Canadian Journal of Nursing Research
2023, Vol. 55(1) 3–24

DOI: 10.1177/08445621211067378
journals.sagepub.com/home/cjn

What Are the Characteristics of the Parish Nursing Research Literature and How Can it Inform Parish Nurse Practice and Research in Canada? A Scoping Review

Elsie Millerd[1,2], Andrea Fisher[2,3], Jeanne M. Lambert[2], and Kathryn A. Pfaff[2,4]

Abstract

Background: Parish nursing is a specialized branch of professional nursing that promotes health and healing by integrating body, mind and spirit as a practice model. Parish nurses contribute to the Canadian nursing workforce by promoting individual and community health and acting as system navigators. Research related to parish nursing practice has not been systematically collated and evaluated.

Purpose: This review seeks to explore, critically appraise and synthesize the parish nurse (PN) research literature for its breadth and gaps, and to provide recommendations for PN practice and research.

Methods: A scoping review was conducted using Levac and colleagues' procedures and Arksey and O'Malley's enhanced framework. The CINAHL, ProQuest and PubMed databases were comprehensively searched for original research published between 2008 and 2020. The final sample includes 43 articles. The Mixed Methods Appraisal Tool was used to critically assess literature quality.

Results: There is a significant gap in PN research from Canada and non-U.S. countries. Methodological quality is varied with weak overall reporting. The literature is categorized under three thematic areas: (1) practice roles of the PN, (2) role implementation, and (3) program evaluation research. Research that evaluates health promotion program interventions is prominent.

Conclusions: More rigorous research methods and the use of reporting checklists are needed to support evidence-informed parish nursing practice. Building relationships among parish nurses, nursing researchers and universities could advance parish nursing research and improve evidence-based parish nursing practice. Research into the cost effectiveness, healthcare outcomes, and the economic value of PN practice is needed.

Keywords

Parish nursing, spirituality, faith community nursing, community health nursing, spiritual care, scoping review

Background and purpose

As Canada's population is living longer than ever and the prevalence of people with chronic diseases continues to grow, the formal care system is less able to meet the increasing health and social care needs of people and families living in the community. There is a need for health care reform and other solutions that prioritize community-focused nursing care (World Health Organization [WHO], 2017). Parish nursing (or faith community nursing, as it is known in some jurisdictions) is a specialized branch of nursing and a health ministry of faith communities that enacts health, healing, and wholeness of body, mind, and spirit as a practice model (Canadian Association for Parish Nursing Ministry [CAPNM], 2021a). Its overarching philosophy is that "all faith communities are places of health and healing and

[1]St. Peter's Seminary, London, ON, Canada
[2]CAPNM Research Committee Chair, Bishop's Mills, ON, Canada
[3]NurseOnBoard, Ottawa, ON, Canada
[4]Faculty of Nursing, University of Windsor, Windsor, ON, Canada

Corresponding author:
Jeanne M. Lambert, CAPNM Research Committee Chair, 351 County Rd. 18, Bishop's Mills, ON K0G 1T0, Canada.
Email: faithcommunitynurse316@gmail.com

have a role in promoting wholeness through the integration of faith and health" (CAPNM, 2021a, para. 1).

In Canada, all parish nurses (PNs) are registered nurses. PNs contribute to the Canadian nursing workforce, yet their impact is poorly understood. The number of Canadian nurses practicing as PNs is not known as many PNs practice in volunteer roles, the numbers of graduates from PN certification courses have not been collated, and there is no common registry for Canadian PNs. Nevertheless, PNs provide comprehensive individual and community assessments, promote and protect health, and act as system navigators for clients and families. As such, their practice positively influences individual and community health across many Canadian jurisdictions.

Brief history of parish nursing

The modern-day practice of parish nursing was founded by Granger Westberg, a hospital chaplain, professor, and pioneer who had an early vision for wholistic care across healthcare settings (Westberg Institute, 2020). In the 1960's he introduced "wholistic" health centers addressing whole-person needs: body, mind and spirit. Westberg learned that nurses helped bridge the gap in language between medicine and faith, making theirs a critical role in whole person health and health promotion. Thus, in 1984 he launched the first demonstration project of parish nursing. In 1997 parish nursing was recognized as a nursing specialty by the American Nurses Association, and in 1998 The Scope and Standards of Parish Nurse Practice was published (Westberg Institute, 2020).

Not aware of the developing movement of parish nursing in the United States, Barbara Craiger, in 1988, developed a "nurse in a church" ministry in Thornhill, Ontario, Canada (Craiger, 2006). In the 1990's, other Canadian nurses were led to this ministry first going to the United States for training and then developing education programs for parish nursing and church health ministry in Canada.

The first Canadian PN course was at the University of Alberta. It was joined by distance education courses through St. Francis Xavier University in Nova Scotia and Concordia College in Alberta. In 1996 a pilot project in health ministries in Oshawa, Ontario was the beginning of InterChurch Health Ministries (ICHM). This organization established a basic PN education program and later partnered with the Toronto School of Theology. The ICHM also spawned affiliate programs in Saskatoon and New Brunswick and held a program at Waterloo Lutheran Seminary in 2009. McMaster Divinity College and Tyndale Seminary held graduate level parish PN courses for a time. All of these courses waxed and waned based on need. In 2010 St. Peter's Seminary in London, Ontario developed the Foundations in Parish Nursing which continues today.

In the 1990s Canadian scholars began publishing their observations of the PN experience in journals and as a book chapter (Olson et al., 1999). In 1996 Lynda Miller developed a nursing conceptual model to help nurses link concepts of faith and health in practice, education, and research; this work was later published as a book (Miller, 2004). Her article in the Canadian Nurse (Martin, 1996) attracted many nurses from across the country to the ministry of parish nursing. Margaret Clark and Joanne Olson provided a description of their experience of teaching PNs using the McGill model of nursing (Clark & Olson, 2000).

