What are the perceptions and experiences of care delivery among faith community nurses? A systematic review.

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2021

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Abstract

Objective: This systematic review set out to identify the unique perceptions and experiences of care delivery among faith community nurses (FCNs').

Data Sources: This review was conducted and has been reported using the PRISMA guidelines. The search was conducted using the following databases, Medline (OVID), EmCare for Nurses (OVID), PsycINFO (OVID); CINAHL (EBSCO), Cochrane and PubMed. The search strategies included the use of truncations, adjacency search parameters, as well as Boolean operators using a range of key search terms. Pre-determined eligibility criteria were applied to all studies. The review process was managed using Covidence systematic review software. Data extraction and quality assessment was conducted across all included studies. Data were analyzed using a narrative synthesis approach.

Conclusion: This review has made an important contribution by identifying the role that FCN's play in care delivery, as trusted members of their communities who act as a conduit at the intersect of faith and healthcare. Irrespective of the location or faith denomination, what was common to FCNs' was that they delivered care to address the physical, psychological, spiritual, congregational, communication, health system and family-related needs of those in their care.

Implications for Nursing Practice: The nurses' represented in the included studies expressed concerns that patients experienced unmet supportive care needs due to a fragmented and highly complex existing healthcare system. Often, FCNs' provided a valuable contribution in supporting patients in their care pathways and facilitated continuity of care among people who lived with pre-existing co-morbidities and who had complex healthcare needs. Further research is needed to understand the role that faith community nursing models might have in cancer care from the perspective of patients and other members of the multi-disciplinary team across different international contexts.

Key words: faith community nurse, experiences, perceptions, faith, spirituality, holistic care, parish nurses, systematic review integrative review.

Background

A parish nurse, also known as a faith community nurse (FCN), provides a model of care which is tailored for members of a parish or faith community [1]. Specifically, this model of nursing integrates faith and healing to promote wellness within the community in which it is delivered. A FCN provides specialized nursing practice that is embedded in a salutogenic [2] lens of healthcare, focused on the individual as a unique whole. A FCN also integrates spiritual and/or faith-based needs across the lifespan to promote wellness, disease prevention, health promotion, and healing within the faith-based community [3]. Religious involvement in health care has a long history in which FCN models have been delivered both in the acute hospital setting and in care homes, encompassing the interrelationship between faith and health [4]. FCN is embedded in an international movement, which represents an inclusive term that incorporates all professional registered nurses fulfilling a "health ministry" role across different denominations and faith-based communities [5]. This specialised nursing role focuses on health promotion within a framework of beliefs, values and practices in accordance with a community of faith. However, the spiritual dimensions and needs of an individual are central[6]. Evidence has shown that not only does the FCN address the emotional, physical, and social needs of individuals within a faith congregation but more importantly the FCN integrates the spiritual needs as a core concern [5].

Research has identified that nursing practice inadequately addresses the spiritual needs of patients across the lifespan [7], including in cancer care [8]. FCNs have been observed to play an important role in cancer screening services and practices [9]. The contribution of FCNs in cancer care and their contributions to existing healthcare systems and services internationally should not be underestimated. Models of faith community nursing were originally founded in 1984 by Granger E. Westberg, a Lutheran pastor in the United States of America (USA). Since then faith community nursing is being provided in: Australia, Bahamas, Canada, Costa Rica, United Kingdom, Finland, Germany, Ghana, India, Japan, Kenya, Korea, Madagascar, Malawi, Malaysia, New Zealand, Nigeria, Pakistan, Palestine, Philippines, Singapore, South Africa, Swaziland, Ukraine, Zambia, and Zimbabwe [4]. For the purpose of this review, a FCN is defined as, a nurse inclusive of all faith traditions which focuses on holistic health (social, physical, psychological, and spiritual) needs of individuals based in faith communities [10].

A recent systematic review [5] identified that FCNs provide an important contribution to public health interventions, and FCNs can fulfil a variety of roles such as: health educators, referral sources to congregational and community resources and services, personal health counsellors, advocates, and facilitators/interpreters of the relationship between faith and health. However, less is known about the actual perceptions and experiences of FCNs in different international contexts [5]. FCNs are

known to embrace and highlight the spiritual aspects of care delivery more than any other nursing specialty. [4] Therefore, understanding their perceptions and experiences may provide valuable insights into addressing the well documented unmet spiritual needs for people affected by cancer [8,11,12] . Consequently, this systematic review aimed to address the following research question:

- what are the perceptions and experiences of care delivery among FCNs?

Methodology

This integrative review was conducted and reported using the Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA) guidelines for systematic reviews [13] (see Supplementary Table 1 for completed checklist). The PICOS framework was used to guide the search strategy (see Supplementary Table 2).

Methods and Materials

Literature Search

The search was conducted using the following databases, Medline (OVID), EmCare for Nurses (OVID), PsycINFO (OVID); CINAHL (EBSCO), Cochrane and PubMed. The search strategies included the use of truncations, adjacency search parameters as well as Boolean operators. A combination of MeSH, EmTree and APA vocabularies as well as keywords were used to develop the search strategy and included keyword searches such as: "faith community nurs*"; "parish nurs*"; and "church nurs*", and were adapted according to the nuances of each database. The search was conducted from the earliest date available to January 2021. See **Table 1** for an overview of the search strategy.

