feeling physically, mentally, emotionally and spiritually what the patient feels and says and offer oneself fully (10) being there physically, giving self wholly (11) offer what you have to give, be holistic and balanced (12) hug, smile, touch the patient for joining of spirit, spiritual bonding, interrelatedness, exchange of energy (13)	Encourage nurses/train nurses/make them aware to view and interact with the patient as a whole

Finding	Summary of findings	Topics identified from the findings	Topics grouped together	Themes: Caring presence can be cultivated through:
			Knowing patient physically, emotionally and spiritually. Be listening, compassionate and in connection with the patient, making eye contact, physical touch, hug and others direct contacts (14) Connection and engagement between the nurse and the patient (14) Presence should not merely be physical, but being in connection with each other (15) Eye contact, touch (16) Use physical contact and be one with patient (17)	
Mcmahon & Christopher, 2011	The findings of this study suggest that not only must the nurse working in health care settings be taught about the cultivation of caring presence. Additionally, five elements are given in enacting caring presence, namely; characteristics of individual nurses, characteristics of the patient, the nurse-patient dyad characteristic, environmental factors, and the practice consideration as the nurse prioritises the patient's needs. Additionally, this study revealed that it is very important to ensure that the enactment of caring presence is well estimated in the working environment. Presence	nurses working in health care settings be taught the followings: the identification and utilisation of the nurse's sensitive points in order to facilitate presence, how to foster professional maturity among nurses, increased ability to identify types of presence and how to apply them, learning to anticipate the patient's needs, offering self, identifying patient's vulnerability and threats and how to implement presence in this case, develop reflective skills in	Identification and utilisation of nurses' sensitive points	Nurses should be encouraged to identify their own sensitive points and use them in caring presence
			Identification and utilisation of nurses' sensitive points (2)	Encourage nurses to identify, be aware and utilise their sensitive points in caring presence

Finding	Summary of findings	Topics identified from the findings	Topics grouped together	Themes: Caring presence can be cultivated through:
	must also be fostered among Baccalaureate students to establish a good foundation in nursing practice (Mcmahon & Christopher, 2011:71-82).	nursing in order to determine how nursing presence can be applied in specific cases Characteristics of individual nurses, characteristics of the patient, the nurse-patient dyad characteristic, environmental factors, and the practice consideration as the nurse prioritises the patient's needs. Presence must also be fostered among Baccalaureate students by teaching them the types of presence and encourage them to practise it in clinical settings	Increased ability of nurses and student nurses to identify types of presence and how to apply them (2) Active dialogue among nurses about the concept of presence (9)	Nurses and nursing students should have learned more and among themselves about the concept presence and be able to identify and apply the types of presence
			Identify patient's vulnerability and how to apply presence in this case (2) Identify the needs of patients (6)	Nurses should be able to identify the needs of patients focusing on things such as their vulnerability in caring presence
			Vulnerability (5) choosing to be vulnerable when with the patient (3)	Reflect with nurses on their own vulnerability when with patients, and how it can cultivate caring presence

Finding	Summary of findings	Topics identified from the findings	Topics grouped together	Themes: Caring presence can be cultivated through:
			Advantages of CP should be made known: deep contact with the patient, it creates a healing environment, contributes patient's safety and security and, enhanced resilience, thus enhancing leadership and wholistic care (3) acceptance of his/health status (1)	Foster awareness among nurses of the advantages of CP