In 1998, the Canadian Association for Parish Nursing Ministry (CAPNM) was inaugurated. The Core Competencies and Standards of Practice were developed and parish nursing became recognized by the national and provincial professional associations, although not as a specialty. With the core framework of the ministry established, CAPNM members turned their interest to the development of a body of knowledge for supporting evidence-based practice (EBP) in parish nursing. This interest is the impetus for this review.

Literature review

Research in parish nursing and faith community nursing is in its infancy. For consistency, we use the terms "parish nurse" (PN) and "parish nursing" throughout this review. Three reviews of the PN literature have been published in the last 17 years (Dandridge, 2014; Dyess et al., 2010; King, 2004). King (2004) published the first review of PN literature, the purpose of which was to map the nature and fit of PN work within the church. The major findings were reported in the areas of needs assessment, parish nursing care, and perceptions of parish nursing. Six years later, Dyess et al. (2010) published a review of the PN literature. Their findings highlighted new research related to the development and implementation of PN roles and practices, such as documentation. Dandridge (2014) review focused on understanding outcomes associated with PN interventions and the value of the PN in health promotion and disease prevention. The search strategy for Dandridge's review was limited to studies conducted in the United States. The aforementioned reviews (Dandridge, 2014; Dyess et al., 2010; King, 2004) lack clear reporting of search strategies, a systematic process for inclusion and exclusion of studies, and critical appraisal. To advance PN practice and research, there is a need to rigorously evaluate PN interventions and their outcomes (Dandridge, 2014: Dyess et al., 2010). Therefore, the purpose of this scoping review is to explore, critically appraise, and synthesize the PN research literature for its breadth and gaps, and to suggest recommendations for PN practice and research. In this review, we answer the following research question: *What are the characteristics of the parish nursing research literature (type, quality, foci) and how can it inform PN practice and research in Canada?*

Methods

We selected a scoping review methodology because of the nature of our research question, its rigor in synthesizing a variety of research, and usefulness in informing practice and future research (Colquhoun et al., 2014; Noble & Smith, 2018). We applied Levac and colleagues' scoping review procedure that includes Arksey and O'Malley's enhanced framework (Arksey & O'Malley, 2005; Colquhoun et al., 2014) for supporting procedural consistency (Arksey & O'Malley, 2005).

Identifying relevant studies

In consultation with a librarian, we conducted an iterative search strategy of the Cumulative Index to Nursing and Allied Health Literature (CINAHL), ProQuest and PubMed databases. To update the most recent reviews (Dandridge, 2014; Dyess et al., 2010) we searched articles published between January, 2008 and June, 2020. We also reviewed the reference lists of various articles for relevant studies that were retrieved and added to our database. Refer to Table 1 for the search terms.

Study selection

To avoid overlooking potentially relevant articles, the eligibility criteria were broad. Original research articles and published and unpublished theses and dissertations written in English were eligible and included in the review. Literature reviews, editorials, commentaries, case reports, and articles that did not directly focus on PN practice were excluded. A three-phased review process was completed that involved title and abstract screening, full manuscript review, abstraction, and critical appraisal by two independent reviewers. The Mixed Methods Assessment Tool (MMAT), 2008 version was selected for its ability to appraise the methodological quality of qualitative, quantitative, and mixed methods studies (Hong et al., 2018). The appraisal criteria are unique to each type of study. The MMAT criteria and detailed explanations for their application are publicly available. Appraisal was conducted by five team members (EM, AF, JL, KP, CG). Two reviewers reviewed each study answering five appraisal questions specific to each study type (Hong et al., 2018) and by applying three possible responses: *"yes," "no,"* or *"can't tell."* A third reviewer was engaged to confirm/disconfirm the discrepancies.

Prior to in-depth appraisal, all studies were assessed against two screening questions: (1) *Are there clear research questions (or objectives)?* and (2) *Do the collected data allow to [sic] address the research questions?* (Hong et al., 2018). We appraised the first screening question as *"yes"* if the research question/objective was not explicitly stated but could be clearly inferred from the purpose statement or aim. Nine studies were excluded because their research question/purpose could not be inferred and/or we assessed the researchers' data collection methods as not addressing the research/purpose. After completion of the review process, a total of 43 studies were included. The study selection process is depicted in Figure 1.

Table 1. Literature Search.

Database	
ProQuest	
I	parish AND nurs*
II	"faith community" AND nurs*
III	MeSH.Exact("Parish Nursing")
IV	I OR II OR III
Date range	From 2008/1/1 to 2020/6/30
Limits	Scholarly journals; dissertations & theses English
CINAHL Complete	
I	Parish AND nurs*
II	"faith community" AND nurs*
III	I OR II
Limits	From 2008/1/1 to 2020/6/30 English
PubMed	
I	(("Parish Nursing"[MeSH]) OR (parish nurs*)) OR (faith community nurs*)
Limits	From 2008/1/1 to 2020/6/30 English

Data charting and sorting

Seven team members (EM, AF, JL, KP, CG, RT, CM) were involved in charting the literature characteristics and MMAT results to an Excel database and four (EM, AF, JL, KP) in data sorting/analysis. We began the analysis by iteratively reviewing the database to form individual insights about the nature of the literature sample. Strategies involved concept mapping and listing potential major and minor categories based on coding the literature table for details such as study design, findings, and reviewer insights. Information was inputted into a document to track the alignment of the studies with emerging themes/categories. Our team met 16 times to share insights and agree upon the final thematic areas and sub-categories. All decisions were documented.