Pre-defined eligibility criteria

Types of studies

Inclusion

- Peer-reviewed studies investigating the experiences and perceptions of care delivery among FCNs, published in the English language.
- Qualitative and quantitative methods irrespective of research design.
- Relevant systematic reviews will be scrutinised for potentially relevant studies for screening.

Exclusion

- Opinion/editorial papers, discussion articles, non-peer reviewed studies, studies published in languages other than English.

Types of participants

Inclusion

- Men and women who identify as a registered FCN irrespective of geographical location or model of practice.

Types of outcomes

Inclusion

- The primary outcome of this review was related to the experiences and perceptions of care delivery among FCNs.

Data collection and analysis

Selection of studies

All references were uploaded to EndNote™ (X9.3) and then exported to Covidence™ (Covidence systematic review software), where duplicates were removed. Covidence™ was used to complete the title and abstract screening based on the pre-determined inclusion and exclusion criteria. Titles and abstracts were screened independently by two reviewers. Relevant titles and abstracts meeting the inclusion criteria were moved to full text review screening. Full text publications were reviewed by two reviewers, and any disagreements resolved through discussion.

Data extraction

Extracted data included 'characteristics of included studies' (study design; purpose, countries, and institutions where the data were collected; participant demographic and clinical characteristics; experience and perceptions of care delivery; numbers of participants who were included in the study; losses and exclusions of participants, with reasons). Data were extracted from all included studies and double-checked for accuracy and completeness. Any disagreement or uncertainty in data extraction was resolved by discussion among the three reviewers.

Quality appraisal

The quality appraisal of all included studies was conducted by utilising the Mixed Methods Appraisal Tool (MMAT)[14]. The MMAT enabled quality appraisal of: qualitative research, randomized controlled trials, quantitative descriptive studies, and mixed methods studies. There are seven questions for each category of study design which were ranked as “Yes” (green), “Unclear” (yellow) or “No” (red). The quality appraisal enabled the research team to identify limitations and potential bias within each of the individual studies. No study was excluded based upon individual methodological quality appraisal scores to enable an understanding of the current state of the evidence base.

Data synthesis

Data were analysed by using completed tabulation of primary research studies and narrative synthesis to generate findings. The data synthesis process followed the integrated review methodology proposed by Whittemore and Knafl [15]. Specifically, this involved data reduction (subgroup classification by domain of experience/perception, with results tabulated), data comparison (identifying patterns and themes through clustering and counting and making contrasts and comparisons) and conclusion drawing and verification (synthesis of subgroup analysis to inform a comprehensive understanding of the topic, verified with the primary source data for accuracy).

Results

Of the 203 articles retrieved from the search, seven articles met the inclusion criteria, see Figure 1. Noteworthy, while the model of FCN is delivered internationally, all existing studies have been conducted and reported from the USA. There were four qualitative studies, two quantitative descriptive studies, and one mixed methods study included in this review which demonstrates that this is an emerging evidence base. A total of 1,325 parish nurses were included in this review and the sample sizes ranged from (n=7 to n=1161). All studies were cross-sectional in design which limits the understanding of how the experiences and perceptions of care delivery among FCNs changes over time. There were a range of religious denominations represented which included: Baptist [6,16], Catholic [6,16,17] , Covenant [18], Congregational [18], Disciplines of Christ [18], Evangelical [17,18], Evangelical Free [18], Episcopal [6,16,17], Foursquare [18], Greek Orthodox [18], Lutheran [6,16,17], Methodist [6,16,17], Pentecostal [16,17], Pentecostal-Assemble of God [18], Presbyterian [6,16], Reformed Church of America [18], Russian Orthodox [6], Seventh Day Adventist [18], Nazarene[6,18], Moravian [18] and non-denomination [16]. Several studies did not report the congregational denominations where FCN services were provided [19-21]. All participants were females (expert Solari-Twadell[18] where 98% of the n=1161 sample was female) and two studies did not report demographic characteristics [6,16]. The years of experience in an FCN role ranged from several months to greater than 10 years, and qualifications attained among participants ranged from registered licensed nurses to PhD level (see **Table 2** for study characteristics). The results of the quality assessment are presented in **Table 3**. The typologies of the levels of evidence ranged from C1 to B3 according to the Hierarchy of Evidence by the Department of Health [22], see **Table 4.**

Findings

This systematic review identified eight themes in relation to addressing the physical and psychological needs, congregational needs, professional perceptions, patient-FCN communication

needs, health system navigation/co-ordination, spiritual needs, and family related needs (see **Table 5**).

Physical and psychological/emotional needs

Across the studies, FCNs provided direct physical care to members of the congregation in relation to blood pressure monitoring [16,20], urinary tract infections, asthma, and other cardiovascular conditions [16]. Other direct physical care provisions included a diversity of services for general wellness [19], basic nutrition and physical activity [19,21], foot care, bone density screening, community flu clinics [16,19], depression and stress management clinics [6,21], conflict resolution [21], financial planning [6], head lice screening [16], ear and eye screening[16] and complementary therapies (meditation, Tai Chi, music therapy, and Yoga) [19]. Responding to the physical needs of the community also included advice for breast-feeding, medication education, and supporting any physical challenges through spiritual reinforcement and care [21].

