Faith Community Nurses and Residents in Long-Term Care Settings:

Bridging Community and Home

Faith

Carol D. Gaskamp PhD, RN

Clinical Associate Professor

University of Texas at Austin School of Nursing

The University of Texas at Austin School of Nursing

Center for Excellence in Aging Services and Long Term Care

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Individuals who transition into nursing homes or other long-term care (LTC) settings or services can experience significant losses, and they must make considerable adjustments (Chenitz, 1983; Sullivan & Williams, 2017). Individuals admitted to LTC facilities may suffer from loneliness and social isolation for many reasons, including the loss of connections to people and activities that they enjoyed when they lived in the wider community (Abbott & Pachucki, 2017; Drageset, Eide, Dysvik, Furnes, & Hauge, 2015; Iden, Ruths & Hjørleifsson, 2015). Elderly persons who receive Home & Community Based Services (HCBS), Medicaid's programs for LTC support and services that allow the frail elderly to remain at home, can experience such loneliness and social isolation too (Medvene et al., 2016).

One of the losses that individuals who enter LTC may experience is that of regular participation in faith communities; whether in an LTC facility or still at home, the individual now depends on the faith community coming to that setting. Spiritual practices offer a resource that can help the individual to adapt to LTC and HCBS settings (Brandburg, Symes, Mastel-Smith, Hersch, & Walsh, 2012; Brownie, Horstmanshof, & Garbutt, 2014; McFadden & Jacobson, 2003).

Clergy or trained lay members of a given faith community can provide pastoral care and visits to their homebound members. However, another bridge between the faith community and both LTC residents and homebound seniors can be found in the role of the faith community nurse (FCN; American Nurses Association and Health Ministries Association [ANA & HMA], 2017; Catholic Health Association of the United States, 2016; Kubat, 2012; Redmond, 2006).

Faith community nursing is a specialized nursing practice situated within specific faith communities: FCNs provide care to individuals and groups within those communities, but their care can extend to the wider community as well. Faith community nursing originated within the Judeo-Christian faith as a means to increase access to health care, and it has expanded to other faith traditions (Ziebarth, 2014). FCNs are uniquely prepared to provide holistic care, and they address physical, psychosocial, and spiritual needs (Shores, 2014; Tuck & Wallace, 2000; Van Dover & Pfeiffer, 2007; Ziebarth, 2014). If visits from dogs and robots can reduce feelings of loneliness and isolation in LTC residents and homebound seniors (Banks, Willoughby, & Banks, 2008; Carey, 2018; H. Robinson, MacDonald, Kerse, & Broadbent, 2013; Vrbanac et al., 2013), one can presume that FCN visits should also be effective. The purpose of this paper is to explore the potential of FCNs working with LTC residents and homebound seniors as a means of maintaining the connection between older adults and their faith communities.

What is faith community nursing?

Healing, medicine, and care for the sick have long been associated with religion (ANA & HMA, 2017; O'Brien, 2003; Wylie & Solari-Twadell, 1999). Dock and Stewart (1920) and V. Robinson (1946) provide succinct accounts of caring for the sick within the context of religious traditions throughout history. In the earliest centuries of the Christian tradition, deaconesses provided sick care under the auspices of the church. As the Christian church evolved, monastic and secular religious communities provided care for the sick in institutional and home settings.

Contemporary faith community nursing, also called parish nursing, is a much more recent phenomenon. It was started in the late 1980s by Rev. Granger Westberg, a hospital chaplain and professor in the Department of Preventive Medicine at the University of Illinois

College of Medicine (Westberg, 1990). A pilot project, funded by the Kellogg Foundation, set up "doctor's offices" in church buildings to provide holistic health care by teams of physicians, nurses, and pastors. The nurses' role in this setting was to identify health problems early in order to prevent hospitalization, and to provide a connecting point for medical and religious professionals. This demonstration project was successful, and it expanded to other congregations in North America. Over time, education for faith community nursing became standardized as a professional nursing specialty (ANA & HMA, 2017; McDermott, Solari-Twadell, & Matheus, 1999; O'Brien, 2003). Certification as an FCN was once offered through the American Nurses Credentialing Center, although currently only renewal of previous certifications is available (https://www.nursingworld.org/our-certifications/faith-community-nursing-renewal).