Finding	Summary of findings	Topics identified from the findings	Topics grouped together	Themes: Caring presence can be cultivated through:
Fahlberg & Roush, 2016	The findings by Fahlberg & Roush (2016:14-15) reveal that caring presence should be holistic, reciprocal, sincere and should be done through attentive listening, intimacy, therapeutic touch, spirituality, empathy, recognition of patient's psychological, psychosocial and physical needs, recognition of a patient's family. Caring presence can also be done through mindfulness (with awareness, acceptance and attention) and it requires the nurse to purposefully pay attention to the moment, active engagement, be non-judgemental, empathic (putting yourself in their shoes). It also requires calmness, taking a deep breath and relaxation, appropriate body language, be focused while eliminating distraction, sit down with patients and family sometimes to show how important they are.	Paying more attention to the patients and the family by learning who they are as people and what their principles are, sitting down with the patients and families in instances such as having an actively dying patient, Slowing down when approaching patients and watch own body language, being focussed, Show empathy.	Paying more attention to patients and family by learning their cultures and principles (3) Sit down with patients and family (3) Connect with patient's experience (5), (7) Bonding with patients and their own (14) Recognition of cultural, religious and personal beliefs of the patient (14)	
			Show empathy (3), (13), (15)	Nurses should show empathy in caring presence
Du Plessis, 2016b	The findings of this study revealed that caring presence should be cultivated in nursing and implemented as it can be used as a first step to do spiritual care for patients. It stresses that nurses are reluctant to offer spiritual care to their patients, more especially when they have different beliefs. Therefore, caring presence can be cultivated by applying the following intervention: choosing to be vulnerable when	choosing to be vulnerable when with the patient, respect individual differences, have unconditional positive regard and Critical thinking skills. Advantages of CP should be made known: deep contact with the patient, it creates a healing environment,	Intimacy (5) being by the patient's bedside (Bedside presence) in which the nurse connects with the patient's experience (4)	Reflect with nurses on intimacy with patients as a way to connect with the patient

Finding	Summary of findings	Topics identified from the findings	Topics grouped together	Themes: Caring presence can be cultivated through:
	with the patient; respect individual differences; and have unconditional positive regard and critical thinking skills. Advantages of such way of caring are also mentioned and must be knowledgeable by the nurse enacting presence such as a deep contact with the patient, it creates a healing environment, contributes to patient's safety and security and, enhanced resilience, thus enhancing leadership and holistic care. The findings encourage further research to explore and describe the enactment of caring presence and mindfulness in nursing in order to take cognisance of the usefulness of the enactment of caring presence and spiritual care (Du Plessis, 2016b: 47-53).	contributes patient's safety and security and, enhanced resilience, thus enhancing leadership and wholistic care		
Godkin, 2001.	The findings by Godkin (2001: 5-21) revealed that as an aspect of holistic nursing care, healing presence must be fostered as it not only improves the patient's well-being, but the nurse as well. Therefore, implementing healing presence entails a three-stage model culminating in healing presence to understand the nurse-patient relationship as follows: being present physically and psychologically; be knowledgeable about what to do and what will work in a specific situation; being clinically presence, which entails going beyond scientific data by being aware of the forms of human response; and sensing by perceiving signals sent by the patient and being able to interpret them, being by the patient's bedside (Bedside presence) in which the nurse connects with the patient's experiences and being aware of his/her own uniqueness and that of the patient. In this	being present physically and psychologically, be knowledgeable about what to do and what will work in specific situation, being clinically presence which entails going beyond scientific data by being aware of the forms of human response and, sensing by perceiving signals sent by the patient and being able to interpret them, being by the patient's bedside (Bedside presence) in which the nurse connects with the patient's experience and Being aware of his/her own uniqueness and that of the patient. uniqueness,	Being aware of own uniqueness (5) Uniqueness (6) Opened to one's uniqueness (7)	Nurses should be conscious that as individuals, they have their own uniqueness and should, therefore, consider it in caring presence

Finding	Summary of findings	Topics identified from the findings	Topics grouped together	Themes: Caring presence can be cultivated through:
	way, patient satisfaction will be met and increase healing potential in nurse-patient dyad.	connecting with the patient's experience, sensing, going beyond the scientific data, Knowing what will work and when to act and, being with the patient.		
Finfgeld-Connett, 2006	The findings by Finfgeld-Connett (2006: 708-714) suggest a meta synthesis of the concept of presence using nursing literature. The findings suggest that its attributes are aspects such as holism, intimacy, vulnerability. The expected outcome of presence is increased mental and physical wellbeing for the patient and enhanced mental well-being for nurses enacting presence. Additionally, presence results in satisfaction for the patient and the healer (the nurse) as well. Therefore, caring presence can be cultivated through identifying the needs of patients, openness, nurse's willingness, personal and professional maturity, moral underpinnings, having a conducive work environment such as supportive colleagues, adequate time and staffing, sensitivity, holism, intimacy, vulnerability and uniqueness.	Identifying the needs of patients, openness, nurse's willingness, personal and professional maturity, moral underpinnings, Having a conducive work environment, sensitivity, Holism, intimacy, vulnerability and uniqueness.	Openness of nurses (6) (9) Openness and Commitment (8) Sharing (8) Have the intention to be healing presence (12) Be opened and arrange space for it (12) Responding to their needs (14) Use self as an intervention instrument for the sake of patient care and be committed (15) Being actively, intentionally and engaged with the patient (17)	Nurses should be taught and encouraged to be opened and willing to share with patients and assist them in their needs in caring presence
			Having a conducive work environment with adequate staffing and supportive colleagues (6) Silence (8)	Nurses and institutions should be encouraged to keep the working environment