Responding to the psychological and emotional needs of individuals was a central part of the FCN's role. Many of the FCNs described providing emotional support to help people deal with death and bereavement [16,18], suicide, helping others to cope with the psychological burden of living with a long-term conditions [16,18], enhancing self-esteem [16], and stress-reduction related to teenage pregnancies [16]. FCNs emphasised that their role was less time restrictive for them (compared to their previous/concurrent nursing positions), which allowed for greater emotional expression to enable in-depth disclosure and psychological care to facilitate healing [19,21]. In responding to the psychological needs, FCNs would frequently use active listening, spiritual growth, appropriate physical touch and prayer [17,18]. For example, one FCN, practising within a Christian belief system, offered the following prayer when delivering care by saying *"Jesus please help with this hurt, this grieving that she is experiencing"* [17 (page 218)]. Addressing the physical and psychological needs of individuals in the congregation FCNs articulated that they felt God's perceived love for others during times of helplessness and depression when others were in need of comfort and compassion [17] .

Congregational needs

It was apparent across most of the included studies that FCNs developed their nursing programs informed directly by the needs of the congregations [6,16,17,21]. It was important that FCNs were visible and present in the congregation to deliver their health ministry [6]. Many of the FCNs were also members of the congregations where they delivered their FCN programs [6], which helped with time management [6,17]. FCN's described developing nursing programs to address the needs of people across the lifespan, which included, babies, children, teenagers, adults and older people [21]. Such examples included: on-call support for breast feeding, delivering CPR courses, delivering babysitting

courses [21] and providing home visits in nursing homes or at the hospital, based on individual needs [21]. FCNs described frequent involvement with wellness issues and lifestyle changes as requested from members of the congregation such as, smoking cessation, diet, diabetes, weight loss, healthy lifestyles, and risk factors of HIV [16]. Developing nursing interventions which were directly informed by the needs of people within the congregation required the development of trust and meeting professional perceptions.

Professional perceptions

The professional relationship between the FCNs and members of the congregation was identified to have a direct relationship with the success of the nursing programs [16,21]. The congregational setting was considered a facilitator by FCNs to developing a long-term relationship with individuals that contributed towards building trust and increased the nurses ability to help in a meaningful and holistic manner [16,21]. Many of the FCNs described that this model of care increased their level of professional autonomy and flexibility, important attributes that were not always experienced in other clinical settings [16]. Some nurses articulated that because of the flexibility in their FCN role they felt a greater level of self-expression to those in their care *"I'm free to show my whole personality [at church] where at work I'm representative of the organisation that I am paid by so I know that I'm to put forth their values, whereas at church I can infuse a little bit of my own" [16 (page 182)].* Professional perceptions of the role also included challenges with time commitments as the majority of FCNs were volunteers [19,20] and often worked in isolation [19] with little opportunity to network with other FCNs. Some FCNs described ongoing challenges with finding their place as an FCN in the wider professional arena of healthcare delivery [20] and related issues of evidencing their impact in terms of service delivery outcomes and patient experience to monitor and evaluate quality assurance [21]. Other issues highlighted included limited access to FCN training and education [20].

Patient-FCN communication needs

The concept of holistic care between the nurse and individuals was echoed throughout all the included studies [6,16,17,19-21], underscoring the importance of trust and connection. FCNs emphasized the importance of being physically present, using active listening, and supporting communication through prayer to provide peace and comfort [17,19,21]. Nurses expressed that often "being present" did not mean fixing something, but communicating that they were providing unconditional care and support [19,21]. Nurses expressed that, often they acted as an advocate and information resource in their communication to help people use the health system appropriately across acute and community services [16,18]. Nurses provided counseling and support to aid complex decision-making

such as treatment decisions for surgery, by providing further information and clarifying procedures that had been recommended by a doctor [16].

Health system navigation and co-ordination

Many FCNs identified that the existing wider health care system was fragmented and many people within congregations experienced unmet needs related to care-coordination [6,19]. FCNs did not seek to replace existing healthcare services but helped people to safely and effectively navigate the system in this large and complicated arena [16,19]. Many FCNs' talked about being a readily available resource within the congregation to help patients use health and community services to aid timely accessibility [16,19]. One nurse explained *"I direct people to the appointment or appropriate physician"* [16 (page 179)]. Nurses also expressed that often patients grappled with the vast amounts of information that was provided to them from their treating doctor, and frequently individuals had problems with health literacy [19]. FCNs identified that their role was unique in addressing unmet informational needs through care co-ordination across both the faith community (pastoral care staff, pastors, priests, and parish members) and wider healthcare system (general practitioners, acute care physician, nurses) [20,21]. FCNs also provided continuity of care for parishioners who were admitted to hospital by providing on-going follow-up care through visiting them as an in-patient [21].