FCNs are registered nurses (RNs); a baccalaureate in nursing (BSN) degree is preferred because health promotion, disease prevention, and community/public health nursing are included in the BSN curriculum. RNs with other preparation may become FCNs with additional preparation in the practice of faith community nursing. How a congregation provides its health ministry varies with the size and financial resources of the faith community. FCNs may be paid staff members or volunteers, and they may or may not be members of the faith community or faith tradition they serve.

What do faith community nurses do?

FCNs practice in the context of a faith community, rather than within a typical public health, community health, or other health care setting. Hallmarks of FCNs' care are holistic health promotion and disease prevention—care concerned with mind, body, *and* spirit. The

FCN typically does not provide physician-ordered skilled care unless the FCN is working for a home health agency such as Wesley Nurses, which can provide such care. According to *Faith Community Nursing: Scope and Standards of Practice*,

> The differentiating factor from general nursing practice is the specific attention that is given to the intentional care of the spirit. The FCN delivers care that promotes whole-person-centered well-being, establishes a therapeutic relationship that acknowledges caring as a sacred practice, and focuses on the relationship between faith and health. A person's faith beliefs, rituals, spiritual practices, and health views are a central focus in relationships formed by FCNs to provide nursing and spiritual care (ANA & HMA, 2017, p. 20).

FCNs work with individuals and groups, within the congregation as a community. The FCN's activities can include assessing health needs, providing individual and group education, health screenings, program planning, and accompanying individuals through life transitions (e.g., birth, illness, death). The FCN may also participate in the congregation's outreach ministry, such as in providing care to the homeless. The FCN may be paid or may volunteer within the faith community, or may be employed by an organization and deployed or assigned to a congregation as an FCN.

From the Field: Current Faith Community Nursing Practices with Congregants in LTC settings

What do FCNs have to say about their work with congregants living in LTC settings or receiving HCBS? To determine current practices of FCNs with congregants in LTC settings, in 2018, an invitation to take an anonymous internet survey on FCNs' practices with LTC residents and homebound seniors was distributed through three faith community nursing networks: the Texas Health Ministry Association, the Westburg Institute, and the Evangelical Lutheran Parish

Nurse Association. The project had the approval of the University of Texas at Austin Institutional Review Board.

Thirty-nine FCNs from 17 different states completed the survey. The majority of respondents (*n* = 34) were Protestant Christians; 24 stated that they were Lutheran. The faith communities where the FCNs practiced were also predominately Lutheran (*n* = 25) or other Protestant denominations. Most respondents practiced in either urban (49%) or suburban (38.5%) settings. Most (*n* = 38) practiced in a congregation with 75 or more regular worship participants. Congregants were predominantly families with young children, or adults over age 40. Most of the FCNs had a BSN or higher degree (49% BSN, 23% MSN, 5% APRN, 5% PhD). Most had prepared for the FCN role through the FCN curriculum (70%) or through seminary, school of religion, or clinical pastoral education (16%). Seven respondents (18%) held FCN certification. Over half (56%) had been in FCN practice for more than 10 years; 39% had been in practice for 3–10 years. Over half of the respondents were in a paid staff position (23% full-time, 41% part-time); 36% were volunteers.