Results

Overall characteristics of the literature sample

Forty-one of the 43 studies (95.3%) were conducted and published in the United States. Only one study emerged from Canada (Millerd, 2010) and another from the United Kingdom (Wordsworth, 2015). The majority of parish nursing research is published in peer-reviewed journals ($n = 38$), with one unpublished Master's thesis (Millerd,

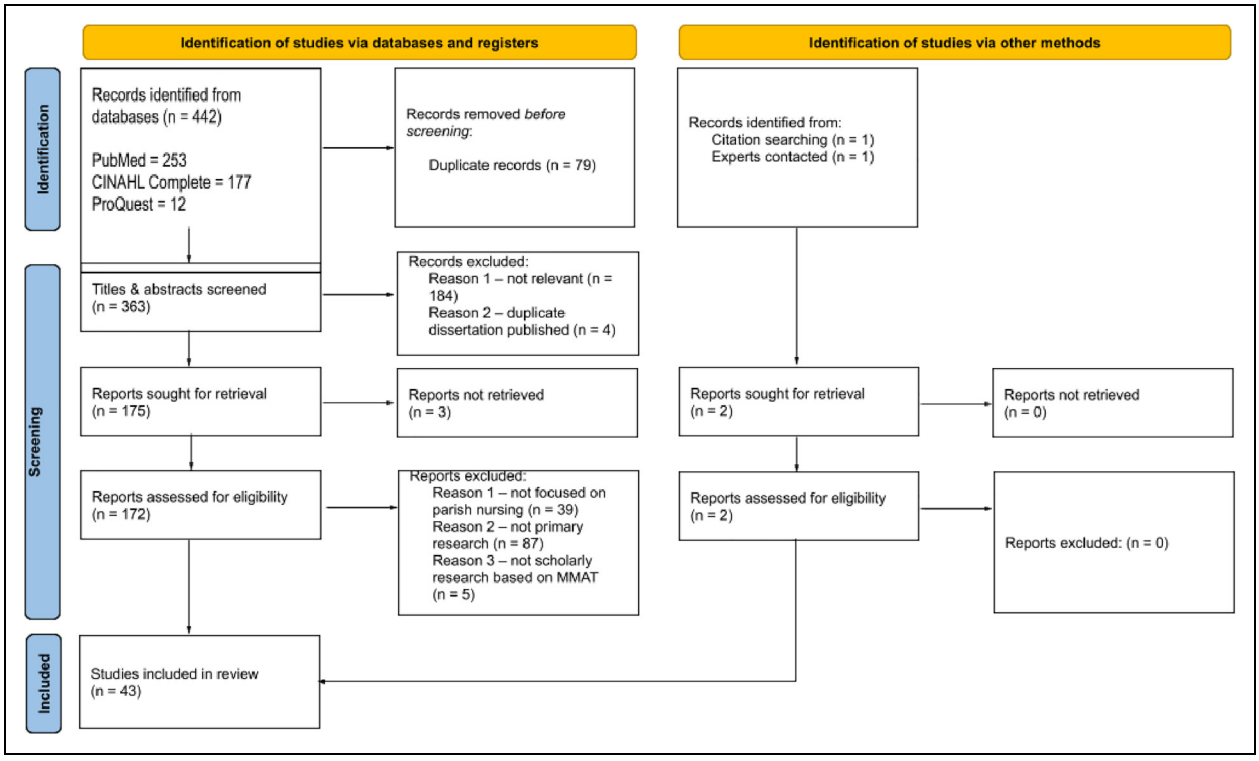

Figure 1. PRISMA flow diagram.

2010), four doctoral dissertations (Bagley, 2011; Dyess, 2008; Tormoehlen, 2009; Ziebarth, 2016b), and one book (Wordsworth, 2015). Over half of the sample ($n = 24$; 55.8%) is published in the Journal of Christian Nursing ($n = 15$) and the International Journal of Faith Community Nursing ($n = 9$). Just over half (51.2%; $n = 22$) of the literature sample reflects quantitative research, with the majority in this category being descriptive ($n = 16$), and the remainder non-randomized ($n = 5$) and randomized controlled ($n = 3$) studies. Qualitative studies make up one-third of our literature sample ($n = 14$; 32.6%). Among the 14, two are grounded theory (Dyess & Chase, 2012; Van Dover & Pfeiffer, 2011) and two phenomenology (Dyess, 2008; Millerd, 2010). The remainder ($n = 10$) report using non-categorical qualitative methods. Finally, seven studies reflect mixed methods research designs (Bagley, 2011; Devido et al., 2017; Dyess et al., 2017; Newcomb et al., 2014; Rydholm et al., 2008; Wordsworth, 2015; Ziebarth, 2016b). Refer to Table 2 for an overview of the literature characteristics.

Quality of the literature sample. There is a wide variation in quality across all types of the documents. In this section, we briefly summarize the quality of the literature sample based on the results of the MMAT appraisal scores. Refer to Table 3 for a summary of scores and Table 4 for detailed quality appraisal scoring by study type.

Qualitative studies. For the most part, all 14 qualitative studies meet the quality criteria for appropriateness of the methods and reporting of the data collection methods and sources (Devido et al., 2018; Dyess, 2008; Dyess & Chase, 2012; Grebeldinger & Buckley, 2016; Kazmer et al., 2017; King, 2011; Millerd, 2010; Mock, 2017; Newbanks & Rieg, 2011; Sheehan et al., 2013; Shores, 2014; Van Dover & Pfeiffer, 2011; Young, 2015; Ziebarth & Miller, 2010). According to MMAT criteria, there is insufficient evidence to confirm that the findings are adequately derived from the data in six of the 14 studies; we appraised this criterion as *"can't tell"* in five articles (Grebeldinger & Buckley, 2016; King, 2011; Mock, 2017; Sheehan et al., 2013; Young, 2015) and *"no"* in one study (Newbanks & Rieg, 2011). Our scoring is based on absent or weak reporting of data analytic procedures with rationale. There is insufficient information to determine coherence between data sources, collection, analysis, and interpretation in four studies (King, 2011; Newbanks & Rieg, 2011; Sheehan et al., 2013; Young, 2015).

Quantitative randomized controlled trials. There are three studies in this study type (Baig et al., 2010; Gotwals, 2018; Mendelson et al., 2008), and reporting is weak for all studies. We are unable to assess whether there were complete outcome data reported in all three studies. We are also unable to determine if outcome assessors were blinded to the intervention (Gotwals, 2018; Mendelson et al., 2008). We

Table 2. Literature Characteristics.