Spiritual needs

Common to all FCNs was that they perceived that their role and mission was to integrate and address the needs of the body, mind, and spirit of all those in their care [6,16-19,21]. One nurse eloquently expressed: *"the psycho-social, the spiritual and the medical are like these separate strands intertwined like a braid. It's all three together. You can't separate them"* [16 (page 180)]. Nurses expressed that this intertwined model of care was of central importance to delivering God's health ministry [6,17,19-21]. Nurses expressed that they provided spiritual care through scripture, prayer and addressing unique individual spiritual needs through conversations [16,17,21]. Some nurses reported that at times they were limited in their theological understanding in delivering spiritual care, but would refer back to a religious leader for support e.g. a pastor or a priest [21].

FCNs found that the integration of their own faith was a positive attribute to this model of nursing care because it was acceptable to members of the congregation to share personal beliefs, which was perceived to be both beneficial for the nurse and individuals [16,19,20]. FCNs expressed a deep sense of connection, spiritual sharing (within and between other FCNs) and observing a higher power in the care that they were providing [17,20]. It was apparent that FCNs felt strongly that they were able and more comfortable to address the spiritual needs and concerns of patients compared with any other

nursing speciality [19]. A focus on spiritual care in FCN models was of central importance to the participants as they expressed that spiritual care delivery was a wide spread unmet supportive care need among individuals and their families [19].

Family needs

FCN models aimed to address the holistic care needs of the whole family unit [6]. Nurses reported that often members of the congregation would seek out advice, guidance or clarification for a health concern of a family member [19]. Providing support to families with new-born babies was also a feature in this model of nursing care, *"the experience that stands out, my wife and I just had a baby, and one night that she got kind of frustrated because she was breast-feeding. And it was probably 10:30pm at night and she (FCN) come over and stayed until 12am … she went totally above and beyond the call of duty"* [21 (page 293)]. Nurses expressed that they tried to *"Bring God Near"* [17] when they were assessing the spiritual needs of individuals and family members [17] in the presence of a higher power. FCNs also reported that they acknowledged the needs of family caregivers who were often unable to attend worship due to existing caring responsibilities[6]. One group of FCNs developed a program to aid the support needs of caregivers in the community [6].

Discussion

This systematic review set out to illuminate the unique perceptions and experiences of care delivery among FCN models. As nursing practice becomes increasingly diverse, providing an evidence-based understanding of the distinctive contribution of FCN is timely. This review has made an important contribution by identifying the role that FCN's play in care delivery, as trusted members of their communities who act as a conduit at the intersect of faith and healthcare. Irrespective of the location or faith denomination, what was common to FCN was that they delivered care to address the physical, psychological, spiritual, congregational, communication, health system and family-related needs of those in their care. The central importance of care co-ordination is widely acknowledged in cancer care practice [23] and often poorly achieved [11,12]. Care co-ordination requires timely, accurate and effective exchange of information about care interventions across patients/families, members of the multidisciplinary team (MDT), community organisations and additional services [24]. Nurses represented in the included studies expressed concerns that patients experienced unmet supportive care needs due to a fragmented and highly complex existing healthcare system. Often, FCNs provided a valuable contribution in supporting patients in their navigation and facilitated continuity of care among people who lived with pre-existing co-morbidities and who had complex healthcare needs. Further research is needed to understand the

role that FCN models might have in cancer care from the perspective of patients and other members of the MDT across different international contexts.

Participants were mostly females, which is reflective of the current demographic of nursing globally. Future research should glean insight into the perspectives of male nurses and their contributions to this emergent model of specialist nursing care. A further limitation to the existing evidence-base is that all studies were conducted in the USA and provided no information about the perceptions and experiences of FCN in other international contexts. Moreover, among the participants in this review, there was diversity in the length of time in the role (ranging from several months to over ten years) and level of academic attainment (ranging from licenced nurse to PhD level). One of the major challenges of this review was combining heterogeneous methodologies, and the findings are constrained due to the methodological limitations of the studies included. Therefore, it was not possible to identify any discernible differences between length of experience, education and the perceptions and experiences of FCNs. Further studies would be advantageous to understand this area and to provide insight and recommendations for FCN educational programmes in the future.

It is apparent that FCNs clearly recognised the interpersonal nature of spiritual caring and the prerequisite of developing a strong and trusting relationship with those in their care. Nurses in these roles contributed to the physical, psychological, spiritual, and family related needs at an individual level, and wider faith community level. What is unique to the experiences and perceptions of those in FCN roles is their openness and acceptance of higher power in their daily care interactions. Nurses expressed that they were working in partnership with patients, families, healthcare teams and importantly, they expanded their awareness and connection during care interactions in the presence of God (Holy Spirit) and this has been identified elsewhere[25]. Noteworthy, participants in the included studies were fulfilling Health Ministry roles in Christian congregations, so transferability to other contexts is limited.

There are several important clinical recommendations from this review. Nurses articulated that FCN programs were often seen as an alternative approach for providing care in the community to a range of people and often provided continuity of care in a disjointed health system, and this has been identified elsewhere [5]. Such models of care could be perceived to be very useful to overcome challenges in today's complex healthcare systems, particularly in cancer care both in the USA[26] and Australia[27], for example. However, further research is needed to understand how, and why, this model of faith community nursing might be useful in cancer care, and what are the potential barriers and facilitators of implementation in practice in different settings and contexts. It is important to recognise that faith community settings are unique; the concerns, size, resources available and

indeed the inherent expectations of the faith community will contribute directly to the role of the FCN.