FCNs' practice in LTC settings

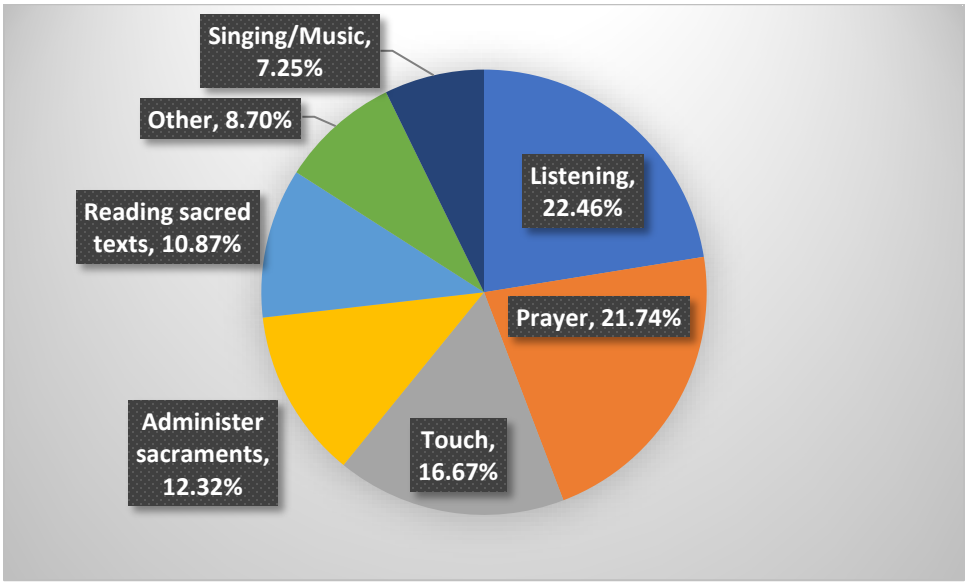
Most of the FCN respondents (95%) made visits to congregational members who lived in LTC settings (nursing homes, skilled nursing facilities, assisted living, independent living, or rehabilitation centers). In addition, 82% made visits to elders who remained in their own homes with the assistance of Medicaid's HCBS or other support. Over 68% reported providing care in their FCN role to LTC or HCBS residents who were not part of their faith community. How often an FCN visits an elder in either a home or an institutional setting depended on needs and situations, with visit schedules ranging from weekly to quarterly. Over 50% of the FCNs had

already established a relationship with congregants prior to the congregant's entering a care setting.

FCNs' Care Practices with Residents in LTC Settings

The FCN survey respondents were asked what care they typically provided to congregants in LTC settings; interventions were listed for their selection, developed from the literature on spiritual care (Brandburg et al., 2012; Brownie et al., 2014; Gaskamp, 2016; Gaskamp, Sutter, & Meraviglia, 2006; Meraviglia, Gaskamp, & Sutter (2012); Meraviglia, Sutter, & Gaskamp, 2008; McFadden & Jacobson, 2003). Figure 1 lists the types of nursing interventions that the respondents selected.

Figure 1. FCN Practices with Congregants in LTC



The practices of prayer, administering sacraments, and reading sacred texts align with the FCN's focus on the care of the spirit. An open-ended question asked respondents to list any additional care that they typically provided during visits with congregants in LTC. Thirty respondents described other nursing practices. *Family support and connecting with the family*

were the most common additional practices, described by 12 respondents. One respondent wrote that “one time a congregant who was very ill asked me to contact her estranged daughter...so I called and left her a detailed message that her mother was very ill and was asking to see her...and the daughter did show up at the nursing home to see her mother.” Another respondent provided the following activities: “attend care conferences; often represent family as many of congregants family members live outside of this state and area, lots of phone contact with the extended family representatives.”

Advocacy was listed by 11 respondents, including “advocacy with staff & family members,” “intervention with staff if necessary,” and “attend all care conferences.” One respondent wrote, “My visits signal to the staff in the LTC that the person has someone who cares and will advocate for him/her.” *Education* was listed by 9 respondents, including “explaining medical care” and “teaching about medications.” *Connecting with the church* was also listed by 9 respondents; such connections included assigning lay visitors and answering questions about the life of the parish. As one wrote, “It helps them to know they have not been forgotten by their church family. Brings their church to them by prayer and presence.” Examples of additional care listed by others included making referrals; transportation; accompaniment to ER or medical appointments if family members were not available; and bringing food or other gifts.

