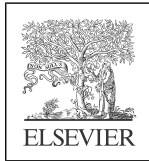




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Being present: Examining the efficacy of an Internet Mantram Program on RN-delivered patient-centered care

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ARTICLE INFO

Article history:

Received 30 July 2020

Received in revised form

31 December 2020

Accepted 10 January 2021

Available online February 8,
2021.

Keywords:

Mantram Repetition Program

Nursing presence

Veterans health

Burnout

Job satisfaction

Patient-centered care

ABSTRACT

Background: The COVID-19 pandemic highlighted nurses' compassionate presence during stressful conditions. Strategies to reduce workplace stress are needed.

Purpose: The purpose of this study was to evaluate a stress reduction strategy, an Internet-based Mantram Repetition Program (MRP), for nurses caring for hospitalized Veterans.

Methods: A one group pre-/post-test design was used to assess change in nurses' perceived outcomes after participating in the MRP. A post-test-only design was used to assess hospitalized Veterans' perceptions of nursing presence and satisfaction with care. Qualitative interviews were used to supplement quantitative data.

Findings: Patients perceived high levels of presence and satisfaction with care. Post MRP, nurses perceived increased mindfulness, compassion satisfaction, spiritual well-being, and nursing presence. Increased mindfulness was associated with greater compassion satisfaction and less burnout.

Discussion: For nurses working on the front lines of patient care, the potential for experiencing stress and burnout is a reality. Participating in a MRP could lessen these effects and facilitate nursing presence.

Cite this article: Kostovich, C.T., Bormann, J.E., Gonzalez, B., Hansbrough, W., Kelly, B., & Collins, E.G. (2021, March/April). Being present: Examining the efficacy of an Internet Mantram Program on RN-delivered patient-centered care. *Nurs Outlook*, 69(2), 136–146. <https://doi.org/10.1016/j.outlook.2021.01.001>.

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0029-6554/\$ -see front matter Published by Elsevier Inc.

<https://doi.org/10.1016/j.outlook.2021.01.001>

Introduction

The COVID-19 pandemic challenged health care systems worldwide. Material resources, including personal protective equipment, ventilators and ICU beds were in short supply; access to COVID-19 testing was limited. Nurses and physicians were working extra shifts, often times out of their comfort zone as units were transformed to care for patients with COVID-19; and more ICU beds were added to accommodate the high influx of critically ill patients (Beresford, 2020). In addition to the daily workload demands, The U.S. Department of Veterans Affairs (US Department of Veterans Affairs, 2020) (VA) noted several sources of work-related stress in health care workers as a result of the COVID-19 pandemic, including the physical strain of prolonged wearing of personal protective equipment, physical isolation, and vigilance in maintaining strict infection control measures. Personal stressors follow, including fear of contracting the virus and infecting family members, possible separation from family, others' fear of interacting with those treating COVID-19 patients, and inner conflict about competing needs and demands (US Department of Veterans Affairs, 2020). News stories began to emerge highlighting the mental health consequences of being a frontline health care provider. Emotional stress (Thompson, 2020), anxiety, depression, post-traumatic stress disorder and burnout (Occupational Health & Safety, May 19, 2020) were being identified in frontline workers. Registered nurses (RNs) shared stories of being present with their patients as they said their final goodbyes to family members via videoconferencing because family were not allowed to visit (Hewings-Martin, 2020). Nurses were there to comfort and pray with their patients who were afraid but had no family at their bedside (Esposito, 2020).

Burnout

While the focus on the physical and emotional impact of providing direct patient care has been brought to the forefront by the COVID-19 pandemic, this has long been a reality for RNs. Exposure to human suffering, physical exertion, and long work hours have contributed to RN stress in the workplace (Jennings, 2008). Burnout, characterized as emotional exhaustion, depersonalization, and decreased personal accomplishment (Maslach & Jackson, 1982), is described as an employee's reaction to chronic stress (Freudenberger, 1974). Burnout has been linked to RN perceptions of decreased patient safety (Halbesleben et al., 2008; Liu et al., 2018), decreased nurse workplace engagement ("PRC National Nursing Engagement Report," 2019), disruptive behaviors (Rehder et al., 2020), short staffing and worklife imbalance (Boamah et al., 2017), and health care acquired infections (Cimiotti et al., 2012). Strategies to reduce RN burnout

are essential to enable nurse-delivered patient-centered care (PCC). RNs who are present for their patients are better able to establish therapeutic nurse-patient relationships so that care can be personalized and patient-centered (Frampton & Charmel, 2009).

Nursing Presence

Models of care have been developed to encourage nurses to be present with their patients as a means of providing PCC (Frampton & Charmel, 2009). In 1976, Paterson and Zderad published their Humanistic Nursing Theory (Paterson & Zderad, 1976) which promoted the nurse's physical "doing for" and emotional "being with" patients. They noted that, "This essential inter-human dimension of nursing is beyond and yet within the technical, procedural, or interactional elements of the event. It is a quality of being that is expressed in the doing" (Paterson & Zderad, 1976, p. 13). Subsequently, periodic writings on nursing presence began to appear in the literature. Benner (1984) identified that expert nurses use "presencing" in their care. As part of the University of Iowa Classification of Nursing Intervention study, Gardner (1985) proposed presence as a nursing intervention. McKivergin and Daubenmire (1994) developed a course to teach nurses how to be present to their patients which included meditation, centering, and intentionality as strategies. The literature provides numerous examples of the value of nurses being present for their patients (Dunniece & Slevin, 2000; Fingeld-Connett, 2006; Melnechenko, 2003; Osterman et al., 2010; Snyder et al., 2000; Wilson, 2008). Two scales were developed to measure nursing presence: The Presence of Nursing Scale (PONS) (Kostovich, 2012) was developed to measure patients' perceptions of nursing presence; and the Presence of Nursing Scale-RN Version (PONS-RN) (Kostovich et al., 2016) was developed to measure nurses' perceived ability to be present to their patients. Consistently being present for patients is often a challenge for RNs who provide bedside care. Adverse working conditions have been associated with changes in nurse job satisfaction and emotional exhaustion (Gelsema et al., 2006). Higher patient acuity, increased reliance on technological advances, and physical and emotional demands contribute to stress and burnout among the RN workforce making it difficult for nurses to be present with their patients. Nurses often prioritize caring for others but participate in minimal self-care, including practicing stress reduction activities (Melnyk et al., 2018; Melnyk, 2020). Despite the deleterious effects of nurse stress and burnout on quality of patient care, few stress reduction strategies are available in the workplace, and only a limited number have been empirically tested for their efficacy in reducing burnout in nurses. Further, no known strategies have been tested to facilitate nursing presence. The purpose of this study was to examine the efficacy of an Internet-based Mantram Repetition Program (I-MRP) for RNs caring for hospitalized Veterans and explore its influence

on RNs' and Veterans' perceptions of nursing presence. The research questions to be answered were:

R1: What is the efficacy of an Internet-based mantram repetition program for nurses caring for hospitalized Veterans?

