ABSTRACT: *A mixed-method, cross-sectional descriptive online survey was used to examine the impact of COVID-19 on faith community nurse (FCN) practice. The seven practice areas for FCNs provided a framework for a 20-question survey comparing their practice pre- and during COVID-19 was completed by 378 FCNs. The top five interventions during COVID were in the areas of spiritual support, health promotion, and advocating for services; a top need was peer support/networking. Creative strategies used to meet the faith community's needs were inspiring. Implications for practice adaptation are discussed.*

KEY WORDS: *COVID-19, faith community nurse, nursing, parish nurse*

FAITH COMMUNITY NURSING AND COVID-19: CREATIVE AND INSPIRED PRACTICE

NCPD **2.0 contact hours**

BY JUDY SHACKELFORD, WENDY ZIMMERMAN, KATHLEEN COLEMAN, LORIE HENLEY, BETSY A. JOHNSON, & LAUREEN DONOVAN

Faith community nursing is a specialty practice that focuses on intentional care of the spirit as well as the promotion of whole-person health and the prevention or minimization of illness within the context of faith communities and the wider community (American Nurses Association [ANA] & Health Ministries Association [HMA], 2017). A faith community nurse (FCN) is a registered nurse who is actively licensed in his or her state and serves as a member of the staff of a faith community. The FCN promotes health and wholeness of the faith community, its groups, families, and individual members through the practice of nursing as defined by the state's nurse practice act in the jurisdiction in which the FCN practices, and the standards of practice set forth in the Faith Community Nursing Scope and Standards of Practice (ANA & HMA, 2017). It is recognized that FCNs serve diverse populations in a variety of settings. Although practice strategies of FCNs have been well documented in the literature, there is a gap in information related to faith community nursing practice strategies during the COVID-19 pandemic.

Since 2020, the world changed due to the emergence of SARS-CoV-2 or COVID-19. The following questions arose among a group of FCNs and healthcare professionals:

- What do these changes mean for the practice of faith community nursing?
- Has the ministry changed?
- How are FCNs operating in the wake of COVID-19?
- What do FCNs do now, in and after this pandemic, compared with what they were doing before COVID-19?
- Will future practice be altered?

- Are FCNs filling a special need during the pandemic?
- Are there lessons we can learn and apply to health crises in the future?

Judy Shackelford, PhD, RN, is a professor and academic dean at St. John's College of Nursing in Springfield, IL. Her program of research is reaching vulnerable populations through faith community nursing.

Wendy Zimmerman, BSN, RN-BC, is a pioneer faith community nurse, working in partnership with Rev. Dr. Granger Westberg. She manages the parish nursing program at Meritus Health and is board certified as an FCN.

Kathleen Coleman, MPH, BSN, RN, faith community nurse, coordinator, and educator, has managed the Faith Community Health Department and Network for Adventist Healthcare since 2014.

Lorie Henley, MSEd, BSN, RN, is the faith community nurse education coordinator at Shenandoah University in Winchester, VA.

Betsy A. Johnson, BSN, RN, is a faith community nurse at the Emmanuel Brinklow Seventh-day Adventist Church in Ashton, MD.

Laureen Donovan, PhD, RN, CCRN, is a nurse scientist at Meritus Health and an assistant professor of nursing at Shepherd University.

The authors declare no conflict of interest.

Accepted by peer review 6/2/2022.

Published Online First 11/10/22.

DOI:10.1097/CNJ.0000000000001028

A research design was developed to discover answers to these questions. Through a short post on the Westberg Institute's Yammer platform, a professional social media communication platform for FCNs, a five-person research group emerged, consisting of FCNs, educators, managers, and an academician to explore the answers to these questions (Ziebarth & Hunter, 2016). The research team conducted a descriptive, comparative study including both quantitative and qualitative data via survey. The purpose of this study was to determine the impact COVID-19 had on FCN practice strategies and interventions. The objective was to compare FCN practice prior to and during the COVID-19 pandemic.

Although collectively the team had 99 years of faith community nursing experience, the gamut of research experience ranged from novice to conducting research at the PhD level. It was truly a learning experience which abated beginner fears and demonstrated that even a novice researcher can contribute to the specialty of faith community nursing.

According to the ANA and HMA, services provided by FCNs related to COVID-19 fall within their scope of practice to educate, advocate, and coordinate healthcare services, both for faith communities and for the larger healthcare community (ANA & HMA, 2017). The HMA (2021) issued a statement encouraging FCNs to answer the call to serve their communities during COVID-19.