Limitations

Only studies published in English were included; thus, the evidence might not capture the different international cultures and experiences of care. Furthermore, while this review followed a clear and transparent review methodology to promote reproducibility there was a significant time lag between the dates of the publications included. Empirical research to inform spiritual care has been identified to have emerged in the early 2000's [28] which may provide one explanation.

Conclusion/Implications for oncology nursing

This systematic review contributes toward an understanding of the perceptions and experiences of care delivery among FCNs. Specialist nurses in these roles afford the opportunity to bridge one's physical, emotional, social, and spiritual lives into one caregiving experience. Future research might consider exploring the diversity of such roles in difference international contexts and compare FCN as a healthcare delivery approach embedded in already established MDTs (across both community and acute care). It is clear is that FCNs provide a holistic model of care because of the inclusion of spirituality, which has clear merit in the nursing profession to address existing unmet needs.

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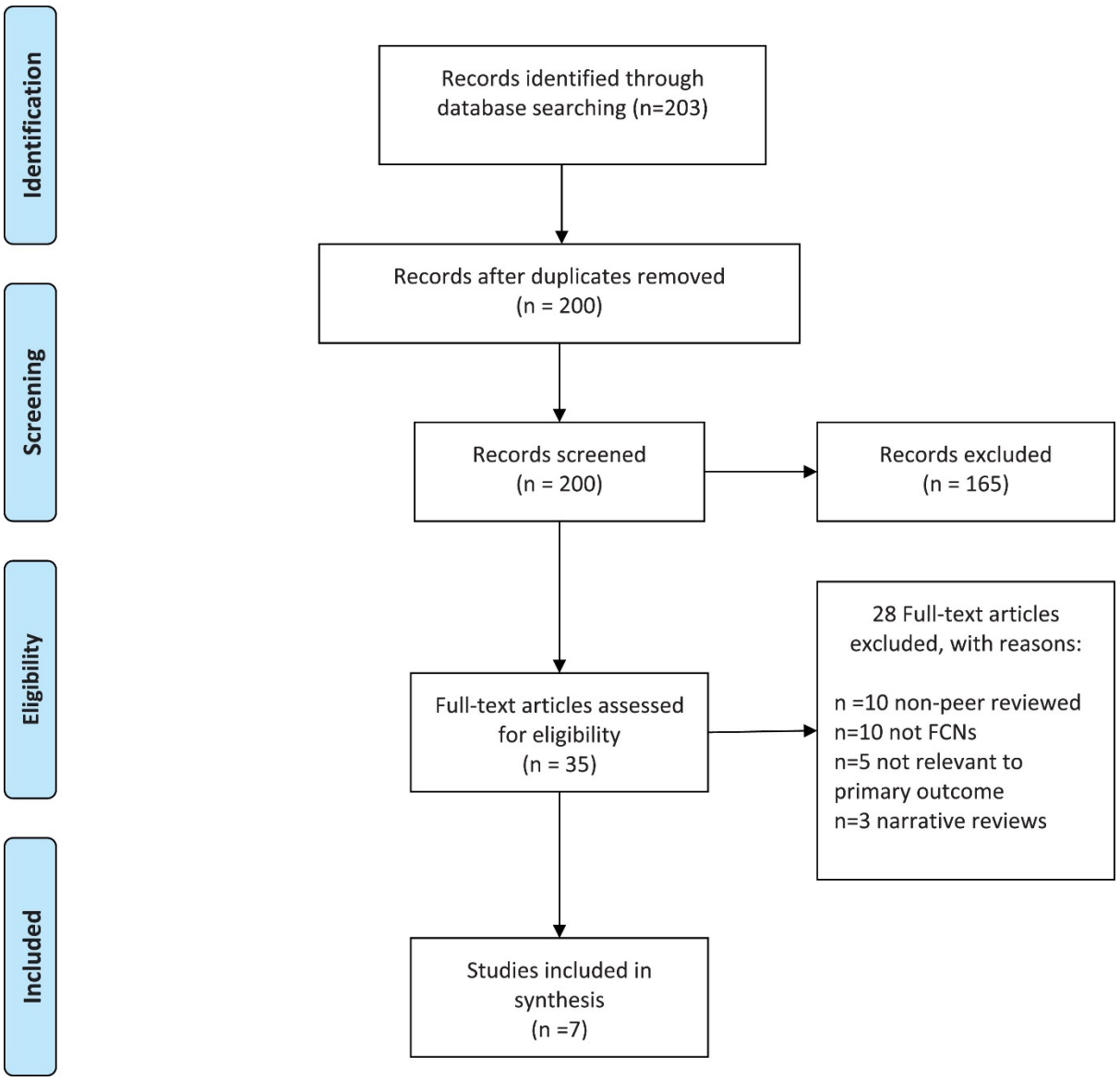

FIG 1. PRISMA 2009 flow diagram. PRISMA, Preferred Reporting Items for Systematic Reviews and Meta-Analyses.