R2: What is the impact of the Internet-based Mantram Repetition Program on nurses and the care they provide?

Mantram Repetition Program

The Mantram Repetition Program (MRP) is a mind-body-spiritual approach to stress management. The stress reduction strategies of MRP include mantram (sacred word) repetition, slowing down, and one-pointed attention. Participants self-select a word or phrase with a spiritual meaning that is repeated silently throughout the day to train attention and redirect unwanted thoughts. By doing so, the thinking process slows and allows one to "pause," be mindful and attentive in the present moment. One-pointed attention or doing one thing at a time, supports being present in the moment and participants are taught the value of monotasking rather than multitasking. Further, for busy RNs, the MRP tools of mantram repetition, slowing down and one-pointed attention can be practiced almost continually throughout the day and between activities. The MRP is portable and can be practiced anywhere; no special equipment, device applications, or specific practice locations are required.

There is a growing body of research that demonstrates the benefits of the MRP in a variety of patient and non-patient groups. Uncontrolled studies have shown reductions in perceived stress, anxiety, anger, and improvements in quality of life and existential spiritual well-being in Veterans with chronic illness (Bormann et al., 2005) and health care workers (Bormann et al., 2006a; Borman, et al., 2006c). MRP was also found to decrease family caregiver burden in those taking care of Veterans with dementia (Bormann et al., 2009).

Randomized clinical trials (RCTs) have demonstrated that the MRP reduces anger and improves existential spiritual well-being in adults living with HIV/AIDS (Bormann et al., 2006b) and reduces PTSD symptom severity in Veterans (Bormann et al., 2013; Bormann et al., 2018; Bormann et al., 2008). Findings from these RCTs have been further validated using qualitative methods (Bormann, et al., 2013; Bormann, et al., 2006c) that describe how the MRP strategies can be used in a variety of situations to regulate emotions and manage stress. Another RCT conducted with Korean nurse managers found that those in the MRP group reported greater reductions in burnout compared to the no-treatment control group (Yong et al., 2011). There are physiological mechanisms that may explain the calming effect of mantram repetition such as the relaxation response (Benson et al., 1975), slower cardiovascular rhythms (Bernardi et al., 2001), and brain deactivation (Berkovich-Ohana et al., 2015).

Traditionally taught in a face-to-face format, the MRP was adapted to an Internet-based MRP format whereby VA employees could learn the MRP online at a time convenient for them. The I-MRP consists of asynchronous individual learning, time to practice techniques between sessions, and then reinforced learning with two online synchronous feedback sessions provided by an expert in MRP. The program was offered with the support of VA Employee Education System (EES) and the Office of Patient Centered Care. Research on this mode of delivery has demonstrated reductions in exhaustion, improvements in personal efficacy and mindfulness, and sustainability of practice in healthcare employees for up to three months post-treatment (Bormann et al., 2017).

It is known that nurses' presence fosters relationships with patients so that care can be personalized and patient-focused (Frampton et al., 2003); nursing presence is positively associated with patient satisfaction (Hansbrough & Georges, 2019; Kostovich, 2012); and nursing presence can be taught using strategies that are very similar to MRP (McKivergin & Daubemire, 1994). The MRP has been found to improve mindfulness, existential spiritual well-being (Bormann et al., 2017) and reduce perceived stress and burnout (Yong et al., 2011). What is not known, however, is the extent to which the I-MRP influences the nurse's ability to be present with patients.

Methods

Design

This study employed a mixed methods design consisting of quantitative surveys and qualitative interviews. A one group, pretest/post-test design was used for assessing change in RNs followed by a one group, post-test only design with patients. To support the validity of the quantitative data, all RN and Veteran subjects were invited to participate in brief face-to-face, audio-recorded, semistructured interviews. RNs were asked to share their perceptions of the I-MRP, including satisfaction with the program and its impact on the care they provide to patients. Veterans were asked to share their experiences of being a patient during their current hospitalization, and specifically, their experiences of care with their current nurse who practiced the strategies taught in the I-MRP.

Sample

The target population included RNs working on acute care units of a VA Medical Center in the Midwestern United States along with their patients. After approval was granted from the Institutional Review Board, a convenience sample of nurses was recruited from four medical-surgical units with the same model of care delivery and similar patient acuity. Nurses were

included if they worked permanent full-time day or evening 8-, 10-, or 12-hour shifts; they were excluded if they were currently in orientation.

Patients were recruited after the nurses had completed their I-MRP training. Patients were included if they met the following criteria: (a) currently being cared for by a RN who received the I-MRP training, (b) anticipated discharge within 24 to 48 hours, (c) not in isolation, (d) alert and oriented to person, place, time, and (e) able to understand and answer the questions.

Intervention

The I-MRP was provided to nurses in a series of six 1-hour sessions (four individual, self-conducted modules and two synchronous group feedback sessions) completed over a three month period. As part of the program, participants received the book, “*Strength in the Storm*”, by Eknath Easwaran (2013). Participants accessed the modules through the VA learning management system while off duty. After each module, participants were asked content knowledge questions; between sessions, nurses were expected to practice MRP tools. During the feedback sessions, the facilitator addressed barriers and successes of the program, answered questions, and provided feedback and suggestions for application in the workplace.

Procedure

Nurses

After providing informed consent but immediately prior to beginning the I-MRP, RNs completed an emailed electronic survey that included the baseline assessments. Two months after completing the I-MRP, RNs completed the post-assessments. This 2-month time interval was selected because studies have demonstrated that participants continue to practice MRP tools up to three months after completing the course (Bormann, Thorp, et al., 2013). A code number was assigned to maintain confidentiality. A screening question to determine if extended leave time was taken during the study period was asked prior to initiating the post-test surveys. Nurses who were on leave ≥ 3 weeks during the study time would be excluded and not required to complete the post assessments as their absence may have limited their opportunity to practice MRP. However, this did not impact any of the participants. After completion of the study, RNs were invited to participate in an audio-recorded semistructured interview conducted by a research assistant (RA) trained in qualitative interviewing.