Finding	Summary of findings	Topics identified from the findings	Topics grouped together	Themes: Caring presence can be cultivated through:
				conducive, free of noise, and with adequate staffing and supportive colleagues.
Godkin & Godkin, 2004	The findings by Godkin & Godkin (2004: 256-267) suggests that caring behaviours can ease the development of nursing presence in many dimensions by practising skills such as uniqueness through communication, respect, aid, comfort and empathy. Another skill is connecting with the patient's experience through communication, respect and inform. The third skill here is sensing using aid, communication and empathy. Caring behaviours can also be developed by connecting with the patient's experiences and by sensing patient's needs. The author of this article sees communication as a key means to attaining nursing presence and, also suggests that more models of caring should be available in nursing to increase flexibility in clinical practice. The author suggests Neurolinguistic Programming (NLP). This is done by creating habits, thus, nursing presence can be analysed and transmitted from generation to generation or to others. Therefore presence can be cultivated through uniqueness, connecting with the patient's experience, sensing, communication, respect, going beyond the scientific data, knowing what will work and when to act and being with the patient.	uniqueness, connecting with the patient's experience, sensing, communication, respect, going beyond the scientific data, knowing what will work and when to act and, being with the patient	Communication (7), (10) Use of thoughtful manner towards patients (9) have good communication with patients and explain to them about their condition (14) dialogue with the patient (15)	

Finding	Summary of findings	Topics identified from the findings	Topics grouped together	Themes: Caring presence can be cultivated through:
Anderson, 2007	The findings of the study by Anderson (2007: 14-21) revealed that presence, as a therapeutic intervention, needs a nurse who has a considerable level of maturity, level of experience and confidence. Therefore, presence entails non-judgemental attitude from the nurse. It also entails therapeutic presence through compassion, support by active listening, touch, humour, continuity of care and alleviation of grief. The nurse needs to be self-aware, open, flexible, ready and willing to accept other's situation. Therefore, a nurse needs a great sense of commitment, be conscious and have a high communication skill in enacting presence. Thus, presence can be cultivated through listening, authenticity, understanding, commitment, reassurance, openness, touch, confidence, silence, humour, compassion, vigilance, sharing, non- abandonment, competence, self-awareness, trust, respect, affirming, coaching, continuity and conscience.	Active listening, authenticity, understanding, commitment, reassurance, openness, touch, confidence, silence, humour, compassion, vigilance, sharing, Non- abandonment, competence, self-awareness, trust, respect, affirming, coaching, continuity, conscience.	Authenticity and genuineness	Nurses should be reminded to be authentic and realistic in caring presence
			Reassurance, affirming (8) Coaching (9) Make patient feel reassured and connected to the nurse (13)	Nurses should be encouraged and taught to be affirming and coach patients to make them feel reassured and connected.
			Confidence, Competence, vigilance (8) Readiness (9)	Nurses should be encouraged to be confident and ready in caring.

Finding	Summary of findings	Topics identified from the findings	Topics grouped together	Themes: Caring presence can be cultivated through:
			Conscience and continuity of care (8)	Nurses should be encouraged to do their duty being conscious and there should be continuity of care.
Osterman, 2010	The findings of this study revealed that the type of enactment used by nurses in caring presence depends mostly on the readiness and openness of patients. Since patients relied on nurses for communication, it shows that they were healing as they were overwhelmed by threats in their mind, body and spirit. Therefore, the author concludes that active dialogue among nurses is also important in enacting presence. Aspects such as reflective thinking, being consciously aware, communication, openness, emotional support of patient, having a good attitudes and being playful (humour) sometimes, are necessary in enacting presence in oncology units. Therefore, means to enact presence identified were as follows: creativity, humour, thoughtful manner towards patients, observing readiness and openness of patients, emotional support, being playful, reflective thinking and active dialogue among nurses about the concept presence (Osterman, 2010:197-205).	creativity, humour, thoughtful manner towards patients, observing readiness and openness of patients, emotional support, being playful, reflective thinking and active dialogue among nurses about the concept presence.		
Delashmutt, 2007	The findings show that being willing to give oneself fully in a relationship empowers the patients and promotes health. Hence, the nurse enacting presence needs the following for optimum patient care: a reciprocal communion between patient and self, which goes beyond just physical needs of the patient; physical closeness through bedside presence;	physical closeness, communication, listening to and hearing, processing, feeling physically, mentally and spiritually what the patient says, Be willing to give oneself fully.		

