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ABSTRACT: *The literature that supports and describes faith community nursing (FCN) practice is extensive, but limited in describing the* value *and* meaning *of FCN to the community. A qualitative investigation of one FCN program led to emergence of five themes that illustrate the perceived importance of FCN to this community: tasks and services offered, nursing expertise, spirituality, familiarity, and community support. This exploration reveals the deeper value and meaning of FCN to the communities these nurses support.*

KEY WORDS: *community healthcare, faith community nursing, medical anthropology, program outcomes, symbolic interactionism*

Faith community nursing is a model of community-based healthcare focused on disease prevention, education, and integration of spirituality into the experience of health and illness. Also known as parish nursing, modern day faith community nursing (FCN) emerged in the U.S. in the 1980s as a way to provide holistic health services with a special emphasis on spirituality and whole person care (Westberg & McNamara, 1987). Extensive literature is published on the design and implementation of the FCN model; however, there is limited data on the efficacy of these programs, both in the short-term and long-term (Dandridge, 2014). Furthermore, little is known about the intrinsic value of FCN services within the community served.

This article describes a qualitative investigation of one FCN program in a medium-sized urban congregation. Researchers investigated the functionality and value of the FCN program in this setting by asking two questions: 1) What do faith community nurses (FCNs) offer their community? 2) Do clients receive all the services and support FCNs aim to provide? In the community examined, the FCNs provide many valuable services, nearly all of which were recognized by clients and discussed in participant interviews.

CE 1.5 contact hours

Value and Meaning of FAITH COMMUNITY NURSING

Client and Nurse Perspectives

The literature describing FCN practice is extensive, but limited in describing the value and meaning of faith community nursing to the community.

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FCN PRACTICE

Faith community nurses work with individuals and families within their faith group, as well as the surrounding community, to promote health and improve quality of life. They support clients in various settings, including visiting clients in the hospital, in long-term care centers, or client homes. Services of FCNs include offering phone support, personal visits, leading educational sessions and health screenings in church and community facilities, and providing basic health services in community clinics (Balint & George, 2015; Morris & Miller, 2014). Although FCNs have helped clients in transitions from hospital to home for years, more recently FCNs are engaging in formal transitional care (Ziebarth & Campbell, 2016). Numerous faith- and hospital-based health ministry networks exist in the U.S. and internationally (Health Ministries Association [HMA], n.d.).

Professional preparation varies among FCNs. In 2006, Solari-Twadell and McDermott found that 12% of FCNs had a master's degree in nursing, 32% a bachelor's degree, and 14% had an associate's degree. The preferred minimum preparation for an FCN is "a baccalaureate or higher degree in nursing, with academic preparation in community- or population-focused nursing" (American Nurses Association [ANA] & HMA, 2012, p. 11). Tuck and Wallace (2000) reported FCNs have, on average, 20 years of nursing experience. Later data on educational preparation or experience of FCNs are not available.

Although FCN training programs, symposiums, and other support resources and networks are available, some FCNs function without formal training and design their efforts around the perceived needs of their community (Thompson, 2010). Some receive stipends or modest salaries from their congregation or are employed by hospitals; many FCNs commonly work as volunteers (Brown, Cppola, Giacona, Petiches, & Stockwell, 2009). Many are nearing or at retirement when they begin their FCN ministry and have some financial security, enabling them to work as volunteers, yet more young nurses entering the specialty work as FCNs in addition to other nursing employment (Bokinskie & Kloster, 2008). Recent data on employment and salary statistics of FCNs are not available.

The services offered by FCNs vary between programs, based on the size of the community, needs of its members, and the amount of support available. Faith community nurses do not regularly perform reimbursable-skilled nursing or home care services but supplement and enhance home care and other health services (Yeaworth & Sailors, 2014). The FCN *Scope and Standards of Practice* indicates that, "with an intentional focus on spiritual health, the FCN primarily uses the interventions of education, counseling, prayer, presence, active listening, advocacy, referral, and a wide variety of resources available to the faith community" (ANA & HMA, 2012, pp. 5–6).