LITERATURE REVIEW

Articles from a recent systematic review by Kruse-Diehr et al. (2021) were reviewed and three relevant articles identified: King (2011), Mock (2017), and Reilly et al. (2011). Although two articles were greater than 5 years old, they were classic to the FCN's holistic care and influence during a pandemic. Searches for faith community nurse, parish nurse, and COVID-19 in the library's Discover service, CINAHL Complete, and PubMed were completed and identi-

Getty Images / aerogondo

fied one more marginally relevant qualitative study by Parkes et al. (2021). Although not identified in original searches, an article by Kiser and Lovelace (2019) identified the role of the faith community as a partner in health promotion during the 2009 H1N1 pandemic and for seasonal influenza prevention.

King (2011) found that clients do receive holistic care from FCNs. Mock (2017) reported that FCNs offered tasks and services that were supportive to clients' healthcare needs. Faith community nurses were valued by faith communities because of accessibility and the way FCNs used their nursing knowledge to serve.

Reilly et al. (2011) noted that, in response to influence from the H1N1 pandemic, adoption of creative strategies to prevent the spread of infection in faith communities was encouraged. Faith communities can be key partners in reducing the spread of disease at organizational levels. Reilly et al. set out to determine if access to infection control information could affect the knowledge and attitudes of faith communities and influence behaviors related to infection control practices; 28 faith communities were surveyed with a collective 16,850 members. Under half (46%) had reviewed information on how to prepare for a public health emergency using a toolkit (Reilly et al., 2011) provided to the faith community during the H1N1 pandemic. All but one of the FCNs reported the importance for faith communities to have a plan in place to stop the spread of disease. Education and providing information were the primary ways FCNs planned to reduce the spread of infection.

Kiser and Lovelace (2019), using national, state, and local collaborative partnerships, enabled information sharing, co-learning, and dissemination of best practices to prevent the spread of H1N1 among vulnerable populations. Faith organizations were a key part of the collaborative partnerships for local capacity building, community outreach, and vaccination administration. Faith organizations strengthened the partnership initiatives because of the tie to community history and context. This enabled an enhanced reach to different racial and ethnic populations. Faith organizations provided distinctive competencies and awareness of community needs that minimized barriers to vaccination participation. The collaborative partnership provided dialogue between a large group of health and faith leaders to address concerns that may have impeded vaccine administration for H1N1. Working with the faith and health organizations was a critical aspect of increasing influenza prevention among hard-to-reach populations. Kiser and Lovelace described the toolkit designed to build state immunization capacity from shared information and co-learning.

> THE CREATIVITY AND INGENUITY OF FCNs PRACTICING DURING THE HEIGHT OF THE PANDEMIC WAS INSPIRING.

Parkes et al. (2021) found that staff, which included FCNs, who worked in third sector homelessness services needed support and good leadership. The researchers also identified opportunities for training, support, and reflective practice. These supports should continue despite the pressures of providing an enhanced service to a client group. To ignore the needs of staff elevates the risk of compassion fatigue and burnout. Partnership between services is also essential, and the COVID-19 pandemic has highlighted the vital role that partnership plays within a treatment and service system (Parkes et al., 2021).

DESIGN

This study was approved by Meritus Medical Center Institutional Review Board and consisted of a mixed-method, cross-sectional descriptive online confidential survey distributed to FCNs across the United States. The seven practice areas of health education, health counseling, referrals, advocacy,

Table 1. SAMPLE LIKERT SCALE QUESTION RATING FCN INTERVENTIONS PRE-COVID-19 & DURING COVID-19

Question 9. FCN as health promoter:	Frequency					
Individual encounters for health promotion	**Pre-COVID**	5	4	3	2	1
	During COVID	5	4	3	2	1
Group classes for health promotion	**Pre-COVID**	5	4	3	2	1
	During COVID	5	4	3	2	1
Health promotion via technology	**Pre-COVID**	5	4	3	2	1
	During COVID	5	4	3	2	1
Use of written resources on health promotion topics (i.e., bulletin boards & newsletters, worship bulletins)	**Pre-COVID**	5	4	3	2	1
	During COVID	5	4	3	2	1

Note. 5 being "Very Frequently" and 1 being "Do not Perform"

training of volunteers, facilitating support groups, and intentional care of the spirit (ANA & HMA, 2017; Solari-Twadell & Hackbarth, 2010) were used as a framework to develop a 20-question survey.