Table 1. Example of the Search Terms Used

S1 parish nurse or parish nursing
S2 faith based nurs* or faith communities
S3 congregational nurs* or health ministry nurs* or crescent nurs* or nurs*
S4 (perceptions or attitudes or opinions) OR (experiences or perceptions or attitudes or views)
S5 (S1) OR (S2) OR (S3)
S6 (S4) and (S5)
No limiters.

Table 2. Overview of Included Studies

Author and YearCountry	Purpose	Setting	Sample size	Participants	Sampling	Response rate	Attrition	Design	Time points	Data collection tools
Brudenell (2003) United States	To explore how faith-based communities form parish nursing programs and what their effects are	13 congregations with parish nursing programs Funding: Parish nursing primarily used an unpaid professional nurse volunteer model, but two nurses were part-time employees of their congregations and were paid through grants.	N = 13 parish nurses N = 8 pastors	Demographic: Not reported The parish nurse programs had existed for 1 to 5 years. Represented: Methodist, Catholic, Presbyterian, Nazarene, Lutheran, Episcopal, Russian Orthodox, and Baptist	Purposive	Not reported	N/A	Qualitative study using grounded theory	Not reported	Qualitative interviews, artifacts, reports, photographs, and other documents to illustrate the programs and direction observations
Chase-Ziolek and Iris (2002) United States	To explore the contributions of nursing care in a congregational setting	15 congregations with parish nursing programs Funding: Parish nursing was unpaid with the exception of one nurse funded part-time.	N = 20 parish nurses	Demographics: ages 30-72 years. Experience of parish nursing 2-4 years. One had been a parish nurse for 6 months. Of the 15 congregations, 8 were predominantly Black, 2 were multiethnic, and 5 were predominantly white. Six different	Purposive	Not reported	N/A	Qualitative study using naturalistic enquiry	Not reported	Nine participated in a focus group, and 15 completed phone interviews with 7 nurses participating in both the focus group and a phone interview

Author and YearCountry	Purpose	Setting	Sample size	Participants	Sampling	Response rate	Attrition	Design	Time points	Data collection tools
				denominations were represented among the 15 congregations: 4 Baptist, 4 Catholic, 3 Lutheran, 1 Methodist, 1 Episcopal, 1 Pentecostal, and 1 nondenominational						
Devido et al (2019) United States	To explore the personal experiences, challenges, and practices of parish nurses in their communities	Most study participants were from the Pittsburgh and surrounding areas in western Pennsylvania (73%), whereas others (27%) practiced in Florida, Ohio, New York, Arizona, and Minnesota. They served a number of congregations not reported. Funding: The participants described financial support. Some participants held paid positions, but	N = 48 parish nurses	Demographic: all female, 83% Caucasian, 94% ages 51 and older, 96% registered nurses, and 61% had completed a Bachelor of Science in nursing degree or higher. Congregational denominations not reported.	Purposive	Not reported	N/A	Concurrent mixed methods	Not reported	11 focus groups were digitally recorded and lasted between 60 and 90 minutes. The complete 11-item focus group guide.

Author and YearCountry	Purpose	Setting	Sample size	Participants	Sampling	Response rate	Attrition	Design	Time points	Data collection tools
		for many their time was as a parish nurse was on a volunteer basis. Funding was sought from their church and through donations or grants. Some participants even used their own money.								
Schweitzer et al (2002) United States	To describe perceptions of the leadership role in parish nursing	66 parish nurse leaders identified from across the United States. Respondents reflected a total of 583 faith communities in their parish nursing programs. Funding: The participants described financial support. Some participants held paid positions, but for many their time as a parish	N = 66 parish nurses	Demographic: all female, worked in parish nursing for an average of 5.2 years, with a range of 1 to 10-plus years of parish nursing practice. Highest education level achieved by the parish nurses ranged from licensed to practice nursing to PhD. Congregational denominations not reported. 583 faith communities, 413 urban or suburban, and 170 in rural communities	Convenience	44%	N/A	Cross-sectional survey	1	The survey consisted of 11 questions to gather demographic data on parish nursing leaders, information on the parish nurses and programs. Perceptions of the role and functions. Two open-ended questions to identify and describe the most satisfying aspects and the major

Author and YearCountry	Purpose	Setting	Sample size	Participants	Sampling	Response rate	Attrition	Design	Time points	Data collection tools
		nurse was on a volunteer basis. Nearly 87% volunteer their time and efforts to their faith communities.								challenges in the leadership position. Reliability and validity not reported.
Solari-Twadell (2009) United States	To describe what parish nurses believe is essential to their practice and identify what nursing interventions they most frequently use	1161 parish nurses across 47 states in the United States, except Vermont, Alaska, and Rhode Island. Number of faith communities not reported. Funding: Not reported.	N = 1161 parish nurses	Demographic: nurse respondents were white (95%) and female (98%), average age was 55, and most were married (83%). Educational preparation: Baccalaureate degree (31.8%), Associate degree (13.7%), Diploma (24.4%), Masters (12.1%) and PhD (3.7%). Congregational denominations included: Evangelical, Covenant, Disciples of Christ, Pentecostal-Assembly of God, Seventh Day Adventist, Nazarene, Moravian, Evangelical Free, Greek Orthodox, Reformed Church in	Convenience	2330 parish nurses/1161 respondents (50%)	N/A	Cross-sectional survey	1	*Nursing Intervention Classification Survey* 3rd edition to measure the most frequently used and essential nursing interventions delivered by parish nurses.