Patients

Data collection from patients began after the RNs completed the I-MRP. The RA identified patients cared for by an I-MRP-trained RN by reviewing the daily assignment board. After the charge nurse verified the patients met inclusion criteria and gave approval to approach them, the RA invited the patients to

participate by completing the survey and participating in a face-to-face audio-recorded interview. Several steps were taken to minimize bias: (a) Data were collected on random days so nurses would not be able to anticipate when data collection would occur; (b) Data were collected at the end of the shift so nursing care would not be influenced by patient participation in the study; (c) To minimize missing or inaccurate data, the RA confirmed that the patient was able to distinguish between the care provided by the RN and other personnel before beginning data collection.

Variables and Outcome Measures

The independent variable in this study was the I-MRP for nurses. The dependent variables included (a) *nurse-related* professional quality of life, nursing presence, mindfulness, spiritual well-being, MRP utilization, I-MRP program satisfaction and, (b) *patient-related* nursing presence and satisfaction with nursing care. Demographic variables were recorded for both nurses and patients.

Measures

Professional quality of life was measured using the Professional Quality of Life Scale (ProQOL) (Stamm, 2010). Professional quality of life is the value one feels related to their work as a helper. Both positive and negative aspects of job work influence the quality of one’s professional life. The ProQOL (Stamm, 2010) is a 30-item instrument developed to measure these aspects. Comprised of three subscales, the ProQOL measures compassion satisfaction, compassion fatigue, burnout and secondary traumatic stress. On a 5-point Likert-type scale, respondents are required to rate the frequency of their experiences related to helping people, from 1 (never) to 5 (very often). Cronbach’s alpha for the subscales ranged from 0.75 to 0.88 with evidence to support construct validity (Stamm, 2010).

Nursing presence, the nurses’ perceived physical and emotional availability to their patients, was measured by the Presence of Nursing Scale-RN Version (PONS-RN) (Kostovich et al., 2016). This 30-item scale is comprised of two subscales: The “Doing For” subscale (18 items) and The “Being With” subscale (12 items). Using a 4-point Likert-type scale, nurses rate their level of agreement regarding their perceived availability to perform elements of nursing presence, from 1 (never had time) to 4 (always make time). A Rasch analysis supported the reliability and validity of the two-dimensional structure (Kostovich et al., 2016).

Mindfulness was measured using the Mindfulness Awareness Attention Scale (MAAS) (Brown & Ryan, 2003). Mindfulness is the presence or absence of attention and awareness to events occurring at the present time. This 15-item self-report scale assesses the presence or absence of attention and awareness to events presently occurring. On a 6-point Likert-type scale, respondents rate the frequency of attention and

awareness they experience during daily activities, from 1 (almost always) to 6 (almost never). Cronbach's alpha has been reported to be 0.84, with evidence to support content, construct, divergent, and convergent validity (Brown & Ryan, 2003).

Existential Spiritual Well-being (SWB) was assessed using the Functional Assessment of Chronic Illness Therapy Spiritual Wellbeing (FACIT-Sp) scale (Canada et al., 2008), a 12-item measure that has been interpreted as a total score and as three subscales: (1) meaning, (2) peace, and (3) faith. Each item is scored on a 5-point scale ranging from 0 (not at all) to 4 (very much). Each of the three subscales contain four items such as "I feel a sense of purpose in my life," "I feel peaceful," and "My illness has strengthened my faith or spiritual beliefs". Cronbach's alpha has been reported to be 0.84 with evidence to support content, discriminant, convergent, and construct validity (Peterman et al., 2002).

Nurse satisfaction with the I-MRP was assessed using the Client Satisfaction Survey (CSQ-8) The CSQ-8 is a unidimensional 8-item measure of client satisfaction with services using a 4-point Likert-type scale. The items for the CSQ-8 were selected on the basis of ratings by mental health professionals of a number of items that could be related to client satisfaction and by subsequent factor analysis. Cronbach's alpha has been reported to range between 0.92 and 0.93 with evidence to support face, content, criterion-related, and construct validity (Larsen et al., 1979).

The use of MRP tools by the RNs was evaluated using the researcher-developed Mantram Practice Questions document at I-MRP training completion and 2 months after completion. Fifteen questions in yes/no, Likert-type scale, and short answer format were asked of RNs upon completion of the program to determine when, where and how often they used mantram, slowing down, and one-pointed attention tools.

Nursing presence as perceived by patients was measured using the Presence of Nursing Scale (PONS) (Kostovich, 2012). This is a 24-item self-report instrument measuring patients' perceptions of the physical and emotional availability of the RN. On a 5-point Likert-type scale, patients rate the frequency that elements of presence were performed by the RN, from 1 (never) to 5 (always). Scores for all items are summed and higher scores indicate higher levels of perceived nursing presence. Cronbach's alpha has been reported at 0.96 with evidence to support content and construct validity (Hansbrough & Georges, 2019; Kostovich, 2012).

Perceptions of nursing care were measured by the Schmidt Perception of Nursing Care Survey (SPNCS) (Schmidt, 2004). This 15-item questionnaire asks patients to rate their satisfaction with nursing care provided by RNs, licensed practical nurses, and nursing assistants combined using a 5-point Likert-type scale, ranging from 1 (strongly disagree) to 5 (strongly agree). The survey is comprised of four subscales: (1) seeing the individual patient, five items; (2) explaining actions, three items; (3) responding to needs, three

items; and (4) watching over patients, four items. Cronbach's alpha levels for the subscales have ranged from 0.84 to 0.92 with evidence to support construct validity (Schmidt, 2004).

Findings

Research Question 1

Sample

To achieve a medium-large treatment effect size at the 0.05 significance level with at least 80% power, a sample of 20 RNs was needed to complete the pre-/post-test survey data. Within one month, the targeted enrollment of 23 RNs was recruited, which reflected 64% of the eligible participants. To account for missing data and attrition, 35 nurses were initially enrolled; 15 completed the study reflecting a retention rate of 41%. The majority of RNs withdrew from the study because of time constraints; one transferred to a unit not involved in the study. The online module format was noted to be both a facilitator and barrier to course completion as it allowed for self-paced learning but also was located behind the VA firewall which provided access challenges when not using a VA computer. A total of 22 patients completed the written surveys (Table 1).