The survey was evaluated by eight practicing FCNs in two pilot studies. Questions were both open- and closed-ended. A five-point Likert scale was used for participants to rate their practice pre-COVID-19 and during COVID-19. Table 1 shows question nine as an illustration of the Likert scale portion of the survey. Participants were asked to review the categories/types of interventions commonly performed by FCNs and indicate how often they used each approach pre-COVID and then during COVID. *Pre-COVID* was defined as the time prior to the virus being active in the FCN's geographic area. *During COVID* was defined as from the time the virus was initially active in the FCN's geographic area to the time of survey completion.

Open-ended questions related to the ways the FCN's practice changed during COVID-19 and FCN resource needs related to the pandemic. The survey was piloted for content validity and for reliability. The following survey changes were made based on FCN feedback: 1) specified questions were reworded for clarity; 2) survey layout was altered for ease of participant response in comparing pre-COVID-19 and during COVID-19; and 3) the time to complete the survey was shortened from 45 minutes to 15 minutes.

The revised survey was piloted a second time by eight FCNs. Cronbach's alpha was used to determine the reliability of the survey tool: Cronbach's alpha for pre-COVID-19 items was .907 and during-COVID-19 items was .876. Cronbach's alpha based on standardized items pre- and during was .909 and .879, respectively.

Data Collection

An email invitation and cover letter with a survey link were sent to FCNs, FCN coordinators, and FCN educators across the United States. Participants were recruited through Yammer, a professional social media communication platform for FCNs, and through FCN coordinators, managers, and educators sharing the email invite and link with FCNs in their local networks.

The list of contacts was generated by the research team and their professional contacts with regional/national colleagues and the search of a national database through the Westberg Institute. Survey Monkey, an electronic survey tool, was used to collect confidential survey data, demographic data such as age, geographic area of practice, faith community and community size, employment status, and length of time in the FCN role. SPSS software was used to analyze data associations both descriptive and inferential, including means and *t*-tests of grouped averages.

Sample

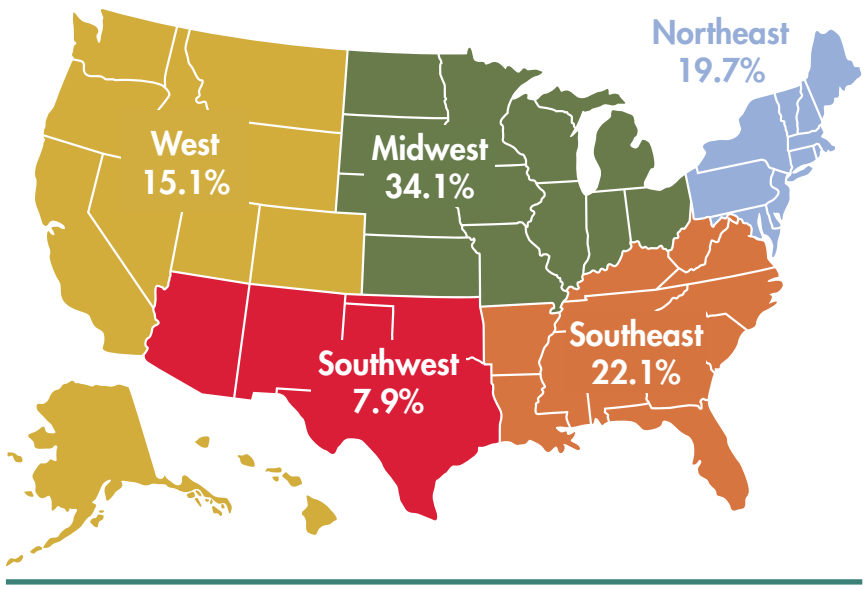
Study participants were self-identified practicing FCNs with a current RN license and practicing in the United States, making it a nonrandom convenience sample. Confidentiality was maintained and no private information was identified with survey participation. Special attention was paid to distributing the survey in a way that would elicit representation from all five U.S. regions: Northeast; Southeast; Midwest; Southwest; and West (Figure 1). Although a profile comparison of FCN demographics to the sample shown in Figure 1 would be helpful, none is currently available.

A desired sample size of 373–375 was calculated using the Creative Research Systems Calculator (The Survey System, 2012). The calculation was based on an estimated 10,000–15,000 practicing FCNs in the United States (Durbin & Haugen, 2010). A total of 378 FCNs completed the survey from March to May 2021.