Author and YearCountry	Purpose	Setting	Sample size	Participants	Sampling	Response rate	Attrition	Design	Time points	Data collection tools
				America, Congregational, and Foursquare.						
Tuck et al (2000) United States	To describe a parish nursing program from an ethnographic perspective	The parish nursing program is a community outreach program of a large, religious-affiliated health care system. Two out of seven congregations with parish nursing program were selected. Funding: The parish nurses reported an average of 20.6 hours of parish work to their employer for compensation but worked 25 to 40 hours per week as a parish nurse. Largely unfunded.	N = 3 administrators N = 5 spiritual leaders N = 7 parish nurses N = 17 clients	Parish nurses: four nurses had associate degrees, two had diplomas, and one had a bachelor's degree in nursing. Mean duration of education 16.3 years. Average nursing experience of 20.7 years (range: 6 to 34 years). 86% were not members of the congregation they served. Served as a parish nurse for an average of 28 months (range: 18 to 36 months). Mean age 47.7 years, all female, 43% Baptist and 53% other denominations, 86% white and 14% Black. Congregation: The congregation membership in the two sites ranged from 700 to 2200 with a mean of 1286 members and weekly attendance that	Purposive	Not reported	N/A	Qualitative study using ethnography research method	Not reported	Audiotaped interviews were conducted with seven parish nurses and transcribed for data analysis. Investigators also used observation at the two sites, observing the activities of the parish nurse and viewing the physical facilities.

Author and YearCountry	Purpose	Setting	Sample size	Participants	Sampling	Response rate	Attrition	Design	Time points	Data collection tools
				ranged from 450 to 1150 with a mean of 695 members. One selected parish program was a Black congregation in a downtown area with membership across a range of socioeconomic backgrounds. The other church was located in a suburban environment in a rapidly growing small town contiguous to the large city. The second congregation was primarily white.						
Van Dover and Pfeiffer (2006) United States	To develop a theory to explain the process that parish nurses use to provide spiritual care	Parish nurses lived and worked in the Midwest and Southwest of the United States. Funding: Seven out of the 10 parish nurses were paid a salary for their services.	N = 10 parish nurses.	Each parish nurse had completed a formal parish nursing preparation course and had been working in a Christian congregation for a minimum of 1 year before being interviewed between 1999 and 2001. The study participants were women aged 38-63 (mean: 51). All were Christians	Purposive	100% All 10 parish nurses approached agreed to participate.	Not reported	Qualitative study using grounded theory	Not reported	An interview guide was used to pose questions to all participants. Interviews were tape-recorded and transcribed verbatim. Transcripts were verified for accuracy by reading each one while simultaneously

Author and YearCountry	Purpose	Setting	Sample size	Participants	Sampling	Response rate	Attrition	Design	Time points	Data collection tools
				(three Roman Catholics and seven Protestants) and had worked for many years in hospital and community settings. One had an associate degree in nursing, six had bachelor's degrees, two had master's degrees, and one held a PhD. Three had some formal chaplaincy or theological training in addition to their nursing credentials. Congregation: served in several denominational settings: Pentecostal, Roman Catholic, Episcopal, Methodist, Evangelical Covenant and Lutheran. Three served more than one congregation.						listening to the audiotape.

Table 4. Hierarchy of Evidence Used by the Department of Health

Typologies of supporting evidence
A1 Systematic reviews, which include at least one RCT (eg, systematic reviews from Cochrane)
A2 Other systematic and high-quality reviews
B1 Individual RCTs
B2 Individual nonrandomized, experimental or interventional studies
B3 Individual well-designed nonexperimental studies, controlling statistically if appropriate. Includes case control, longitudinal, cohort, matched pairs or cross-sectional random sample methodologies, and well-designed qualitative studies and well-designed analytical studies including secondary analysis.
C1 Descriptive and other research or evaluations not in B (eg, convenience samples)
C2 Case studies and examples of good practice
D Summary review articles and discussions of relevant literature and conference proceedings not otherwise classified

RCT, randomized controlled trial.