Health promotion and disease prevention appear to be the most cost-effective roles of FCNs (King & Pappas-Rogich, 2011; Yeaworth & Sailors, 2014). Faith community nurses have implemented programs to encourage healthy eating (Sheehan et al., 2013); increase health and physical activity among community members (Whisenant, Cortes, & Hill, 2014); offer

health promotion to prevent and manage diabetes, hypertension, and obesity (Cooper, King, & Sarpong, 2015; Gore, Williams, & Sanderson, 2012; Whisenant et al.); provide sex education (Cockroft, 2012); increase medication adherence (Mayernik, Resick, Skomo, & Mandock, 2010); prevent injury and the spread of infections (Willis & Krichten, 2012); provide osteoporosis prevention and management (Forster-Burke, Ritter, & Zimmer, 2010); extend healthcare access to needed populations (Balint & George, 2015); improve immunization rates (Pappas-Rogich, 2012); and promote *Healthy People 2020* objectives (Pappas-Rogich & King, 2014). They also complete risk assessments and make referrals to other healthcare providers (Bokinskie & Kloster, 2008; Buijs & Olson, 2001). FCNs offer personal health counseling through health transitions and conduct home and hospital visits, where they participate in the healthcare team and foster integration of faith and health (Ziebarth & Campbell, 2016). Collaboration between FCN programs and hospitals is an effective way to lower healthcare costs, while supporting the community and supplying important services (Messerly, King, & Hughes, 2012; Yeaworth & Sailors; Ziebarth, 2015).

The literature describing FCN practice is extensive but is limited in describing measuring the *value* and *meaning* of FCN to the community, especially intrinsic value. This article qualitatively investigates and describes one FCN program and discusses the value, meaning, and importance of FCN in that congregation.

EXPLORING FCN VALUE AND MEANING

Symbolic interactionism assumes that humans communicate via shared symbols, such as language, and that all understanding and meaning is formed from the observation of others acting and interacting with each other and surrounding objects (Berg, 2001). Symbolic interactionism is useful to help justify both the shared and differing understandings of the FCN program between nurses and clients in one community.

Each participant describes FCN based on the lens through which he or she has experienced the program and using symbols he or she associates with FCN. Each client describes FCN based on the limited interactions she has with FCNs and the specific services she received. Faith community nurses share more symbols of FCN with each other and their many clients because they experience the program in more ways and interact with many individuals in the context of the FCN program. These shared symbols, such as medical equipment, community bulletins, or prayer, construct participants' understanding of the FCN program in this community.

FCNs were valued over other healthcare professionals because of their accessibility and the various ways they used their nursing knowledge....

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This qualitative study consisted of 10 participants, including three FCNs and seven of their clients. All the clients and FCNs attend the same Presbyterian congregation in an affluent neighborhood of a large Midwestern city. This congregation was selected because it has a well-developed program, with three FCNs and a diverse client base in age, gender, and socioeconomic status. Clients ranged in age from school-aged children to seniors. This program existed for 2 years before this research was conducted and monthly supports about 100 to 200 clients.

All participants were white, non-Hispanic individuals, ages 28 to 85. The sample of clients included two males and five females. All the FCNs in this community were female; all had clinical nursing experience; and one was retired. One FCN reported experience in geriatrics, one in mental health, and one in pediatrics. All nurses had completed FCN training or the *Foundations of Faith Community Nursing* educational program (Westberg Institute, n.d.).

The researcher initiated contact with congregation members at community gatherings, before and after church services, and at FCN events, such as blood pressure screenings. The most senior FCN also contacted recent clients and invited their participation. The church's pastor requested that there be no formal invitation to participate that might interfere with, or discourage, community members from seeking FCN nursing services. Once clients agreed to participate, their contact information was provided to the investigator, who contacted the client to arrange an interview.

The Institutional Review Board of the sponsoring university approved this study. Participant anonymity was maintained by assigning code numbers for each informant. Each participant provided verbal consent; the

pastor provided written consent. The researcher has no affiliation with this faith community.

Interviews took place in informants' homes, coffee shops, and church facilities. One interview was conducted over the phone. All interviews were semistandardized. Broad, open-ended questions were composed to begin conversation including, "Would you tell me about your experiences with faith community nursing?" Follow-up questions were used to explore the direction determined by participants. Most participants provided a detailed narrative of the situation that brought them or their loved ones into the care of FCNs, and the impact FCNs had on them throughout their illness, recovery, or bereavement. Interviews ranged from 25 minutes to 2 hours in length and were recorded and transcribed. Additionally, the researcher took observatory field and interview notes.

An initial content analysis of interview transcripts and field notes was done by hand. Then coding and analysis was repeated in more depth, using the qualitative research platform, NVivo 10. Coding revealed frequently recurring key points and topics of importance in the client and FCN interaction. Importance was measured both by the gravity of participants' comments and the frequency of occurrence throughout interviews. Recurring points were organized into themes describing the usefulness and value of the FCN program in this community.

Although there were only 10 participants, analysis revealed significant overlap between responses. Each narrative was unique, but the described value and the shared concerns for the FCN program were nearly unanimous. Each participant's lengthy and detailed explanations provided contextualized and nuanced depictions of the impact the program had on each client and nurse.