Data Analysis

Statistical analysis was performed using IBM SPSS for Windows, version 26.0. Descriptive statistics were gathered along with percentage, mean, and standard deviation for the sample characteristics of employment status, length of time in practice, age, geographic area and region, size of community, and incidences of COVID-19. A matched paired *t*-test was analyzed for pre-COVID-19 and during COVID-19 FCN practices. SPSS software identified major categories for the descriptive questions along with key word identification and classification done by the research team.

Figure 1. GEOGRAPHIC DISTRIBUTION OF FCN RESPONDENTS



Getty Images / adamkaz

RESULTS

The predominant descriptive statistics were as follows ($N = 378$): 68.5% of the FCNs were in unpaid positions, whereas 31.5% were in paid positions. The majority of FCNs were over the age of 60 (80%). Their years of service were: >10 years 45%; 1–5 years 29%; 6–10 years 22.8%; <1 year 4%. Geographic area of practice was suburban 42%; urban 32.8%; rural 25.6%; other 3.9%. All U.S. regions were well represented (Figure 1).

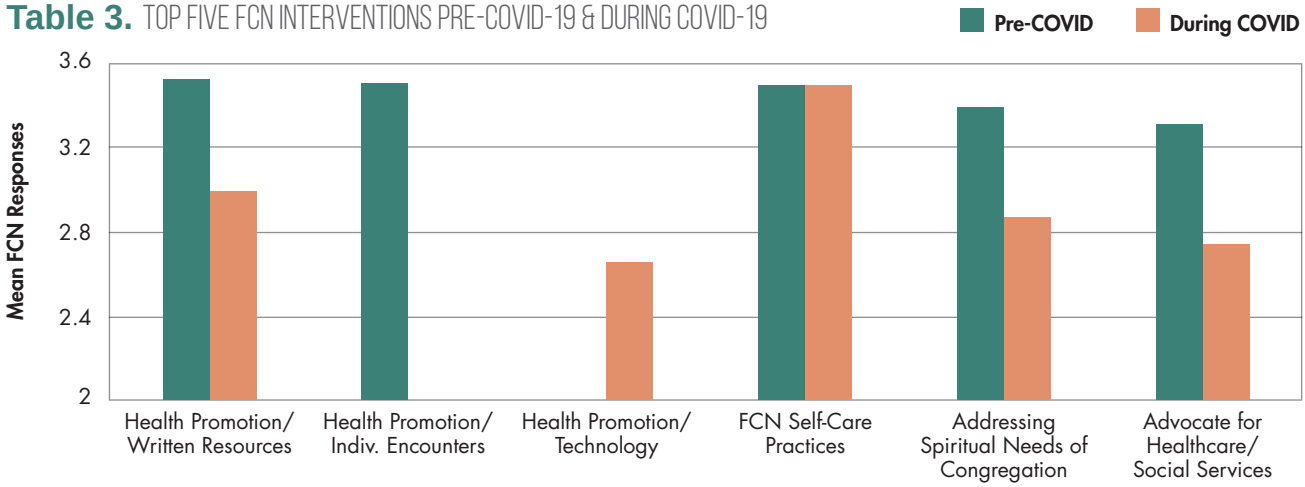
Fourteen FCN interventions, falling into five general categories, were measured: Health Promotion (individual encounters, group classes, encounters using technology, written resources), Screening and Advocacy (health screenings, advocating for social services, transitional/care coordination), Referrals (for medical services or for social services), Training of Volunteers and Safety (recruitment/training, planning for safe environment), and Intentional Care of the Spirit (attending to spiritual needs of faith community, facilitating faith rituals, self-care practices). Each intervention was rated on a 5-point Likert Scale as to the frequency it was performed, with 5 being "Very Frequently" and 1 being "Do not Perform." Participants subjectively estimated the frequency of each intervention before COVID (pre-COVID) followed by an estimate during COVID.