I-MRP Completion

To be included in the study, RNs needed to complete both pre- and post-surveys and at least half of the online learning modules. Most RNs completed all four online modules ($n = 13$; 86%). The live synchronous sessions were most challenging for nurses to attend, with 66% ($n = 10$) attending both and the remaining 33% ($n = 5$) did not attend any live sessions. A total of 66% ($n = 10$) completed all online and synchronous sessions.

Mantram Use

Two months post intervention, over half of the RNs continued to use the MRP tools. Nine RNs (60%) stated they continued to use their mantram with eight (53%) using it within the past week. Slowing down was used by 11 ($n = 73%$) of the RNs between daily to once/month. Most ($n = 9$; 60%) practiced slowing down while at work. One pointed attention was practiced by nine RNs (60%) between daily to once/week, with 11 RNs (73%) using it while at work.

Research Question 2

RN Pre-Post Intervention Comparison

A Wilcoxon signed rank test was used to test for significant differences (alpha = 0.05 level) between variables pre- and postintervention. There was a significant increase in peace as a dimension of spiritual well-being, compassion satisfaction as a dimension of professional quality of life and mindfulness. While not

Table 1 – Demographics of Participants

Registered Nurses (n = 15)		
Age (n, %)	20–29	2 (13.33%)
	30–39	5 (33.33%)
	40–49	4 (26.67%)
	50–59	2 (13.33%)
	60–69	1 (6.67%)
	Prefer not to answer	1 (6.67%)
Educational background (n, %)	Associates (AA, AS)	3 (20%)
	Bachelors (BA, BS)	11 (73.33%)
	Masters (MA, MS)	1 (6.67%)
Gender (n, %)	Female	13 (86.67%)
	Male	2 (13.33%)
Ethnicity (n, %)	Latino or Hispanic	1 (6.67%)
	Non-Latino or Hispanic	12 (80%)
	Prefer not to answer	2 (13.33%)
Race	Caucasian/White	7 (46.67%)
	Asian or Pacific Islander	7 (46.67%)
	Bi-racial	1 (6.67%)
	Less than 1 year	1 (6.67%)
Number of years worked as a RN (n, %)	Less than 1 year	1 (6.67%)
	1 – 3 years	6 (40%)
	4–6 years	4 (26.67%)
	More than 19 years	4 (26.67%)
Number of years worked in the VA (n, %)	Less than 1 year	3 (20%)
	1–3 years	1 (6.66%)
	4–6 years	2 (13.33%)
	10–12 years	2 (13.33%)
	Prefer not to answer	7 (46.66%)
Certified in area of practice (n, %)	Yes	7 (46.67%)
	No	6 (40%)
	Prefer not to answer	2 (13.33%)
Current employment status as a Nurse (n, %)	36–40 hours	13 (86.67%)
	More than 40 hours per week	2 (13.33%)
Number of online modules Completed (mean, sd)	Total of 4 modules online in program	3.60 (1.12)
	Total of 2 live synchronous sessions in program	1.47 (0.91)
Veterans (n = 22)		
Age	Range 47–83 years	Mean = 65.09 years
Gender (n, %)	Male	20 (90.9%)
	Female	2 (9.1%)

(continued)

Table 1 – (Continued)

Registered Nurses (n = 15)		
Race (n, %)	African American/Black	5 (22.7%)
	American Indian/ Alaska Native	1 (4.5%)
	Caucasian/White	14 (63.6%)
	Other (specify)	2 (9.1%)
	Prefer not to answer	3 (13.6%)
Ethnicity (n, %)	Latino or Hispanic	3 (13.6%)
	Non-Latino or Hispanic	16 (72.7%)
	Prefer not to answer	3 (13.6%)

significant, both being with and doing for dimensions of nursing presence and the meaning and faith dimensions of spiritual well-being increased. There was no change in burnout or secondary traumatic stress related to professional quality of life (Table 2).

RN Post Intervention Scale Correlation

Spearman correlation coefficient, significant at alpha <0.05, was used to compare scales post RN intervention. There were four statistically significant relationships noted among the scales. The Compassion Satisfaction subscale of the ProQOL was moderately correlated with the Being With subscale of the PONS-RN (0.54) and the MAAS (0.50). The MAAS was also moderately correlated with the Meaning subscale of the FACIT (0.54). The Burnout subscale of the ProQOL showed a moderate-high negative correlation with the Peace subscale of the FACIT (-0.7) (Table 3).

Patient Summary

Patients’ perceptions of nursing presence as demonstrated by their MRP-trained RN were very high. The potential total score on the PONS ranges from 24 to 120. In this sample, the mean score was 109.92 (SD = 12.04) with a median of 112.16 (range 107–115.33). Patients also demonstrated high levels of satisfaction with overall nursing care. Scores on the SPNC potentially range from 15 to 75. In this sample, the mean score on the total scale was 67.33 (SD = 4.49) with a median of 68.5 (range 67–69.67). A Spearman’s Rho correlation was used to determine the relationship between nursing presence and overall satisfaction with nursing care. All four subscales of the SPNC Survey were positively correlated with the PONS at a significance level of at least 0.05 (Table 4).

Qualitative Findings

Semi-structured Interviews were conducted with eight of the nurses who participated in the I-MRP. Eleven Veterans who received care from RNs in the program were also interviewed. All interviews were recorded and transcribed verbatim by the RA. Two of the researchers met to conduct an interpretative analysis of the data using an iterative dialogical process (Crist & Tanner, 2003).