Finding	Summary of findings	Topics identified from the findings	Topics grouped together	Themes: Caring presence can be cultivated through:
	uniqueness of the nurse through the art of nursing action; and being a good listener. All in all, the nurse must be physically, mentally and spiritually present. Thus, the skills needed to enact presence are: physical closeness; communication; listening to and hearing; processing; feeling physically, mentally and spiritually what the patient says; and be willing to give oneself fully (Delashmutt, 2007: 183-189).			
Du Plessis, 2016a	The findings by Du Plessis (2016a: 377-380) show that presence can be divided into three components, namely; physical and partial presence, which entails merely being close to the patient (not the full being is present at the moment). The second type of presence as viewed by Du Plessis in this study is full presence, which is unique and entails empathy, caring and innovation (creativity). The third type of presence in this study is transcendental presence, which is spiritual in nature and arouses positive feelings of connection and happiness. The author of this article stresses that it is the most powerful means of restoration to wholeness after a trauma to an individual. Thus, to cultivate caring presence, the following are essential: being there physically; going beyond the scientific data; knowing what will work and when to act; and giving self wholly.	being there physically, going beyond the scientific data, Knowing what will work and when to act, giving self wholly.		
Coffman, 2007.	The findings of this study show that having an attitude of care and /practising caring presence should be known by students in nursing programmes and could be taught at school. Therefore, steps for becoming a healing presence begin with oneself as the carer by being honest, insightful, open to one's	insightful, open to one's uniqueness, humanness, Avoid prejudices and brokenness have the intention to be a healing presence, arrange space for it,		

Finding	Summary of findings	Topics identified from the findings	Topics grouped together	Themes: Caring presence can be cultivated through:
	uniqueness, humanness, prejudices, brokenness and wholeness. Other steps for being present include having the intention to be a healing presence, arrange space for it, respect the one under your care, offer what you have to give, receive the person as they are, and be holistic and balanced. Thus, to foster presence among nurses, the following can be used: insightful; open to one's uniqueness; humanness; avoid prejudices;and brokenness. Other steps for being present include having the intention to be a healing presence, arrange space for it, respect the one under your care, offer what you have to give, receive the person as he or she is, be holistic and balanced (Coffman, 2007: 52-56).	respect the one under your care, offer what you have to give, receive the person as they are, be holistic and balanced		
Covington, 2002	The findings by Covington (2002) show that presence is journeying towards mutual goal for both the nurse and the patient. Caring presence has three components as follows: - mutual trust in which a trust must be established between the two parties; -transcending connectedness, which entails the joining of the spirits of two individuals, physical connection (e.g.: hug, smile and touch). Transcending connectedness also entails unconditional acceptance, empathy, making the patient feel reassured and connected to the nurse; - Metaphysical experience: this happens when the parties are absorbed in the moment. It entails spiritual bonding, interrelatedness, feeling of exchange of energy, it entails a feeling of a force beyond self when absorbed wholly and	hug, smile, touch for the joining of spirits unconditional acceptance, empathy, Making the patient feel reassured and connected to the nurse, spiritual bonding, interrelatedness, exchange of energy,		