Results of the 14 pre-COVID and during COVID FCN interventions showed a statistically significant decrease in 12 of the 14 interventions ($p < .05$): Health Promotion (individual encounters, group classes, written resources, health screenings), Advocacy (healthcare/social service, transitional care, care coordination), Referrals (medical, social services), Training of Volunteers (recruitment/training, safe environment), and Intentional Care of the spirit (addressing spiritual needs of members, faith rituals). There was a statistically significant increase in one interven-

Table 2. OPEN-ENDED QUESTIONS: TOP THREE RESPONSES FOR QUESTIONS 14, 16, & 18 ($N = 378$)

Question	Technology	Communications	Supportive Interventions	Education	Supports/ Resources
Q14. Describe adaptations to your practice. ($n = 210$)	58.6% ($n = 123$)	20% ($n = 42$)	19% ($n = 40$)		
Q16. What strategies do you want to continue? ($n = 199$)	47.2% ($n = 94$)		34.7% ($n = 69$)	20.1% ($n = 40$)	
Q18. What resources would have been helpful? ($n = 231$)	20.3% ($n = 47$)			9.5% ($n = 22$)	60.6% ($n = 140$)

Table 3. TOP FIVE FCN INTERVENTIONS PRE-COVID-19 & DURING COVID-19



tion—health promotion using technology (p = .00). The intervention of self-care practices for FCNs was the only intervention that remained unchanged (p = .949).

Several open-ended questions were asked; SPSS software categorized the open-ended responses. The research team grouped and reviewed patterned responses. The general categories identified were consistent with FCN roles and nomenclature. Repeated categories across open-ended questions were identified as most common. These common response categories were communications, education, technology, supportive interventions, and support/resources. The top three responses are listed for questions 14, 16, and 18 as shown in Table 2.

Question 14 responses described adaptations to FCN interventions during COVID-19. The predominant approaches/adaptations used were in the technology category, with 41.7% indicating phone calls and virtual visits. Written communication was the next highest category including mailing notes, cards, newsletters, and flyers. Support was offered through a variety of interventions, such as outdoor visits, providing groceries/meals, referrals, and health promotion.

Question 16 asked for creative strategies FCNs implemented during the pandemic and want to continue. The top ranked categories were technology, supportive interventions, and education with many unique examples highlighted in the discussion.

FAITH COMMUNITY NURSES NEED TO REIMAGINE WHAT THEIR PRACTICE WILL LOOK LIKE IN THE EVENT OF A COMMUNITY CRISIS, EPIDEMIC, OR PANDEMIC.

Question 18 focused on resources that would have been helpful to FCNs during COVID-19. Responses indicated that helpful resources included support from clergy, non-clergy, other FCNs, and volunteers. Denominational, governmental, networking, professional, and spiritual support also were identified. Supplies, vaccines, and money were resources needed. Regarding technology, FCNs requested more availability and direction on how to use technology.

The top five interventions of FCNs pre- and during COVID-19 are shown in Table 3. The frequency ranking for interventions was from one to five, with one being the most frequently used intervention.

Question 19 was multiple choice, providing FCNs an opportunity to identify the type of support that would be most helpful personally in the FCN role as the practice moves forward. A total of 346 FCNs responded: 78% identified peer support/networking; 41.3% selected spiritual sustenance; 39.3% selected stress reduction; and 34.7% selected grief/loss support. Among the 37 comments were reflections of support needed in other areas, such as support in rebuilding/new start to ministry (2.6%), pastoral support/dealing with resistance (2%), FCN education on how to facilitate best practices in the context of diverse perspectives within populations served (2%), and feeling well supported through networking with Christian nurses and other members of faith communities (1.7%).

Question 20 inquired about plans for the FCN role in the future. Faith community nurses could check all that applied (Table 4). The top responses indicate that a large majority of FCNs (78.9%) planned to continue their ministry as soon as restrictions were lifted or planned to reenergize or refresh their ministries as churches reopened (53.8%). Forty-four percent planned to recruit more people to their ministry team, whereas others indicated the need to pause and reassess (14.9%). Retirement or "other" was selected by 11.9% of FCNs.

DISCUSSION

The three open-ended questions in Table 2 identified actions and strategies FCNs reported implementing during the initial height of the

Table 4. FCNS' FUTURE PLANS (QUESTION 20; *N* = 378)

FCN Future Plans (*N* = 370)	*n*	%
Continue my ministry	292	78.9
Reenergize and refresh my ministry	199	53.8
Recruit more people to my ministry team	163	44.1
Pause and reassess	55	14.9
Other (retire and personal)	44	11.9