Table 2 – RN Pre-Post Intervention Comparison

Variable	Pre: Mean (SD)	Post: Mean (SD)	Difference: Mean (SD)	p-Value
Mindfulness	3.22 (1.18)	4.42 (0.66)	1.19 (1.48)	0.008*
Professional quality of life:				
Compassion	41.27 (4.43)	42.47 (4.48)	1.20 (2.93)	0.04*
Satisfaction				
Burnout	20.20 (3.40)	20.27 (4.40)	0.07 (3.92)	0.93
Secondary	18 (3.51)	18.30 (4.06)	0.30 (3.52)	0.70
Traumatic stress				
Nursing presence:				
Being with	36.53 (4.45)	38.87 (4.27)	2.33 (4.98)	0.10
Doing for	65.33 (5.37)	66.07 (6.08)	0.73 (7.41)	0.94
Spiritual well-being:				
Meaning	14.8 (1.32)	15.21 (1.31)	0.43 (1.22)	0.34
Peace	11.87 (2.44)	13.14 (2.14)	1.28 (1.82)	0.03*
Faith	12.67 (4.91)	14.93 (2.27)	1.93 (3.73)	0.11

* Significant $p < .05$.**Table 3 – RN Post Intervention Correlation**

	Presence:Being With (p-Value)	Presence: Doing For (p-Value)	MAAS: (p-Value)	ProQOL:Compassion (p-Value)	ProQOL:Burnout (p-Value)	ProQOL:Secondary Traumatic Stress (p-Value)
MAAS:	0.30 (0.27)	-0.06 (0.83)	-	-	-	-
ProQOL: Compassion	0.54 (0.04)*	0.38 (0.16)	0.50 (0.05)*	-	-	-
ProQOL: Burnout	-0.31 (0.26)	-0.01 (0.96)	-0.33 (0.23)	-	-	-
ProQOL: Secondary Traumatic Stress (p-Value)	-0.14 (0.61)	-0.14 (0.62)	-0.34 (0.22)	-	-	-
FACIT: Meaning	0.22 (0.45)	0.009 (0.97)	0.54 (0.04)*	0.26 (0.36)	-0.32 (0.26)	-0.34 (0.22)
FACIT: Peace	0.09 (0.75)	-0.30 (0.29)	0.46 (0.09)	0.29 (0.30)	-0.7 (0.005)*	-0.37 (0.19)
FACIT: Faith	0.13 (0.66)	-0.26 (0.37)	0.25 (0.39)	-0.11 (0.70)	0.15 (0.59)	-0.12 (0.69)

* Bold Significant $p < .05$.**Table 4 – Patient Summary**

Scale Summary	
Nursing presence	Mean (SD) 109.92 (12.04)
Satisfaction with nursing care	Median (Interquartile Range) 112.16 (107–115.33)
	67.33 (4.49)
	68.5 (67–69.67)
Scale Correlations	
	SPNCS- Individual Care
	SPNCS- Explained Care
	SPNCS- Responded to Needs
	SPNCS- Watched Over
PONS-Sum	0.604*
	0.517[†]
	0.629*
	0.624*

* Significant at 0.01 level.

† Significant at 0.05 level.

Transcripts were read independently, central ideas were discussed, followed by a re-reading with coding of meanings. These were compared and grouped into themes to

address the research questions. A second grouping organized the identified themes under the larger concepts of PCC and nursing presence.

The RNs described the impact of the I-MRP on their ability to be present with patients. A theme of being able to focus attention on one patient was evident. One RN stated, “I’m able to approach the patient with more mindfulness with being set and organized and concentrating on that patient at that time.” Another theme related to connecting with the patient on a deeper level. One RN recalled, “It is such a reward for me and for them. I go home and tell my husband, ‘you know what? I had these few moments with this patient’.” Another RN related an exchange with an older patient who was adjusting to living alone and said, “I could see tears in his eyes and I had tears in my eyes so we connected.” This theme was echoed by a Veteran who felt more closely bonded to a nurse who shared a personal story with him.

The Veteran data also revealed nursing presence in a theme of being watched over and cared for. Veterans talked about nurses responding quickly when called, checking back, easing anxiety, and doing more than what was needed. One Veteran commented, “You are secure. You are not here by yourself.” Another noted, “It felt like he came in when he really didn’t have to. He could have been doing something else. And, he makes you feel like you are part of the family.”

Themes related to PCC were evident in the Veterans’ data. These included the nurse being knowledgeable to explain care and answer questions. One Veteran described the nurse as “totally involved with what my needs were as well as the reason why [the nurse was] interacting at that particular time.” Patient advocacy was another theme repeated by Veterans who needed action taken on their behalf. One patient described needing home care equipment which was not readily available, and the nurse who “stayed on the case to make sure” it was obtained so the Veteran could go home. These qualitative findings support the validity of the quantitative results.

Discussion

A mind-body-spiritual approach to stress management, the I-MRP, was implemented with 15 RNs at a VA hospital. The rapid recruitment of the targeted enrollment suggests that RNs were eager to learn a stress reduction strategy. The retention rate over a 3-month period was 41%. Compared to other I-MRP studies conducted with health care workers within VA, (Bormann et al., 2017; Leary et al., 2018) this is substantially lower. However, this study included only RNs, with the most common reasons for attrition being time commitment to participate and juggling participation with working 12-hour shifts. This was confirmed with only 66% ($n = 10$) completing both synchronous live learning sessions. The possibility that the RN role, when compared with other health-care workers, has unique stressors that challenge time for self-care activities warrants further investigation.

While the online modules facilitated completion of the I-MRP because they were self-paced, the ability to access modules while not at the VA was a barrier to completion. To enable the ability to complete the I-MRP, the development of a shorter, all asynchronous and more easily accessible I-MRP could be considered. Two months after I-MRP training, 60% ($n = 9$) of participants were still using the MRP tools, with between 60% and 73% ($n = 9–11$) using the tools at work. In addition to its sustainability, this supports the portability of the MRP as a stress reduction strategy with RNs while at work.

After completing the I-MRP, RNs demonstrated a significant increase in mindfulness and the peace subscale of the FACIT-Sp. These findings are consistent with a previous study of 39 health care workers, the majority of whom were RNs (39%) (Bormann et al., 2017) and with a sample of 273 Veterans (Buttner et al., 2015).

Due to the COVID-19 pandemic, the risk for burnout of frontline nurses has increased (Ross, 2020; US Department of Veterans Affairs, 2020). In a study of ICU nurses in VAs, greater than 30% experienced symptoms of burnout (Swamy et al., 2020). Burnout has been related to absenteeism and poor work performance (Dyrbye et al., 2019). However, VA health care workers (Bormann & Abraham, 2019; Leary et al., 2018) participating in MRPs have experienced decreased burnout.

Overall professional quality of life includes compassion satisfaction and compassion fatigue, which is comprised of burnout and secondary traumatic stress. Finding ways to increase compassion satisfaction while decreasing compassion fatigue, and subsequently burnout and secondary traumatic stress, are essential. This study found a significant increase in compassion satisfaction in RNs post- I-MRP. Compassion satisfaction was moderately and significantly correlated ($0.54; p < .05$) to the Being With subscale of the PONS-RN and mindfulness ($0.50; 0.05$).