Author (Year)	Aim	Design	Sample	Data Collection	Relevant Findings
Austin et al. (2013)	To evaluate outcomes of Healthy Living classes delivered by FCNs to prevent and manage Type 2 diabetes.	Quantitative Pre-post evaluation	149 participants from 6 churches in New York State	Self-report data collected pre-post classes instruments: • Summary of Diabetes Self- Care Activities Measure - Short Form • Health Empowerment Scale BMI and BP at baseline, four weeks and monthly	Improved scores in awareness of self-care, motivation for health and coping strategies for stress.
Bagley (2011)	To understand PN perceptions of the barriers and opportunities to implementing PN programs in Alaskan faith communities.	Exploratory mixed methods design	Phase 1: 5 PNs who graduated from basic PN courses Phase 2: 20 PNs	Phase 1: Individual interviews for survey development Phase 2: Survey	Opportunities: enhanced outcome-focused course materials; recruitment of PNs; structured PN coordinator support. Barriers: Time constraints for volunteer PNs.
Baig et al. (2010)	To measure the effect of FCN referrals versus telephone assisted physician appointments on BP control among persons with elevated BP at health fairs.	Randomized community based intervention trial	100 multi-ethnic participants; 50 participants in each trial arm	Pre and post measures: BP change; medication intensification / adherence; hypertension knowledge and self-care	Greater drop in BP with telephone-assisted physician appointments than FCN referrals; rates of medication intensification and adherence were similar across both groups.
Bokinskie and Kloster (2008)	To identify the factors that contribute to a successful PN ministry and barriers to practice.	Exploratory descriptive survey development	Total of 1329 RN alumni of the Concordia College Parish Nurse Center	Self-report surveys completed in three phases in 2003, 2004 and 2005	Facilitators: clergy and congregational support most highly ranked Barriers: Time/scheduling constraints and lack of funding most highly ranked.
Cooper and Zimmerman (2016)	To evaluate the effectiveness of blood pressure control program delivered by an FCN network in Maryland.	Quantitative pre-post evaluation	58 participants engaged in BP self-monitoring and coaching for lifestyle changes.	Secondary data from quarterly reports: BP; education received; BP monitor provision. Self-report instrument: • Model for Healthy Blood Pressure Self-Rating Scale	Improvement in 6 out of 7 lifestyle areas on the self-rating scale; improved systolic and/or diastolic BP for 42 participants (82%) over 3 months.
Cooper and Zimmerman (2017)	To determine the effect of a PN teaching, coaching and self-monitoring intervention on BP and lifestyle changes on an at-risk, hypertensive population.	Quantitative pre-post intervention	58 participants (2014 cohort); 61 participants (2015 cohort)	Baseline BP by PNs followed by participant weekly monitoring Self-report instrument: • Model for Healthy Blood Pressure Self-Rating Scale	Improved participant satisfaction with BP monitoring, healthy activity, healthy weight, managing medications, healthy eating and managing stress.
Devido et al. (2017)	To explore the role and experiences of the PN in providing diabetes education and preconception counseling to women with diabetes.	Mixed methods: concurrent embedded	48 parish nurses recruited from the Parish Nurse and Health Ministry Program database in Western Pennsylvania	Virtual focus group Self-report instruments: • Preconception Counseling Knowledge for Certified Diabetes Educators	Themes: awareness, experience, formal training, usefulness, willingness, confidence, "wise women." PN knowledge was low at

(continued)

Table 2. Continued.

Author (Year)	Aim	Design	Sample	Data Collection	Relevant Findings
				• Preconception Counseling Self-Efficacy for Certified Diabetes Educators	baseline; self-efficacy positively associated with knowledge.
Devido et al. (2018)	To explore the personal experiences, challenges, and practices of PNs in their communities	Qualitative descriptive	48 PNs recruited from 2017 study	11 focus groups	4 themes: gaining entry through trust; enhanced focus on spiritual caring; accomplishing much despite challenges; practice making a difference.
Dyess (2008)	To explore the experience of adults actively affiliated with a faith community who are living with one or more chronic illnesses and who have access to a PN.	Phenomenology	Purposive 8 participants (4 men, 4 women) with at least one chronic illness	Semi- structured interviews 1 dyadic interview Observation and field notes	Essential theme: living in abundance Sub-themes: living faith; living caring.
Dyess and Chase (2012)	To investigate the process of FCN practice to identify a theoretical foundation for developing new research models.	Grounded theory	3 part-time FCNs from 3 denominations southeast United States	FCNs provided written nursing situation stories from their practice	4 processes: entering the private world; connecting to faith; mutually transforming experience; sustaining health.
Dyess et al. (2017)	To explore and describe documentation practices for FCNs and identify perceived barriers to documentation.	Exploratory descriptive mixed methods	Phase one: 153 FCNs recruited within two targeted conferences and FCN list serves in the U.S. Phase two: 28 FCNs	Phase one: Paper/online researcher developed survey: demographics documentation practice information. Phase two: 3 focus groups 3 key informant interviews	Quantitative: Documentation frequencies and approaches varied. Qualitative: FCNs recognize professional mandate for documentation but lack clarity and infrastructure. FCNs attempt to capture the fullness of specialty encounters but lack supportive infrastructure and interprofessional communication.
Gotwals (2018)	To examine FCNs self-efficacy perceptions following a nutritional educational intervention.	Experimental correlational	92 actively practicing FCNs (55 experimental group; 37 control group)	Pre-post self-report Instrument: • Health Promotion Self-Efficacy Counseling Scale	Statistically significant increase in post-test scores on nutrition knowledge self-efficacy and total knowledge self-efficacy as compared to pre-test scores for experimental group only.
Grebeldinger and Buckley (2016)	To examine family caregiver burdens and stressors, sources of social support, and perceptions of support provided by parish nurses.	Qualitative descriptive	15 family caregivers	Individual semi-structured interviews	Family caregiver stressors: difficulty in transition; lifestyle adjustments; communicating with HCPs; finding community resources Support provided by PNs: the gift of presence; bearer of blessings; messenger of spiritual care; bridging challenges.

(continued)

Table 2. Continued.