EXPERTISE, SPIRITUALITY, FAMILIARITY

Five themes emerged from coding nursing and client interviews, which describe the meaning and value of FCN to participants in this community. These include: tasks and services offered, nursing expertise, spirituality, familiarity, and community support. Table 1 supplies a sample of participants' comments, organized by theme.

Spirituality is an essential component of faith community nursing and defines this program in contrast to other healthcare services.

Tasks and Services. The most basic way to understand the FCN program is by listing its functions; therefore, the first theme is a basic compilation of services provided by FCNs in this community. During interviews, participants listed a few of the services they knew FCNs provided. Each list primarily reflected the services participants received directly, plus a few services they heard promoted or learned about from a friend. Individually, most clients were unable to reference even half of the services the FCNs offer. However, a compilation of the services reported by clients closely matched the list of services described in FCN interviews. The only services not discussed by clients were those offered to the youngest community members, who were not included in the sample, such as car seat safety. Not surprisingly, FCNs more easily detailed the extent of their services during the interviews.

Faith community nurses in this community support ill members by visiting them in the hospital and at home, answering questions about illnesses, explaining medications, organizing the lending or obtaining of medical equipment, and organizing support in the form of meal preparation and house cleaning. They accompany sick members and their families through difficult transitions, provide support during bereavement, and help plan memorial services. The FCNs offer support to healthy community members through health screenings, including blood pressure readings or home safety assessments. They provide health education through displays in the church building and by organizing classes on exercise, diet, driving, or fire safety. These services address a range of needs for community members, both in sickness and health.

Nursing Expertise. Nursing expertise is a critical theme of FCN service. Although FCNs do not provide reimbursable skilled-nursing services, they guide clients through the complex healthcare system and empower them to participate actively in their healthcare decision making. With healthcare knowledge, FCNs can address health and illness concerns by answering questions, explaining medications, and educating about health risks. With client consent, FCNs can act as a liaison with providers, pharmacies, or insurance companies on the client's behalf. They set up and monitor use of medical durable equipment and explain the meaning of therapies. When appropriate, they can assist with bathing and other physical needs of their clients.

Nursing expertise proved particularly useful for members of this community experiencing transitions. Some clients received support from FCNs when they were in the hospital and transferring to rehabilitation, or from rehabilitation back home, or from home to long-term care facilities. Aside from physical relocations due to health, FCNs provided comfort and education as their clients' state of health transitioned. The FCNs anticipated disease progression or healing to predict needed accommodations and plans, and helped prepare families with realistic expectations regarding the health of loved ones. Multiple clients discussed this type of planning and emotional support as an important function that helped them cope with personal or a family member's illness. Faith community nurses use their nursing knowledge in many ways, both to support their clients directly and to improve the health of the community.

Table 1: Sample Participant Comments by Theme

Theme	Faith Community Nurses' Comments	Clients' Comments
Services	"Community health promotion and health education, blood pressure screening, colon cancer kits, a health fair, online education posts and in the newsletter, a bereavement resource package, an equipment room, teaching the kids about their hearts and how they can take care of their hearts, nutrition information about child-sized portions, driver safety, fire safety, car seat safety, when to take the keys away, a low impact aerobics class, prayer and Communion, transportation to healthcare appointments, visiting people in the hospital, and a mental health support group."	• "The nurse brought literature, cancer literature, books, and booklets." • "They called on us, brought us to our appointments, and sat with us. The nurses got the deacons to bring us food once a week." • "She brought [medical equipment] over and set it up and showed me how to use it." • "Sundays, they do blood pressures and they handed out colon cancer kits in March."
Nursing Expertise	"We can access information on the computer, put it in large font, and talk to them about it. So, we are another person talking to them about the plan, and then they also have an available copy that they can read."	• "When I had a treatment, the nurse talked to the physician to make sure I got the message. She wanted to make sure they didn't tell me something, and I didn't get it." • "I had medical questions and, 'what do you do with this?' questions. She'd help problem-solve, as this was new to us. We'd never been sick before this happened."
Spirituality	"When you go to see somebody, prayer and Communion have been powerful. It's that power of prayer to tie the whole family together. It helps to open emotions and feelings amongst the family members. The people that are sick say, 'Thank you so much for coming and praying with me.' It seems to relieve a lot for them to have a community prayer time over them, and with them, when they are ill."	• "She helped spiritually. She prayed with us and read devotions." • "The spirituality aspect was heartwarming... She always knew what to say at the right time. She is so positive." • "It was just sort of quietly being there for us. She would come and sit next to my husband and talk softly. She really filled that spot that had been sort of left in us."
Familiarity	"It is the emotional side that seems to be missing in the care that people already get…We are trying to do what we can within our group to meet the needs of our community, within our community, and to take care of our community where they feel most comfortable."	• "When we see them, they inquire after us." • "I didn't know her very well, before, but now I consider her a friend." • "She is the type of person one would want to have as a friend. And she is doing what a friend would do."
Community Support	"People do not seek help when they could. I think every month the understanding of the program is growing." "Even though we are having trouble with the financial part, we have the emotional support of the church leadership."	• "The funding is just terrible. I don't know how they make it! The church has to take more action." • "I don't know how many people take advantage of it. If I had known, I probably would have sought it out, but now that I know they are there, I keep going back."