Mindfulness and meditation techniques allow one to become more self-aware and present in the moment (Kelly, 2020). In this study, pre-post PONS-RN Being With subscale scores were trending toward significance ($p = .10$) even with a sample size that was underpowered. The MRP specifically teaches participants to slow down and be present in the moment, which directly relates to the nurses’ ability to be present to their patients. Therefore, it is recommended that additional studies with a larger sample size be conducted to further explore this relationship.

In this study, patients perceived high levels of nursing presence and overall satisfaction with nursing care. Each of the four SPNC subscales demonstrated significant ($p > .05$) positive relationships to patients’ perceptions of nursing presence. Because hospital reimbursement rates are, in part, related to patient satisfaction (Mazurenko et al., 2017), creating a positive patient experience has implications for the financial status of the institution. Thus, identifying strategies to facilitate nursing presence becomes even more vital.

This study had many strengths, including the use of instruments with evidence of reliability and validity,

initiation of several procedures to minimize bias during data collection, feedback sessions conducted by an international expert on MRP, and interviews conducted to validate quantitative data. However, this study is limited by subjects self-selecting to participate as they may have been more open to the effects of the MRP. No comparison group was included in the study, which limits the ability to determine the outcome if no MRP was used. The sample size was small and included only Veteran patients and RNs working on acute care units of a single VA hospital. Further, a more diverse sample of both RNs and Veterans could improve the generalizability of findings. Future research related to MRP and nursing presence should be considered with a focus on recruiting a larger sample size from multiple sites. This study focused on perceived patient satisfaction with nursing care as a nurse-sensitive patient outcome of nursing presence. Future studies should consider exploring the relationship between nursing presence and other patient outcome variables, such as patient falls, perceived pain, pressure injury prevalence, hospital acquired infections, and medication errors.

Conclusion

This is the first study to examine the use of an I-MRP to facilitate the ability of nurses to be present with their patients. Nurses' perceived ability to be present with their patients is positively associated with professional quality of life, mindfulness and spiritual well-being. Patients cared for by nurses who practiced the mantram repetition tools perceived high levels of nursing presence and overall satisfaction with nursing care. Findings from this study suggest that RNs are willing to learn portable stress reduction techniques which have the potential to minimize burnout and increase their presence with patients.

Funding Sources

This study was funded by the US Department of Veterans Affairs, Office of Nursing Service, Nursing Research Initiative Grant, NRI 13-353; Award number 1 IK3 HX001426-01A1.

Credit Statement

Carol Kostovich: Conceptualization, Methodology, Project administration, Formal analysis, Writing-original draft, Writing- review & editing, funding acquisition; Jill Bormann: Conceptualization, Methodology, Validation, Writing-original draft, Writing- review & editing, Supervision; Beverly Gonzalez: Formal

analysis, Writing-original draft, Visualization; Wendy Hansbrough: Formal analysis, Writing-original draft; Brendan Kelly: Investigation; Eileen Collins: Methodology, Validation, Supervision

REFERENCES

- Benner, P. (1984). *From novice to expert: Excellence and power in clinical nursing practice*. Addison-Wesley.
- Benson, H., Greenwood, M. M., & Klemchuk, H. (1975). The relaxation response: Psychophysiologic aspects and clinical applications. *International Journal of Psychiatry in Medicine*, 6, 87-98.
- Beresford, L. (2020). Hospitalists stretch into new roles on COVID-19 front lines. https://www.medscape.com/viewarticle/932204?nlid=135907_4622&src=WNL_mdplsnews_200612_mscpedit_nur&uac=318963BZ&spon=24&impID=2417216&faf=1.
- Bernardi, L., Sleight, P., Bandinelli, G., Cencetti, S., Fattorini, L., Wdowczyk-Szulc, J., & Lagi, A. (2001). Effect of rosary prayer and yoga mantras on autonomic cardiovascular rhythms: Comparative study. *British Medical Journal*, 323(7327), 1446-1449, doi:10.1136/bmj.323.7327.1446.
- Berkovich-Ohana, A., Wilf, M., Kahana, R., Arieli, A., & Malach, R. (2015). Repetitive speech elicits widespread deactivation in the human cortex: the "Mantra" effect? *Brain and Behavior*, 5(7), e00346, doi:10.1002/brb3.346.
- Boamah, S. A., Read, E. A., & Spence Laschinger, H. K. (2017). Factors influencing new graduate nurse burnout development, job satisfaction and patient care quality: A time-lagged study. *Journal of Advanced Nursing*, 73(5), 1182-1195, doi:10.1111/jan.13215.
- Bormann, J. E., & Abraham, T. H. (2019). Evaluation of the mantram repetition program for health care providers. *Federal Practitioner: For the Health Care Professionals of the VA, DoD, and PHS*, 36(5), 232-236. <https://www.ncbi.nlm.nih.gov/pubmed/31138977>.
- Bormann, J. E., Becker, S., Gershwin, M., Kelly, A., Pada, L., Smith, T. L., & Gifford, A. L. (2006a). Relationship of frequent mantram repetition to emotional and spiritual well-being in healthcare workers. *The Journal of Continuing Education in Nursing*, 37(5), 218-224, doi:10.3928/00220124-20060901-02.
- Bormann, J., Gifford, A., Shively, M., Smith, T., Redwine, L., Kelly, A., Becker, S., Gershwin, M., Bone, P., & Belding, W. (2006b). Effects of spiritual mantram repetition on HIV outcomes: A randomized controlled trial. *Journal of Behavioral Medicine*, 29(4), 359-376, doi:10.1007/s10865-006-9063-6.
- Bormann, J. E., Hurst, S., & Kelly, A. (2013). Responses to mantram repetition program from veterans with post-traumatic stress disorder: A qualitative analysis. *Journal of Rehabilitation Research and Development*, 50(6), 769-784.
- Bormann, J. E., Oman, D., Kemppainen, J. K., Becker, S., Gershwin, M., & Kelly, A. (2006c). Mantram repetition for stress management in veterans and employees: A critical incident study. *Journal of Advanced Nursing*, 53(5), 502-512, doi:10.1111/j.1365-2648.2006.03752.
- Bormann, J. E., Smith, T. L., Becker, S., Gershwin, M., Pada, L., Grudzinski, A. H., & Nurmi, E. A. (2005). Efficacy of frequent mantram repetition on stress, quality of life, and spiritual well-being in veterans. *Journal of Holistic Nursing*, 23(4), 395-414, doi:10.1177/0898010105278929.