Author (Year)	Aim	Design	Sample	Data Collection	Relevant Findings
Hixson and Loeb (2018)	To examine FCNs' most frequently documented interventions and health services for older adults.	Quantitative descriptive	13,715 care recipients across 5 networks made up of 169 faith communities in Illinois, Michigan, Nebraska, and Indiana	Deidentified quantitative data and summary data reports from the Henry Ford Macomb Hospital Faith Community Nursing/ Health Ministries Documentation and Reporting System	Most frequent group activities were educational with nutrition education most frequently attended. Others were exercise/ support groups and blood pressure screening. Active listening was the most frequently occurring intervention along with presence, prayer and touch.
Kazmer et al. (2017)	To elicit caregivers' and FCNs' perceptions of a FCN-led cognitive, behaviora,l and spiritual counseling (CBSC) intervention for dementia caregivers.	Qualitative descriptive	7 FCNs and 7 dementia family caregivers	Semi-structured telephone interviews conducted 4 times over 6 months = 56 interviews	Themes: caregivers' perception of burden and experiences with care partners; formation of the therapeutic alliance between FCNs and caregivers; CBSC tools, skills and resources; role of spirituality in caregivers' relationships with their care partners; changes in the FCNs' expectations of the spiritual counseling process; impact of FCNs' prior professional experience; time as a resource for FCNs and caregivers.
King (2011)	To explore reasons clients choose the PN for health care services.	Qualitative descriptive	17 clients using the services of 3 PNs in Christian faith communities	Face-to-face interviews using a semi- structured interview guide	Reasons for health care use: education, personal counseling, health screening, referrals, spiritual support, health advocacy.
King and Pappas-Rogich (2011)	To ascertain if FCN model supports implementation strategies to address Healthy People 2010 standards and FCN functions and standards.	Quantitative exploratory descriptive survey	102 FCNs from 30 states and 15 faith denominations	Researcher developed instrument: • The FCN Questionnaire developed from the Healthy People 2010 Critical Health Indicators, International PN Resource Center & American Nurses' Association Scope and Standards for FCNs	High frequency functions: integrating faith and health by working to improve body, mind and spirit; offering health counseling; promoting health education. High frequency Healthy 2010 Health Indicators: promoting daily physical activity; promoting emotional health and well-being through education and counseling; promoting good nutrition and healthier weight.
	To learn about the health	Quantitative			PN clients ± 40 years Practice

(continued)

Table 2. Continued.

Author (Year)	Aim	Design	Sample	Data Collection	Relevant Findings
King and Tessaro (2009)	promotion activities conducted by PNs and health issues of interest to parishioners.	descriptive survey	75 PNs from Pennsylvania and Maryland	Mailed survey with 33 questions that assessed PN role	focused on health promotion: BP screening; health counseling and education; spiritual health counseling. PN perceived parishioner needs: exercise; nutrition; stress; weight control; diabetes and cancer screening.
Mattingly and Main (2015)	To identify FCN documentation practices, explore factors impacting intention to adopt Electronic Health Records (EHR), and identify barriers and benefits to EHR use.	Quantitative cross-sectional exploratory survey	114 FCNs in the midwest United States	39-item researcher developed questionnaire administered by mail and e-mail with reminders at 2 and 4 weeks: • Measurement of Perceptual Impact on FCN Technology Adoption	Majority (47%) reported using paper documentation, 23% used electronic documentation and 32% reported not documenting their FCN practice. Financial barriers: cost of EHR; cost of laptop/tablets. Benefits: data access, communication, coordination.
McCabe and Somers (2009)	To learn how PN programs meet the needs of seniors.	Quantitative cross-sectional survey	38 PNs Phoenix, Arizona	Mailed survey developed by the Nurse and Health Ministries Network agency	Top ranked seniors' needs were social support and prescription drug coverage; PN characteristics were interpersonal skills and spiritual maturity; and PN primary functions were personal health counselor and health educator. Barriers were seniors' denial of healthcare problems and PN time constraints.
McGinnis and Zoske (2008)	To examine the characteristics and practice patterns of a large group of FCNs.	Quantitative descriptive cross-sectional survey	517 FCNs from mailing lists of FCN coordinators in 20 states in the United States and the District of Columbia	Novel survey developed by 8 members of the Ascension Health FCN Leadership Network. Paper surveys sent to FCNs on mailing lists or handed out by FCN coordinators	67% older than 54 years; age of entry to FCN practice between 55 and 64; 87% served in volunteer FCN roles; 54% worked in another nursing role. Most common health issues for congregations: chronic disease, nutrition and obesity, caregiving and end-of-life.
Medley et al. (2018)	To examine barriers to colorectal cancer (CRC) screenings in a faith-based population and to	Quantitative Pre-post evaluation	161 parishioners in 4 faith-based communities	Self-report collected pre-post educational session. Instrument:	Post-test results showed: statistically significant increase in knowledge of CRC screening, sigmoidoscopy

(continued)

Table 2. Continued.