Table 5. Overview of Findings Related to Experience and Perceptions of Care Delivery Among FCN

	Physical needs	Delivering care for the physical needs of members of the faith community [6, 16, 19, 20, 21]
	Psychological needs	Supporting emotional well-being during times of stress, depression, bereavement, suicide, burden of coping with long-term conditions, and teenage pregnancies [16, 17, 18, 19, 21]
	Congregational needs	Nursing interventions and programmes aligned to the direct needs of the congregations across the lifespan [6, 16, 17, 21]
	Professional perceptions	FCN perceptions of the role highlighted factors related to autonomy, mutual trust and respect, flexibility, education and training needs, and issues related to lack of time/funding with limited scope for service evaluation [16, 19, 20, 21]
	Patient-FCN communication needs	Holistic care relationships were built upon trust and connection, interpersonal skills, and being actively present [6, 16, 17, 19, 20, 21]
	Health system navigation/co-ordination	FCN acted as resources and conduits for care co-ordination across community and acute healthcare services [6, 16, 19, 20, 21]
	Spiritual needs	Role and mission of FCN were to integrate care dimensions of body, mind, and spirit in delivering God's health ministry [6, 16, 17, 18, 19, 20, 21]
	Family related needs	Delivering holistic care to the entire family unit including addressing the needs of family caregivers [6, 17, 19, 21]

FCN, faith community nurse.

Supplementary Table 1. PRISMA checklist

Section/topic	#	Checklist item	Reported on page #
TITLE			
Title	1	Identify the report as a systematic review, meta-analysis, or both	1
ABSTRACT			
Structured summary	2	Provide a structured summary including, as applicable: background; objectives; data sources; study eligibility criteria, participants, and interventions; study appraisal and synthesis methods; results; limitations; conclusions and implications of key findings; systematic review registration number.	2
INTRODUCTION			
Rationale	3	Describe the rationale for the review in the context of what is already known.	2-3
Objectives	4	Provide an explicit statement of questions being addressed with reference to participants, interventions, comparisons, outcomes, and study design (PICOS).	3
METHODS			
Protocol and registration	5	Indicate if a review protocol exists, if and where it can be accessed (e.g., Web address), and, if available, provide registration information including registration number.	We followed a review protocol but this was not published (available from the authors)
Eligibility criteria	6	Specify study characteristics (e.g., PICOS, length of follow-up) and report characteristics (e.g., years considered, language, publication status) used as criteria for eligibility, giving rationale.	3-4
Information sources	7	Describe all information sources (e.g., databases with dates of coverage, contact with study authors to identify additional studies) in the search and date last searched.	3
Search	8	Present full electronic search strategy for at least one database, including any limits used, such that it could be repeated.	Table 1
Study selection	9	State the process for selecting studies (i.e., screening, eligibility, included in systematic review, and, if applicable, included in the meta-analysis).	3-4
Data collection process	10	Describe method of data extraction from reports (e.g., piloted forms, independently, in duplicate) and any processes for obtaining and confirming data from investigators.	4
Data items	11	List and define all variables for which data were sought (e.g., PICOS, funding sources) and any assumptions and simplifications made.	N/A
Risk of bias in individual studies	12	Describe methods used for assessing risk of bias of individual studies (including specification of whether this was done at the study or outcome level), and how this information is to be used in any data synthesis.	4

Section/topic	#	Checklist item	Reported on page #
Summary measures	13	State the principal summary measures (e.g., risk ratio, difference in means).	5
Synthesis of results	14	Describe the methods of handling data and combining results of studies, if done, including measures of consistency (e.g., I^2) for each meta-analysis.	5
Risk of bias across studies	15	Specify any assessment of risk of bias that may affect the cumulative evidence (e.g., publication bias, selective reporting within studies).	5
Additional analyses	16	Describe methods of additional analyses (e.g., sensitivity or subgroup analyses, meta-regression), if done, indicating which were pre-specified.	5
RESULTS			
Study selection	17	Give numbers of studies screened, assessed for eligibility, and included in the review, with reasons for exclusions at each stage, ideally with a flow diagram.	5, Figure 1
Study characteristics	18	For each study, present characteristics for which data were extracted (e.g., study size, PICOS, follow-up period) and provide the citations.	5
Risk of bias within studies	19	Present data on risk of bias of each study and, if available, any outcome level assessment (see item 12).	Table 2, 5
Results of individual studies	20	For all outcomes considered (benefits or harms), present, for each study: (a) simple summary data for each intervention group (b) effect estimates and confidence intervals, ideally with a forest plot.	Table 3, 4
Synthesis of results	21	Present results of each meta-analysis done, including confidence intervals and measures of consistency.	5-9
Risk of bias across studies	22	Present results of any assessment of risk of bias across studies (see Item 15).	Table 2
Additional analysis	23	Give results of additional analyses, if done (e.g., sensitivity or subgroup analyses, meta-regression [see Item 16]).	N/A
DISCUSSION			
Summary of evidence	24	Summarize the main findings including the strength of evidence for each main outcome; consider their relevance to key groups (e.g., healthcare providers, users, and policy makers).	10-12
Limitations	25	Discuss limitations at study and outcome level (e.g., risk of bias), and at review-level (e.g., incomplete retrieval of identified research, reporting bias).	11
Conclusions	26	Provide a general interpretation of the results in the context of other evidence, and implications for future research.	12
FUNDING			
Funding	27	Describe sources of funding for the systematic review and other support (e.g., supply of data); role of funders for the systematic review.	N/A

Supplementary Table 2. PICOS Framework

Population:	Faith community nurses
Intervention*:*	Faith community nursing model
Comparator:	Other models of care
Outcomes:	Experience and perceptions of care delivery among FCNs
Studies:	Quantitative and qualitative studies (irrespective of research design).