Spirituality. Spirituality was one of the most frequently discussed themes in client and nurse interviews. Spirituality is an essential component of faith community nursing and differentiates it from other healthcare services. Clients appreciate that FCNs can support their physical and mental health, while also nurturing their spiritual well-being. Nurses were appreciative of the religious aspect of their role and felt that supporting clients spiritually gave them a special significance in the church and a unique way to serve community members and friends.

Spirituality was especially important to those experiencing terminal illnesses or the death of a loved one. Clients appreciated that nurses prayed with them and for their families, read devotions, and communicated news from the church community. Both clients and nurses reported that prayer together helped relieve anxiety about illness and provided comfort. Homebound clients were especially thankful that nurses brought them the sacrament of Communion when it was difficult for them to get to church, which helped them maintain spiritual practice at home. Spirituality appeared as a crucial factor in every client and nurse interview.

Familiarity. Familiarity shared among members of the faith community is another essential and defining feature of the FCN program. This theme acknowledges the common, and sometimes close, relationships FCNs share with their clients. In church activities and services, nurses revealed their familiarity with clients by identifying clients and their families by name or inquiring about them. Many clients mentioned this in their interviews and appreciated recognition and expression of concern from the FCNs. Clients showed their ease and familiarity with the FCNs by welcoming them into their homes and lives, sometimes into intimate events like the birth or death of a loved one. In some interviews, the clients and nurses referred to one another as friends; in other interviews, familiarity was obvious from shared experiences, such as ongoing counseling through a difficult prognosis or life event. Some clients reported

knowing the nurses before their health-focused interaction, and some did not; most considered their FCN to be a friend after their exchange. Familiarity was expressed in many ways throughout participant interviews.

Community Support. Community support is an important theme to the FCN program, even though participant interviews offered conflicting views. Most clients appreciated the FCN program and desired more support from the faith community and ministry leaders for the FCNs, especially financial support. Nurses agreed that they needed more support from the community and speculated that with more funding and backing from community leaders, they could serve additional members. Nurses and clients reported that some in the broader faith community, who have fewer interactions with the FCNs, are less aware, and therefore less supportive of the FCN program. Several clients expressed concern that the FCN program would not last without increased support from the faith community; nursing interviews echoed this sentiment.

Two participants showed less enthusiasm for the FCN program. These participants had brief and limited interactions with the FCNs. In addition, they received healthcare services from elsewhere and did not have a great need for FCN services. Being somewhat isolated from the church community and homebound, what they knew about the FCN program was gathered from their brief and focused exchanges with FCNs.

All themes collected from interviews with clients and nurses help describe the role and value of FCN in this community. The FCNs appear successful in providing supportive services to their faith community because of their nursing expertise, familiarity with members, and shared spirituality. Most clients expressed high respect for the FCNs and appreciation of their efforts. The FCNs and clients agreed that with additional financial and community support, the nurses could accomplish more. This program appears to effectively support many faith community members mentally, physically, and spiritually.

Most clients... desired more support from the faith community and ministry leaders for the FCNs, especially financial support.

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DISCUSSION

The themes presented here help describe the function and value of FCN in one faith community. One limitation is that an invitation to participate was not made to the entire faith community, which may have elicited additional perspectives. However, significant overlap between participant accounts of this FCN program suggests that this sample may have adequately captured community sentiment.

The tasks and services offered by nurses are extensive and suggest various ways nurses can support their community members. It was difficult for clients to describe the breadth of the FCN program individually, although collectively, client interviews provide a more complete picture of the program. Clients discussed their experiences, using the symbols they shared with their FCN, such as medical equipment, prayer, or Communion elements. The two clients who had the most difficulty describing what the FCNs do were the ones who had the briefest interactions and shared the fewest symbols with the FCNs. It appears that the longer a client works with the FCNs, the more they understand the services FCNs provide and the easier it is for them to describe the nurses' functional roles and impact on the faith community.