Author (Year)	Aim	Design	Sample	Data Collection	Relevant Findings
	determine if an educational session is successful in reducing barriers.		in a mid-southern state in the United States	• Colon Cancer Screening Survey; 8 items assess knowledge and attitudes towards screening.	and fecal occult blood tests; decrease in barriers (pain, messiness, inconvenience) and increased intent to be screened.
Mendelson et al. (2008)	To examine the effects of PN Intervention Program (PNIP) on maternal health behaviors, glycemic control and neonatal outcomes.	Randomized controlled trial; two group design	100 Mexican American women with gestational diabetes Usual care ($n = 51$) PNIP group ($n = 49$)	Medical records abstracted for glycemic control, newborn weight, maternal and newborn hospitalized days Instruments: • Health Promoting Lifestyle Profile II (HPLP II) completed on intake and 3 weeks post-intervention • 16-item acculturation scale at intake	Statistically significant improvement in HPLP II scores among PNIP group. No significant differences between two groups on glycemic control, maternal and newborn hospitalized days.
Millerd (2010)	To explore the spiritual experience of PNs.	Phenomenology	8 PNs from various urban and suburban settings, denominations, church sizes	Individual semi-structured interviews	5 themes: connectedness; centrality in one's being; empowering action; presence in solitude and quiet; feelings of peace.
Mock (2017)	To describe an FCN program and the value, meaning and importance of the FCN in one congregation.	Qualitative descriptive	10 participants (3 FCNs and 7 of their clients) Presbyterian church in a large Midwestern city United States	Individual semi-structured interviews, face-to-face and telephone, 25 min to 2 h in length	5 themes: tasks and services, nursing expertize, spirituality, familiarity, community support.
Monay et al. (2010)	To describe the services FCNs provide to a community sample of patients with hypertension.	Quantitative descriptive	100 health fair participants and 10 FCNs from 11 churches	Secondary data Measures included: • Demographics • Nurse visits • Nurse services	Majority of participants were female, Latino and diagnosed with hypertension. Each patient visited the nurse an average of 3.3 times. Most frequent FCN services: BP measurement, education on diet and exercise and supportive counseling.
Newbanks and Rieg (2011)	To assess whether PNs perceive if the PN education they received prepared them to incorporate spiritual dimension into their practice.	Qualitative descriptive	15 PNs who had been practising 1-5 years	Telephone interviews	All participants believed that the spiritual dimension is very important in health care. There were variations in PN perceptions regarding the degree to which programs prepared them for spiritual practice.

(continued)

Table 2. Continued.

Author (Year)	Aim	Design	Sample	Data Collection	Relevant Findings
Newcomb et al. (2014)	Describe the feasibility and outcomes of introducing small groups to the My Family Health Portrait tool in faith-based communities using FCNs.	Mixed methods	33 participants from four churches in north Texas, United States FCN education intervention group ($n = 10$); Information sheet only control group ($n = 23$)	Quantitative data: Post-test measure at three months • The Family Health History Survey Qualitative data: researcher field notes and observations of FCN teaching sessions	Majority of participants believed health history is important; intervention group was significantly more likely to claim they had documented family history; some distrust in storing family health information electronically; questionable feasibility of intervention delivery to faith-based communities by FCNs.
Pappas-Rogich and King (2014)	To identify how often FCNs use the 7 classic functions and Faith Community Nursing Scope and Standards of Practice and how often FCNs implement Healthy People 2010 Health Indicators in their practice.	Quantitative descriptive	247 FCNs across 38 U.S. states and Canada ($n = 2$); 27 faith denominations	Instrument: • Parish Nurse Questionnaire	Top cited weekly FCN functions: health counseling, integrating faith and health. Top cited Healthy People 2020 health indicators addressed weekly by FCNs was promotion of physical activity; 43 different types of community partnerships reported with hospitals most reported.
Reilly et al. (2011)	To determine the practicality and effectiveness of a toolkit in changing attitudes and behaviors about infection control and emergency preparedness.	Mixed methods	Representatives from 28 faith communities (clergy, PNs, administrative assistants and others)	Survey data collected after toolkit presentation sessions. Quantitative measure: • Infection Control and Emergency Preparedness for Faith Communities Survey Qualitative: Written comments solicited at end of survey	Quantitative: statistically significant increases in the numbers of resources and practices that faith communities planned to prevent the spread of infection. Qualitative themes: acknowledgment of quality resources for faith communities; recognition of the skilled presentation of the toolkit materials; gratitude for the information and time saved for the faith community; increased awareness of infection control issues in faith communities.
Rydholm et al. (2008)	To discern the nature and impact of FCN interventions on community-dwelling older adults.	Mixed methods	75 FCNs in Minnesota and surrounding municipalities	Participants submitted diary tools of elder care experiences that were quantified for analysis and analyzed qualitatively. Diary tool domains: • symptoms warranting	Psychosocial spiritual concerns were the dominant FCN focus with worry being most recurrent. Predominant intervention was anticipatory guidance. Most prevalent signs and symptoms where concern was averted were

(continued)

Table 2. Continued.

Author (Year)	Aim	Design	Sample	Data Collection	Relevant Findings
				immediate intervention and barriers to access • self-care, lifestyle modification, chronic illness • functional concerns • psychosocial and spiritual concerns	falls (syncope) and stroke. Qualitative findings suggested FCN interventions linked to early interventions, risk reduction and cost savings.
Sheehan et al. (2013)	To report the impact on FCNs from participating in the Defy Diabetes! and teaching Healthy Living classes.	Qualitative	5 FCNs and 1 community health worker	1.5-h focus group with open-ended questions	2 themes: observations of the congregants' lifestyle changes; personal benefits to the FCNs.
Shillam et al. (2013)	To describe role of FCN and medication practices among older adults who participated in Brown Bag Medication Review (BBMR) events provided by pharmacists and FCNs.	Quantitative Pre-post evaluation	67 participants enrolled; 49 participants completed surveys at 3 months Portland, Oregon	Investigator developed 12-question survey: demographics, number of times visiting urgent and/or emergency care, primary care physician, talked with a pharmacist or FCN re medication concerns, and general experiences with taking medications	Statistically significant decrease in the number of medications taken following BBMR and FCN follow-up at 3 weeks; 32% reported changing medication behaviors based on FCN instruction at 3 weeks.
Shores (2014)	To identify nursing interventions FCNs use in specialized practice and to examine the spiritual impact of a FCN program.	Qualitative	35 faith community members, 6 clergy, 11 FCNs	Mailed questionnaire with 6 open-ended questions that asked participants to describe the impact of the FCN program impact, especially on various areas of a person's life.	Spiritual care interventions included: active listening; coping enhancement; dying care; forgiveness facilitation; grief work facilitation; hope inspiration; humor; presence; religious ritual enhancement; self-awareness enhancement; self-esteem enhancement; spiritual growth facilitation; spiritual support; touch.
Solari-Twadell and Hackbarth (2010)	To generate a comprehensive national data set describing parish nursing and the role of PNs in promoting health; to assess what PNs believe is the essence of their practice and a unique nursing specialty.	Quantitative cross-sectional survey	1161 FCNs representing all major religious denominations and 47 states.	Mailed survey Instruments: • Researcher developed items that assess PN and parish demographics • Nursing Intervention Classification Survey	Of the 486 possible nursing interventions listed in the survey, PNs reported using 417, with the majority in the behavioral domain. The second most prominent domain involved interventions that supported effective use of the

(continued)

Table 2. Continued.