- Bormann, J. E., Thorp, S. R., Smith, E., Glickman, M., Beck, D., Plumb, D., Zhao, S., Ackland, P. E., Rodgers, C. S., Heppner, P., Herz, L. R., & Elwy, A. R. (2018). Individual treatment of posttraumatic stress disorder using mantram repetition: A randomized clinical trial. *American Journal of Psychiatry*, 175(10), 979–988, doi:10.1176/appi.ajp.2018.17060611.
- Bormann, J. E., Thorp, S., Wetherell, J. L., & Golshan, S. (2008). A spirituality based group intervention for combat veterans with post-traumatic stress disorder: A feasibility study. *Journal of Holistic Nursing*, 26(2), 109–116.
- Bormann, J. E., Thorp, S. R., Wetherell, J. L., Golshan, S., & Lang, A. J. (2013). Meditation-based mantram intervention for veterans with post-traumatic stress disorder: A randomized trial. *Psychological Trauma: Theory, Research, Practice and Policy*, 5(3), 259–267, doi:10.1037/a0027522.
- Bormann, J. E., Walter, K. H., Leary, S., & Glaser, D. (2017). An internet-delivered mantram repetition program for spiritual well-being and mindfulness for health care workers. *Spirituality in Clinical Practice*, 4(1), 64–73, doi:10.1037/scp0000118.
- Bormann, J., Warren, K., Regalbuto, L., Glaser, D., Kelly, A., Schnack, J., & Hinton, L. (2009). A spiritually based caregiver intervention with telephone delivery for family caregivers of veterans with dementia. *Family & Community Health*, 32(4), 345–353, doi:10.1097/FCH.0b013e3181b91fd6.
- Brown, K. W., & Ryan, R. M. (2003). The benefits of being present. *Journal of Personality and Social Psychology*, 84(4), 822–848, doi:10.1037/0022-3514.84.4.822.
- Buttner, M. M., Bormann, J. E., Weingart, K., Andrews, T., Ferguson, M., & Afari, N. (2015). Multi-site evaluation of a complementary, spiritually-based intervention for veterans: The mantram repetition program. *Complementary Therapies in Clinical Practice*, 22, 74–79, doi:10.1016/j.ctcp.2015.12.008.
- Canada, A. L., Murphy, P. E., Fitchett, G., Peterman, A. H., & Schover, L. R. (2008). A 3-factor model for the FACIT-sp. *Psycho-Oncology*, 17(9), 908–916.
- Cimiotti, J. P., Aiken, L. H., Sloane, D. M., & Wu, E. S. (2012). Nurse staffing, burnout, and health care-associated infection. *American Journal of Infection Control*, 40(6), 486–490.
- Crist, J. D., & Tanner, C. A. (2003). Interpretation/analysis methods in hermeneutic interpretive phenomenology. *Nursing Research*, 52(3), 202–205.
- Dunniece, U., & Slevin, E. (2000). Nurses' experiences of being present with a patient receiving a diagnosis of cancer. *Journal of Advanced Nursing*, 32(3), 611–618, doi:10.1046/j.1365-2648.2000.01518.x.
- Dyrbye, L. N., Shanafelt, T. D., Johnson, P. O., Johnson, L. A., Satele, D., & West, C. P. (2019). A cross-sectional study exploring the relationship between burnout, absenteeism, and job performance among American nurses. *BMC Nursing*, 18(1), 1–57, doi:10.1186/s12912-019-0382-7.
- Easwaran, E. (2013). *Strength in the storm*. Nilgiri Press.
- Esposito, S. (2020). When a coronavirus patient has no one else, a suburban Chicago nurse holds her hand and prays with her. <https://chicago.suntimes.com/coronavirus/2020/4/10/21214226/coronavirus-nurse-shari-paragins-memorial-hospital-harvey-comfort-ailing-prayer>.
- Fingeld-Connett, D. (2006). Meta-synthesis of presence in nursing. *Journal of Advanced Nursing*, 55(6), 708–714, doi:10.1111/j.1365-2648.2006.03961.x.
- Frampton, S. B., & Charmel, P. (2009). *Putting patients first: Best practices in patient-centered care* (2nd ed.). Jossey-Bass.
- Frampton, S. B., Gilpin, L., & Charmel, P. A. (2003). *Putting patients first: Designing and practicing patient centered care*. Jossey-Bass.
- Freudenberger, H. J. (1974). Staff burn-out. *Journal of Social Issues*, 30(1), 159–185.
- Gardner, D. L. (1985). Presence. In G. M. Bulechek, J. C. McCloskey, M. K. Aydelotte (Eds.), *Nursing interventions* (pp. 316–324). WB Saunders.
- Gelsema, T. I., van der Doef, M., Maes, S., Janssen, M., & Akerboom, S., & Verhoeven, C. (2006). A longitudinal study of job stress in the nursing profession: Causes and consequences. 14 (4), 289299.
- Halbesleben, J., Wakefield, B. J., Wakefield, D. S., & Cooper, L. B. (2008). Nurse burnout and patient safety outcomes: Nurse safety perception versus reporting behavior. *Western Journal of Nursing Research*, 30(5), 560–577.
- Hansbrough, W., & Georges, J. (2019). Validation of the presence of nursing scale using data triangulation. *Nursing Research*, 68(6), 439–444, doi:10.1097/NNR.0000000000000381.
- Occupational Health & Safety. (2020, May 19) Healthcare workers suffer from PTSD and burnout during COVID-19. <https://ohsonline.com/articles/2020/05/19/health-care-workers-suffer-from-ptsd-andburnout-during-covid19.aspx>.
- Hewings-Martin, Y. (2020). "It's really a hard time right now". <https://www.medicalnewstoday.com/articles/its-really-a-hard-time-right-now-says-chicago-nurse-looking-after-covid-19-patients>.
- Jennings, B. M. (2008). Work stress and burnout among nurses: Roles of the work environment and working conditions. In R. G. Hughes (Ed.), *Patient safety and quality: An evidence-based handbook for nurses* Agency for Healthcare Research and Quality.
- Kelly, L. (2020). Burnout, compassion fatigue, and secondary trauma in nurses: Recognizing the occupational phenomenon and personal consequences of caregiving. *Critical Care Nursing Quarterly*, 43(1), 73–80, doi:10.1097/CNQ.0000000000000293.
- Kostovich, C. T. (2012). Development and psychometric assessment of the presence of nursing scale. *Nursing Science Quarterly*, 25(2), 167–175.
- Kostovich, C. T., Dunya, B. A., Schmidt, L. A., & Collins, E. G. (2016). A Rasch rating scale analysis of the presence of nursing scale-RN. *Journal of Applied Measurement*, 17(4), 476–488.
- Larsen, D. L., Attkisson, C. C., Hargreaves, W. A., & Nguyen, T. D. (1979). Assessment of client/patient satisfaction: Development of a general scale. *Evaluation and Program Planning*, 2, 197–207.
- Leary, S., Weingart, K., Topp, R., & Bormann, J. (2018). The effect of mantram repetition on burnout and stress among VA staff. *Workplace Health & Safety*, 66(3), 120–128.
- Liu, X., Zheng, J., Liu, K., Baggs, J. G., Liu, J., Wu, Y., & You, L. (2018). Hospital nursing organizational factors, nursing care left undone, and nurse burnout as predictors of patient safety: A structural equation modeling analysis. *International Journal of Nursing Studies*, 86, 82–89, doi:10.1016/j.ijnurstu.2018.05.005.
- Maslach, C., & Jackson, S. (1982). Burnout in health professions: A social psychological analysis. In G. Sanders, & J. Suls (Eds.), *Social psychology of health and illness* (pp. 79–103). Lawrence Erlbaum.
- Mazurenko, O., Collum, T., Ferdinand, A., & Menachemi, N. (2017). Predictors of hospital patient satisfaction as measured by HCAHPS: A systematic review. *Journal of Healthcare Management/American*