Table 5. CREATIVE STRATEGIES IMPLEMENTED DURING COVID-19: FCN VERBATIM RESPONSES

Technology	• Virtual platforms (Zoom, support groups online, caregiver webinar/live Facebook devotions, tele-med visits), Zoom wellness checks for seniors • Phone calls (care and call ministries) • Distant healing with healing touch
Supportive interventions	• More inclusive of elderly and immune-compromised congregants • Grief support/more involved with funerals and grief work/grief care bags/sunshine bags to lift spirits • Parking lot visits • Knock, drop, and run • Winter Wellness Challenge • Just Got Mail • Care teams/buddy system care circles • Senior wellness checks, daily prayer, and check-in group • Increasing recognition of loneliness and increase in suicide • Partner with local mental health program (including chaplains, physicians, faith leaders to offer support, information, and wellness in a holistic way) • Partner with others in community (county health, state sources) • Wellness Wednesday at Westside • Mobile prayer in driveways • COVID-19 volunteer care team • Drive-through events (food and clothing distribution, vaccine clinics)
Education	• Mailing inserts with CDC COVID information • Weekly to monthly articles for faith communities • Virtual health presentation via Zoom
Communication	• Personal notes (bereavement, those in health crisis) • Birthday and Christmas cards to homebound • Prayer and pen pal ministries • Weekly/monthly articles/bulletin inserts/newsletters/daily texts • Bilingual COVID-19 resources
Spiritual resources	• Fellowship offerings • Bible studies • Devotions placed in groceries • Apps for artwork • Increased awareness of spiritual needs of dementia patients
Other	• Comment on self-care and mental health of the FCN

pandemic. These were consistent with the six aspects of FCNs defined by King (2011): education, personal counseling, health screenings, spiritual support, referrals, and health advocacy. Although the top five interventions of FCNs during COVID-19 remain in the areas of spiritual support, health promotion, and advocating for services, the mode of delivery was via technology and written communications compared with in-person. The unique and innovative activities of the FCNs reported during COVID-19 pandemic (see Table 5) reflected Proverbs 3:25-26: "Have no fear of sudden disaster or of the ruin that overtakes the wicked, for the LORD will be at your side and will keep your foot from being snared" (NIV).

Regarding strategies implemented during COVID-19 (question 16), the creativity and ingenuity of FCNs practicing during the height of the pandemic was inspiring (see Table 5). These examples coincide with the Mock's (2017) findings that FCNs use their nursing knowledge in many ways both to support their own faith community directly and to improve the health of the community. A motivational verse from Matthew 17:20 reflects the FCNs who persevered during the COVID-19 pandemic: "Truly I tell you, if you have faith as small as a mustard seed, you can say to this mountain, 'Move from here to there,' and it will move. Nothing will be impossible for you" (NIV).

Question 18 allowed FCNs to identify resources that would have been helpful to support them in their practice during the pandemic. The respondents reported an overwhelming need of the use of and the need for support services. Mock (2017) describes the role of FCNs with examples of providing support during bereavement and addressing the needs of community members both in sickness and health. As in Reilly et al. (2011), FCNs called attention to the need for an emergency preparedness plan and making information

THE PANDEMIC HEIGHTENED THE AWARENESS OF THE IMPACT THE FCN CAN HAVE IN A FAITH COMMUNITY AND WIDER COMMUNITY.

available. Kiser and Lovelace (2019) found that a national, state, and local faith organization partnership was a critical aspect to enable information sharing, co-learning, and dissemination of best practices. Such partnerships were necessary to engage local networks, to strengthen assets, and to support learning communities.

In question 19, FCNs identified supports that would be most helpful to the FCN role. Respondents identified the need for peer support and networking, especially during the pandemic-enforced isolation and uncertainty. A homeless center adapted to provide a range of services during the height of the COVID-19 crisis and proactively responded to the pandemic (Parkes et al., 2021). Partnerships and networking between services was an essential component of that success. COVID-19 has highlighted the need for networking and support services to facilitate the FCN role. Strategies to educate on vaccine efficacy and support best practices in the context of diverse perspectives within populations served are needed. In this area, FCNs can relate to this truth: "Two are better than one, because they have a good return for their labor: If either of them falls down, one can help the other up. But pity anyone who falls and has no one to help them up" (Ecclesiastes 4:9-10, NIV).