Finding	Summary of findings	Topics identified from the findings	Topics grouped together	Themes: Caring presence can be cultivated through:
	in harmony as energy flows from one person to another.			
Duis-Nittsche, 2002	The findings of the study show that nursing presence goes beyond just being physically present and rendering technical care. It entails attention, connection and engagement between the nurse and the patient. Presence also entails knowing the patient, responding to their needs, having a positive attitude towards the patient. It involves bonding with patients and their own and encouraging them. Presence also involves considering the patient as a human being, knowing the patient physically, emotionally and spiritually, it entails being intuitive about if the patient is recovering or not. It involves a good communication and explaining to the patient about his or her condition, listening, being compassionate, and connection, recognition of cultural, religious and personal beliefs of the patient, being patient, using humour effectively and making eye contact. It entails physical touch, hugs and other direct contact, the nurse ensures that particular events concerning patients such as birthdays are taken into consideration, keeping in contact with patients when transferred to others wards by calling or visiting (Duis-Nittsche, E.R. 2002).	attention, connection and engagement between the nurse and the patient, knowing the patient, responding to their needs, having a positive attitude towards patients, bonding with patients and their own and encouraging them, considering the patient as a human being, knowing the patient physically, emotionally and spiritually, being intuitive about if the patient recovering or not, good communication and explaining to patients about their condition, listening, being compassionate, connection, recognition of cultural, religious and personal beliefs of the patient, being patient, using humour effectively, Making eye contact, physical touch, hugs and other direct contact, Ensure that particular events concerning patients such as birthdays are taken into consideration, keeping in contact with patients when transferred to other wards by calling or visiting.	Consider patients as human beings (14) Do not rely much on technology to care for patients (16)	Encourage nurses to show humanity towards patients and not to rely much on technology
			Ensure that particular events concerning patients such as birthdays are considered. Keep in contact with patients when transferred to other wards (14) Step outside of just doing your job (17)	Encourage nurses to consider particular events concerning patients such as birthday celebrations in caring presence
Pederson,1993.	The findings of this study show that -presence is characterised by openness, availability and being wholly at the disposal of another being	openness, availability and being wholly at the disposal of another,	Encourage parents to be by the side of their children when hospitalised or going through	Encourage parental presence for children in need

Finding	Summary of findings	Topics identified from the findings	Topics grouped together	Themes: Caring presence can be cultivated through:
	-Presence is the connection between two different people. A nurse practising presence views a patient as a person and not an object. Some expressions of nursing presence are communication (dialogue), empathy, using self as an intervention instrument for the sake of a patient's care. Presence should not merely be physical but being in connection with each other, using eye contact, friendly body language, a tender tone of voice Another aspect of nursing presence is parental presence, when the nurse encourages parents to constantly be by the side of their children as they can, more especially when going through situations such as surgical operations. Nurses display caring presence here by being there physically and giving emotional support to both parents and their children. Nurses need to be in touch with self in order to provide caring presence with their patients, having self-awareness, be committed to assist others and having the necessary skills for their duties as a carer, therefore, must acquire, when necessary, relevant skills (Pederson,1993: 75-81).	view a patient as a person and not an object, communication (dialogue), empathy, using self as an intervention instrument for the sake of patient's care, Presence should not merely be physical but being in connection with each other, using eye contact, friendly body language, a tender tone of voice, Encourage parents to constantly be by the side of their children as they can, more especially when going through situations such as surgical operation, being there physically and giving emotional support to both parents and their children. Nurses need to be in touch with self in order to provide caring presence with their patients, having self-awareness, be committed to assist others and having the necessary skills for their duties as a carer, must acquire, when necessary, relevant skills	procedures such as an operation.	such as hospitalised children.
Snyder *et al*. 2000	The findings of this study show that people should provide presence and not act as objects to one another. The following techniques could be used by nurses in critical care units: -use "centring" (being in the meditative mood) before getting into contact with the patient. For example, take a pause and do some reflection	use "centring" (being in the meditative mood) before getting into contact with the patient, take a pause and do some reflection before entering the room, focus on the patient by repeating his or her name,		

Finding	Summary of findings	Topics identified from the findings	Topics grouped together	Themes: Caring presence can be cultivated through:
	before entering the room, focus on the patient by repeating his or her name. Another technique is eye contact, touch as appropriate to make. As a nurse pauses before entering the room, he or she should take many slow breaths. Do not rely much on technologies to care for patients, so show humanity (Snyder *et al.*, 2000: 27-33).	Eye contact, touch as appropriate. As a nurse pauses before entering the room, he or she should take many slow breaths, Do not rely much on technologies to care for patients, so show humanity.		
Hooper, 2013	The findings of this study show that patients undergoing a surgical procedure in the paranaesthesia setting, need nurses, should be fully committed and patients need their enactment of presence. Techniques that can be used to foster caring presence with such patients are as follows: being actively and intentionally engaged with the patient; be one with the patient; step outside of just doing your job, use eye contact, actively listening, be fully engaged (Hooper, 2013: 255-256).	Being actively and intentionally engaged with the patient, be one with the patient, Step outside of just doing your job, use eye contact, actively listening, Be fully engaged.		