Faith Community Connections

In addition to FCN visits, the FCN survey asked about other services provided by faith communities to residents in LTC settings that connected the elderly to the broader community. The respondents identified visitation pastors (clergy) and lay visitation ministries as the most

common services. Other ministries were also described, such as holding worship services or streaming worship services, youth group caroling at Christmas, providing large print devotionals, and sending a parish newsletter.

Further Insights Regarding Faith Community Nursing with LTC Residents

Respondents who did not make visits to congregants living in LTC settings were asked what kept them from doing so. The most common reason was that others in the faith community were responsible for visitations. One stated, "I am the Coordinator of Care and Health Ministry and I have Care Ministers who I train and assign to members who need visits. They are to visit monthly and I occasionally visit the recipient as does our minister." Another wrote that "Most of our parishioners in LTC are also seen by parish visitors so for this reason and lack of time I do not go to see them more often myself."

The importance of setting boundaries and working well with LTC staff was described by one respondent thus: "It is challenging as your congregant sees you as 'his or her' nurse but you have no standing in the LTC setting … I work hard to have good relations with the LTC or Assisted Living administrator, DON, and nursing staff so they do not feel I am stepping outside my boundaries."

Twenty-five respondents shared additional thoughts about visiting congregants living in LTC facilities or with HCBS. Several commented that the visits assured the resident that they were not forgotten. As one FCN wrote, "What I hear from our members and non-members who are in LTC is visits are important because often they feel forgotten since they are not able to attend church or church functions." Another shared that "Our congregants GREATLY appreciate the visits and the small gifts we bring. But they mostly appreciate the visit itself and being able

to talk about ordinary things with someone from their church family. They are happy that we haven't forgotten them. The pastor visits regularly every month, but our FCN and lay ministry visit brings another dimension and an opportunity for the person to talk friend to friend."

Faith community nursing with residents in LTC facilities or with HCBS has benefits not only for the patient, but for the nurse. As one FNC stated, "This is probably the most important part of my ministry. Blessings imparted and received are vital." Another wrote that "There are several parishioners who have early stages of dementia who still want to receive communion and participate in the Lord's Prayer. It is a beautiful experience to be able to share that with them. Then as these elderly parishioners reach their end of life, it is a gift to be able to support them and their family through that process." Yet another stated, "I feel that visiting the homebound is very important, really isn't that hard to do, and benefits the FCN/lay minister as much as it does the congregant."

The FCN survey respondents also identified two specialized areas of knowledge and practice as being important: knowledge of insurance, and end-of-life care. Regarding insurance, one respondent described the importance of the FCN's "being familiar with Medicare and insurance guidelines related to admission to LTC or other facility, since the FCN helps the congregant and family understand Medicare, Medicaid and other insurances and works with the LTC Social Services to assist the families and residents in discharge planning." Another respondent also described providing insurance information, and information about selecting LTC facilities. Because insurance guidelines change frequently, one respondent pointed out that it was important for FCNs to stay up-to-date.

Among suggestions for the expansion or further development of the FCN role in LTC, several respondents listed care of the dying. After attending seminars on palliative care, one wrote that "much of what I do in my FCN role and maybe what many other FCNs do, IS Palliative care as currently defined in the literature. As FCNs, we are perfectly positioned and equipped to provide some of the 'palliative' care that is being delivered through palliative care agencies." Another suggested that an FCN be a paid staff member of the LTC facility to work with the Chaplain. One recommended a "No One Dies Alone" program at a local hospital as a "wonderful program for FCNs."

FCNs as Care Partners in LTC Settings

The FCNs who responded to the survey clearly described the value of the FCN for residents in LTC settings. Not only are FCNs able to provide spiritual care to the individual and connect them with the faith community outside the institution or home, they are health educators and advocates for the resident, and a support for families. Their visits can ease the loneliness experienced by residents in FTC and connect residents with the broader community. They can provide end-of-life care, attending to physical and spiritual comfort measures. FCNs can become partners with LTC staff in residential and home-based settings, augmenting the care provided by the agency with competent, holistic care.

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