Consistent with the literature, FCNs reported the use of Zoom, phone calls, and other forms of virtual visits with members of the faith community and wider community. Parkes et al. (2021) described the initial reduction of services in the homeless center that necessitated the switch to telephone and online support to communicate with clients. Faith community nurses in this study reported the need to be better equipped with technology and educational strategies. King (2011) found that clients do receive holistic care from FCNs and that care was overwhelmingly positive. During the COVID-19 pandemic, during healthcare system crisis, isolation, disruption, and limited services, FCNs delivered holistic care. Mock (2017) found that FCNs offered tasks and services that were supportive to clients' healthcare needs; they were valued by faith communities because of accessibility and how they used nursing knowledge to serve targeted populations.

Significantly, self-care for the FCN was ranked as one of the top five interventions pre- and during COVID-19 (Table 3). It was the only intervention of the 14 measured that did not show a statistically significant change. The FCNs identified the need and faithfully continued with self-care practices during COVID-19. Parkes et al. (2021) found that staff, including FCNs, need support and good leadership. Opportunities for training and reflective practice should continue, despite the pressures of providing enhanced service to a client group, particularly during COVID-19. To ignore such needs elevates the risk of compassion fatigue and burnout. It is encouraging to know that the majority of FCNs in this survey reported a plan to continue their ministry post-COVID-19. Stress management as part of self-care reflects 1 Peter 5:7, "Cast all your anxiety on him because he cares for you" (NIV).

PRACTICE IMPLICATIONS

Faith community nurses need to reimagine what their practice will look like in the event of a community crisis, epidemic, or pandemic in the future and consider living after the event. The pandemic has heightened the awareness of the impact that the FCN can have in a faith community and wider community. As FCNs look to the future, they are challenged with ways they can contribute to the faith community nursing body of knowledge and glorify God through service to his people.

Based on these research findings, the following five areas reflect implications for FCN practice:

- *Identify baseline faith community needs and existing resources*. This enables the FCN to identify gaps in services and resources that may need to expand and allows for adaptation of opportunities to fast-changing demands.
- *Enhance technology support and education*. Technology and education were top categories of identified needs and interventions. Technology provides an avenue for connectivity when gathering is not an option and can provide greater access to greater numbers. This may be part of reimagining practice.
- *Maintain networking relationships* with other FCNs, faith community leaders, volunteers, denominational and governmental leaders, including public health organizations at the national and state levels. Networking can serve as a source of valid reliable information, resources, and support both personally and professionally, particularly in the context of diverse perspectives with populations served.
- *Identify the nearest emergency preparedness plan and crisis command center for your community.* This is where you should get the most current information pertaining to your faith community. Know the key stakeholders managing operations and

Web Resources

- **Infection Control & Emergency Preparedness Toolkit for the Faith Community**
  https://cdn-links.lww.com/permalink/ncf-jcn/a/ncf-jcn_28_4_2011_07_22_reilly_200161_sdc1.pdf
- **United Church of Canada: Are You Ready for Health Emergency?**
  https://united-church.ca/sites/default/files/ready-for-a-health-emergency.pdf
- **Lutheran Disaster Response**
  https://download.elca.org/ELCA%20Resource%20Repository/PandemicChecklist.pdf?_ga=2.181554471.1409316316.1655829606-240201832.1655829606

making decisions to funnel communication appropriately. Additionally, this is helpful for work efficiency, networking, resources, and support.

- *Utilize an emergency preparedness toolkit.* The need for basic infection control and health promotion messages is apparent in the FCN's role as a health educator and health promotor. Toolkits for faith communities on infection control topics exist (see Web Resources).

A strategic focus on recruitment and succession planning for sustainability to engage all ages of FCNs for paid and unpaid flexible FCN positions is essential within local and national ministries. Two-thirds of FCNs being unpaid in the United States creates cost-effective opportunities for attracting and engaging nurses in the specialty practice through volunteer services. There are FCNs preferring not to be paid in their role; one respondent reported, "The hospital system I work for created a clinical volunteer pathway for FCNs to work in vaccine clinics either in a paid or unpaid capacity."

During the COVID-19 pandemic, many healthcare services were limited or inaccessible. It was a time of uncertainty, confusion, disruption, isolation, and constant change. Faith community nurses were able to provide care and support when other healthcare services were not available. Care strategies were adapted to provide a range of physical and emotional supports. Awareness and commitment of FCNs to help in times of need remains apparent.

American Nurses Association & Health Ministries Association. (2017). *Faith community nursing: Scope and standards of practice* (3rd ed.). American Nurses Association.