Author (Year)	Aim	Design	Sample	Data Collection	Relevant Findings
					health care system. Third most common domain involved supportive family care.
Thompson (2010)	To pilot test an instrument to measure knowledge, attitudes about faith community nursing.	Quantitative survey	34 clergy from suburban, urban and rural parishes of the United Church of Christ	Novel instrument: • The Knowledge, Attitudes and Opinions Concerning Faith Community Nursing Survey	Clergy had overall good knowledge and positive attitudes about FCNs; there was uncertainty / disagreement about spiritual counseling as a nursing intervention.
Tormoehlen (2009)	To examine the learning needs of novice PNs who had completed a basic PN preparation course and were on the threshold of establishing a PN ministry.	Quantitative survey	32 PNs reflecting various religious denominations	Online questionnaire developed by the researcher	PN skills of highest importance in rank order: confidentiality, praying, working with volunteers, spiritual caregiving, health activities, making an assessment, documentation, utilizing resources, functioning in an organization, making a budget.
Van Dover and Pfeiffer (2011)	To examine the process that patients of PNs experience when they are provided spiritual care in Christian churches.	Grounded theory	20 participants (6 men and 14 women) who were patients of PNs in the Midwest and Southwest United States	Two rounds of individual interviews	The process involves 4 sequential phases: Finding a safe place; releasing burdens; changing perspectives; joining or rejoining the family of faith.
Wordsworth (2015)	To discover how parish nursing makes a difference to the mission of an English church.	Mixed methods	15 ministers of churches in England with PNs 77 ministers of churches without PNs	Semi-structured face-to-face and telephone interviews with ministers of churches with PNs Secondary data from a PN statistical survey database Instruments: • Researcher developed questionnaires for: (1) ministers whose churches had PNs, and: (2) churches without PNs	Evidence of increased wholistic care (physical, mental, community and spiritual) and integrated care plans for members in churches with PNs; churches with PNs had twice as much volunteer coordination and support.
Young (2015)	To deconstruct and critically examine the factors that shape the work of Christian nurses in urban congregations.	Qualitative Contextual interview approach	23 PNs from 22 congregations	Face-to-face individual interviews	Tasks included health screenings, education, referring to community resources, coordinating health fairs. Emergent themes: ministry, relationships, advocacy and visibility.

(continued)

Table 2. Continued.

Author (Year)	Aim	Design	Sample	Data Collection	Relevant Findings
Ziebarth (2016b)	To describe transitional care as implemented by FCNs using a standardized nursing language: Nursing Intervention Classification (NIC).	Mixed methods	3 FCNs who work with a faith community in providing transitional care.	Quantitative: Secondary data from documentation records of 73 unique visits over a 3-month period Qualitative: 22 written nursing notes Focus group with 3 FCNs	26 frequently used NICs identified and validated by PNs. Majority were in the behavioral domain (coping assistance, communication enhancement, patient education).
Ziebarth (2018)	To explore FCN termination	Quantitative cross-sectional national survey	87 FCNs who experienced termination	On-line researcher developed survey	Top 3 reasons for termination: leadership change (29.11%); not a strategic priority to leadership (26.58%); organizational restructuring (25.32%). Among those terminated, 46.58% were in paid positions.
Ziebarth and Miller (2010)	To describe the perceptions of the educational experiences of PNs.	Qualitative descriptive	8 PNs who were within 2 years of completing their PN training courses; represented six regions of Wisconsin	Face-to-face semi-structured interviews	Numerous challenges to learning and transition. Recommendations for supplemental interventions included enhanced role modeling, mentoring, education related to integration of spirituality and health, communication and disease-specific topics.

rated participant adherence to the intervention as *"can't tell"* in two studies (Gotwals, 2018; Mendelson et al., 2008) and *"no"* in one study (Baig et al., 2010).

Quantitative non-randomized studies. We retrieved five studies of this study type (Austin et al., 2013; Cooper & Zimmerman, 2016, 2017; Medley et al., 2018; Shillam et al., 2013). Our appraisal points to limitations related to confounding bias in all five studies. There are also limitations in reporting of measures (Austin et al., 2013; Cooper & Zimmerman, 2016, 2017; Shillam et al., 2013) and sample representativeness (Cooper & Zimmerman, 2016, 2017; Medley et al., 2018; Shillam et al., 2013). We are unable to determine if the intervention was administered as intended or whether there were unplanned co-exposures in three studies (Austin et al., 2013; Cooper & Zimmerman, 2017; Medley et al., 2018).

Quantitative descriptive studies. We retrieved 14 quantitative descriptive studies. The sample is not representative of the target population in four studies (McCabe & Somers, 2009; Monay et al., 2010; Thompson, 2010; Tormoehlen, 2009) and insufficiently reported to determine sample representativeness in two studies (King & Tessaro, 2009; Ziebarth, 2018). Measures are insufficiently described to determine appropriateness in 11 studies (Bokinskie & Kloster, 2008; King & Pappas-Rogich, 2011; King & Tessaro, 2009; McCabe & Somers, 2009; McGinnis & Zoske, 2008; Monay et al., 2010; Pappas-Rogich & King, 2014; Reilly et al., 2011; Thompson, 2010; Tormoehlen, 2009; Ziebarth, 2018). Non-response bias is not low in six studies (McCabe & Somers, 2009; McGinnis & Zoske, 2008; Monay et al., 2010; Thompson, 2010; Tormoehlen, 2009; Ziebarth, 2018) and indeterminate in four studies (Bokinskie & Kloster, 2008; Hixson & Loeb, 2018; King & Pappas-Rogich, 2011; King & Tessaro, 2009).