- College of Healthcare Executives, 62(4), 272-283, doi:10.1097/JHM-D-15-00050.
- McKivergin, M. J., & Daubenmire, M. J. (1994). The healing process of presence. *Journal of Holistic Nursing*, 12(1), 65-81.
- Melnechenko, K. L. (2003). To make a difference: Nursing presence. *Nursing Forum*, 38(2), 18-24, doi:10.1111/j.1744-6198.2003.tb01207.x.
- Melnyk, B. M. (2020). Burnout, depression and suicide in nurses/clinicians and learners: An urgent call for action to enhance professional well-being and health-care safety. *Worldviews on Evidence-Based Nursing*, 17(1), 2-5, doi:10.1111/wvn.12416.
- Melnyk, B., Orsolini, L., Tan, A., Arslanian-Engoren, C., Melkus, G., Dunbar-Jacob, J., Rice, V. H., Millan, A., Dunbar, S. B., Braun, L. T., Wilbur, J., Chyun, D. A., Gawlik, K., & Lewis, L. M. (2018). A national study links nurses' physical and mental health to medical errors and perceived worksite wellness. *Journal of Occupational and Environmental Medicine*, 60(2), 126-131, doi:10.1097/JOM.0000000000001198.
- Osterman, P. L., Schwartz-Barcott, D., & Asselin, M. E. (2010). An exploratory study of nurses' presence in daily care on an oncology unit. *Nursing Forum*, 45(3), 197-205, doi:10.1111/j.1744-6198.2010.00181.x.
- Paterson, G., & Zderad, L. T. (1976). *Humanistic nursing*. National League for Nursing.
- Peterman, A. H., Fitchett, G., Brady, M. J., Hernandez, L., & Cella, D. (2002). Measuring spiritual wellbeing in people with cancer: The functional assessment of chronic illness therapy-spiritual wellbeing scale (FACIT-sp). *Annals of Behavioral Medicine*, 24(1), 49-58.
- PRC National Nursing Engagement Report, (2019). Utilizing the PRC Nursing Quality Assessment Inventory. https://prccustomresearch.com/wpcontent/uploads/2019/PRC_Nursing_Engagement_Report/PRC-NurseReport-Final-031819-Secure.pdf.
- Rehder, K. J., Adair, K. C., Hadley, A., McKittrick, K., Frankel, A., Leonard, M., Frankel, T. C., & Sexton, J. B. (2020). Associations between a new disruptive behaviors scale and teamwork, patient safety, worklife balance, burnout, and depression. *The Joint Commission Journal on Quality and Patient Safety*, 46(1), 18-26, doi:10.1016/j.jcjq.2019.09.004.
- Ross, J. (2020). The exacerbation of burnout during COVID-19: A major concern for nurse safety. *Journal of Perianesthesia Nursing*, doi:10.1016/j.jopan.2020.04.001.
- Schmidt, L. A. (2004). Patients' perceptions of nurse staffing, nursing care, adverse events, and overall satisfaction with the hospital experience. *Nursing Economic*, 22(6), 295-306.
- Snyder, M., Brandt, C. L., & Yseng, Y. (2000). Use of presence in the critical care unit. *AACN Clinical Issues*, 11(1), 27-33.
- Stamm, B. (2010). Concise ProQOL manual. http://www.proqol.org/ProQOL_Test_Manuals.html.
- Swamy, L., Mohr, D., Moss, M., Mealer, M., Wong, E., & Rinne, S. (May, 2020). Characterizing trends in ICU nurse burnout in VA and relation to outcomes. Poster presented at the American Thoracic Society 2020 International Conference. https://www.atsjournals.org/doi/10.1164/ajrccmconference.2020.201.1_MeetingAbstracts.A4638.
- Thompson, D. (2020). U.S. Nurses already facing severe stress over coronavirus. <https://www.webmd.com/lung/news/20200323/us-nurses-already-facing-severe-stress-overcoronavirus#1>.
- US Department of Veterans Affairs. (2020). Managing healthcare workers' stress associated with the COVID-19 virus outbreak. https://www.ptsd.va.gov/covid/COVID_healthcare_workers.asp.
- Wilson, M. H. (2008). There's just something about Ron. *Journal of Holistic Nursing*, 26(4), 303-307, doi:10.1177/0898010108315186.
- Yong, J., Kim, J., Park, J., Seo, I., & Swinton, J. (2011). Effects of a spirituality training program on the spiritual and psychosocial well-being of hospital middle manager nurses in Korea. *The Journal of Continuing Education in Nursing*, 42(6), 280-288, doi:10.3928/00220124-20101201-04.