Creative Research Systems. (2012). *The Survey System.* https://www.surveysystem.com/sscalc.htm

Durbin, N. L. R., & Haugen, D. (2010). Parish nursing: A specialty practice of professional nursing. *Caring Connections, 7*(3), 6–9. https://lutheranservices.org/wp-content/uploads/2022/06/CaringConnections_2010_vol07_3.pdf

Health Ministries Association, Inc. (2021). *Faith communities and faith community nurses (FCN) answering the call to serve our communities during the global COVID-19 pandemic.* http://hmassoc.org/wp-content/uploads/FCN-covid-19-statement-2021-FINAL.pdf

King, M. A. (2011). Parish nursing: Holistic nursing care in faith communities. *Holistic Nursing Practice, 25*(6), 309–315. https://doi.org/10.1097/HNP.0b013e318232c5e0

Kiser, M., & Lovelace, K. (2019). A national network of public health and faith-based organizations to increase influenza prevention among hard-to-reach populations. *American Journal of Public Health, 109*(3), 371–377. https://doi.org/10.2105/AJPH.2018.304826

Kruse-Diehr, A. J., Lee, M. J., Shackelford, J., & Hangadoumbo, F. S. (2021). The state of research on faith community nursing in public health interventions: Results from a systematic review. *Journal of Religion and Health, 60*(2), 1339–1374. https://doi.org/10.1007/s10943-020-01168-4

Mock, G. S. (2017). Value and meaning of faith community nursing: Client and nurse perspectives. *Journal of Christian Nursing, 34*(3), 182–189. https://doi.org/10.1097/CNJ.0000000000000393

Parkes, T., Carver, H., Masterton, W., Falzon, D., Dumbrell, J., Grant, S., & Wilson, I. (2021). 'They already operated like it was a crisis, because it always has been a crisis': A qualitative exploration of the response of one homeless service in Scotland to the COVID-19 pandemic. *Harm Reduction Journal, 18*(1), 26. https://doi.org/10.1186/s12954-021-00472-w

Reilly, J. R., Hovarter, R., Mrochek, T., Mittelstadt-Lock, K., Schmitz, S., Nett, S., Turner, M. J., Moore, E., Howden, M., Laabs, C., & Behm, L. (2011). Spread the word, not the germs: A toolkit for faith communities. *Journal of Christian Nursing, 28*(4), 205–211. https://doi.org/10.1097/CNJ.0b013e31822afe7f

Solari-Twadell, P. A., & Hackbarth, D. P. (2010). Evidence for a new paradigm of the ministry of parish nursing practice using the nursing intervention classification system. *Nursing Outlook, 58*(2), 69–75. https://doi.org/10.1016/j.outlook.2009.09.003

Ziebarth, D., & Hunter, C. (2016). Moving toward a virtual knowledge platform for faith community nurses. *Computers, Informatics, Nursing, 34*(11), 503–512. https://doi.org/10.1097/CIN.0000000000000273

For more than 34 additional nursing continuing professional development activities related to faith community nursing topics, go to NursingCenter.com/ce.

Lippincott® NursingCenter®

NCPD Nursing Continuing Professional Development

TEST INSTRUCTIONS

- Read the article. The test for this nursing continuing professional development (NCPD) activity is to be taken online at **www.nursingcenter.com/CE/CNJ**. Tests can no longer be mailed or faxed.
- You'll need to create an account (it's free!) and log in to access My Planner before taking online tests. Your planner will keep track of all your Lippincott Professional Development online NCPD activities for you.
- There's only one correct answer for each question. A passing score for this test is 7 correct answers. If you pass, you can print your certificate of earned contact hours and access the answer key. If you fail, you have the option of taking the test again at no additional cost.
- For questions, contact Lippincott Professional Development: 1-800-787-8985.
- Registration deadline is March 6, 2026.

PROVIDER ACCREDITATION

Lippincott Professional Development will award 2.0 contact hours contact hours for this nursing continuing professional development activity.

Lippincott Professional Development is accredited as a provider of nursing continuing professional development by the American Nurses Credentialing Center's Commission on Accreditation.

This activity is also provider approved by the California Board of Registered Nursing, Provider Number CEP 11749 for 2.0 contact hours. Lippincott Professional Development is also an approved provider of continuing nursing education by the District of Columbia, Georgia, West Virginia, New Mexico, South Carolina, and Florida, CE Broker #50-1223. Your certificate is valid in all states.

Payment: The registration fee for this test is $21.95 for nonmembers, $15.95 for NCF members.