Nursing and healthcare expertise is another important theme because nursing expertise separates the FCNs from other faith community members or from those providing pastoral care. Symbols used to discuss nursing expertise included educational materials, prescription organization, and home medical equipment. Although most clients in this community had access to adequate health resources, FCNs were sought for their nursing expertise. Faith community nurses were valued over other healthcare professionals because of their accessibility and the various ways they used their nursing knowledge to support families in the community. Clients told stories of difficult life transitions when the FCNs provided comfort, as well as helped them understand and arrange

for specific health needs. The FCNs also prepared families by helping them plan for what was ahead, and assist in turning difficult situations, such as a terminal illness, into a more peaceful and comfortable passing.

The theme of spirituality is equally important to FCN practice, as is nursing expertise. Spirituality allows FCNs to be not only nurses but also spiritual companions. Clients and nurses share many symbols of spirituality such as prayer, solidarity in suffering, togetherness in church, and Communion. Shared symbols of spirituality augment the healthcare interaction in a unique way and can make it possible to convert a challenging disease sequence into a meaningful spiritual experience. The spiritual component is especially important during health transitions, when clients are unstable in their surroundings or uncertain of their future. Spirituality is an essential component of FCN that affords this model of care much of its community value.

The theme of familiarity complements nursing expertise and spirituality in the FCN practice. Because clients and nurses are in the same social and religious community, as well as often live in the same neighborhood, they are generally familiar with one another and culturally similar. They share symbols of like dress, language, food, and common rituals. Familiarity sets the foundation for a trusting client–nurse relationship and allows nurses to give uniquely intimate and specific care to clients. Familiarity helps nurses know the right thing to say and helps them interpret the actions of a community member. Familiarity results in nurses sharing with their clients culturally sensitive and appropriate care.

Client interviews suggested that community support for the FCN program is proportional to exposure to the program. Clients who experienced more of the FCNs services, who share more symbols of FCN, have a better understanding of services the FCNs offer and showed greater appreciation for the program; those who recognized fewer symbols offered less endorsement.

Clients may also be unaware of services provided to others in their community because some services offered by the FCNs are innately intimate and private, such as bereavement support. These interactions are defined by quietly shared symbols, such as holding hands or silent prayer. In contrast to these intimate symbols, more visible symbols such as blood pressure cuffs, which represent weekly hypertension screenings, are tangible and public symbols of the FCN program. Every study participant mentioned blood pressure screenings as a function of the FCNs, but not all discussed bereavement. The way symbols of FCN services are shared between community members helps explain how FCN is understood in this community.

Another explanation for role ambiguity may originate in the familiarity and subtlety of the type of care provided. Faith community nurses are likely to develop close friendships with their clients, which augments the caring relationships but may interfere with clients recognizing the functional roles of the FCN, which are, instead, interpreted as acts of friendship.

A client's desire to avoid seeming needy or invalid also may contribute to the inability to explain FCN roles. One client revealed that she sometimes could have used more FCN support but did not seek help because she did not want to lose any independence. Increased community awareness might help potential clients understand how FCNs could support them and reduce stigma associated with seeking help. This might make the program more available to those who need FCN services the most.

If individual clients do not recognize or experience FCN care to the fullest, it is not surprising that the extended community does not fully support or engage the available resources. Overall, clients say that FCN is a good thing but struggle to define it based on limited interactions. As more faith community members interact with the FCNs and use their services, community support may follow.

IMPLICATIONS FOR FCN PROGRAMS

This study discusses the services and benefits provided by FCNs in one community and identified important themes of nursing expertise, spirituality, and familiarity in the client–nurse relationship, as well as the struggle for community support. These themes suggest the utility of the FCN model and describe the value of the faith community nurse–client relationship. The leaders of this FCN program plan to explore additional avenues to increase awareness and the FCNs' impact on community members, which may lead to further community acknowledgment, visibility, and support for the program and FCNs.

To congregations without an FCN program, this study provides support for the development of additional programs in more communities by revealing the valuable ways the FCN model impacts the health and well-being of community members. Of note, combining spirituality and healthcare had a positive effect on clients interviewed and provided nurses with a rewarding role in their faith community.

Future research is needed to explore the health benefits of certain services, compared to the resources expended to perform FCN. Research also could explore how FCN can be financially supported.

Numerous studies have revealed important ways FCN can improve health and offer care to community members. This exploration reveals the rich value of FCN.

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