Mixed methods studies. There is variation in quality across the seven studies of this type (Bagley, 2011; Devido et al., 2017; Dyess et al., 2017; Newcomb et al., 2014; Rydholm et al., 2008; Wordsworth, 2015; Ziebarth, 2016b). Reasons for using a mixed methods design is not reported in three studies (Dyess et al., 2017; Newcomb et al., 2014; Rydholm et al., 2008). The quantitative and qualitative components are not effectively integrated and adequately interpreted in two studies (Newcomb et al., 2014; Ziebarth, 2016b) and we are unable to determine whether divergence/inconsistencies in the components are adequately addressed in these same studies.

Literature sample themes

The literature is categorized under the following three broad thematic areas: (1) practice roles of the PN, (2) role implementation, and (3) program evaluation research.

Practice roles of Parish nurses. Much of the literature (32 studies) reports the roles of PNs. To provide context to a Canadian audience, we mapped the literature to the roles identified in the CAPNM Standards of Practice (CAPNM, 2021b).

Professional practice and accountability. Three studies focus on professional practice and accountability with two studies reporting documentation practices of PNs (Dyess et al., 2017; Mattingly & Main, 2015) and one reporting the core practices of nurses that define parish nursing as a specialty (Solari-Twadell & Hackbarth, 2010).

Wholistic nursing care. Ten of 43 articles (23.3%) address the role of PNs in providing wholistic nursing care (Dyess, 2008; Dyess & Chase, 2012; Grebeldinger & Buckley, 2016; Hixson & Loeb, 2018; King, 2011; McCabe & Somers, 2009; Rydholm et al., 2008; Sheehan et al., 2013; Solari-Twadell & Hackbarth, 2010; Wordsworth, 2015). Wholistic PN practice involves physical, psychological, emotional, and spiritual support (Grebeldinger & Buckley, 2016; Sheehan et al., 2013; Solari-Twadell & Hackbarth, 2010; Wordsworth, 2015). It is reported to be a primary PN role (King, 2011; McCabe & Somers, 2009; Rydholm et al., 2008) that supports how clients derive personal meaning from life situations and in relationships with self, God, and others (Dyess, 2008; Dyess & Chase, 2012; Hixson & Loeb, 2018; McCabe & Somers, 2009)

Health promotion. Thirteen studies (30.2%) describe the PN role of promoting health (Austin et al., 2013; Cooper & Zimmerman, 2016, 2017; Dyess, 2008; Gotwals, 2018; King, 2011; King & Tessaro, 2009; McGinnis & Zoske, 2008; Monay et al., 2010; Newcomb et al., 2014; Sheehan et al., 2013; Young, 2015; Ziebarth, 2016b). Health promotion activities include conducting family histories (Newcomb et al., 2014), health screening, monitoring, teaching (Ziebarth, 2016b), coaching (Austin et al., 2013; Cooper & Zimmerman, 2016, 2017; King, 2011; King & Tessaro, 2009; McGinnis & Zoske, 2008; Monay et al., 2010; Young, 2015), and developing/implementing health promotion programs (McGinnis & Zoske, 2008).

Facilitation of spiritual care. Spiritual care activities of PNs are described in 13 of the 43 studies (Dyess & Chase, 2012; Grebeldinger & Buckley, 2016; Hixson & Loeb, 2018; Kazmer et al., 2017; King, 2011; McCabe & Somers, 2009; Millerd, 2010; Mock, 2017; Newbanks & Rieg, 2011; Shores, 2014; Solari-Twadell & Hackbarth, 2010; Van Dover & Pfeiffer, 2011; Ziebarth, 2016b). Two grounded theory studies explore the meaning of PN spiritual care practices (Dyess & Chase, 2012; Van Dover & Pfeiffer, 2011). PNs affirm that spiritual care is very important (Newbanks & Rieg, 2011), and interpersonal skills and spiritual maturity are viewed as necessary PN characteristics

(McCabe & Somers, 2009). PNs engage in spiritual care practices among members of their faith communities (Hixson & Loeb, 2018; King, 2011; Mock, 2017), and spiritual support is a frequently documented PN intervention (Solari-Twadell & Hackbarth, 2010; Ziebarth, 2016b). Spiritual support is facilitated by being fully present (Dyess & Chase, 2012; Grebeldinger & Buckley, 2016), active listening, prayer, instilling hope, providing touch, comfort, care, compassion, and kindness (Shores, 2014), and by providing a safe place to release burdens and change perspectives (Van Dover & Pfeiffer, 2011). PNs may experience spirituality as connectedness, centrality in one's being, empowering action, presence in solitude and quiet, and feelings of peace (Millerd, 2010).

Communication and collaboration. Communication and collaboration are described in 12 studies (Kazmer et al., 2017; King, 2011; King & Pappas-Rogich, 2011; McCabe & Somers, 2009; McGinnis & Zoske, 2008; Monay et al., 2010; Rydholm et al., 2008; Shillam et al., 2013; Shores, 2014; Solari-Twadell & Hackbarth, 2010; Young, 2015; Ziebarth, 2018). Communication is enacted through health education, active listening and presence (Solari-Twadell & Hackbarth, 2010; Ziebarth, 2016b), and referrals to community resources (McGinnis & Zoske, 2008; Young, 2015). PNs engage in interprofessional care (Rydholm et al., 2008; Shillam et al., 2013), such as with pharmacists to promote medication safety for older adults (Shillam et al., 2013).

Advocacy and ethics. Only four studies specifically address advocacy in PN practice (Dyess, 2008; King, 2011; King & Pappas-Rogich, 2011; Young, 2015). Advocacy is described as a supportive intervention for chronic illnesses management (Dyess, 2008), health promotion (King & Pappas-Rogich, 2011), and healthcare system navigation (Young, 2015). There are no studies that address ethics in PN practice.

Research and evidence-informed practice. There are no studies in our sample that explicitly evaluate the extent to which PNs participate in research and evidence-informed practice. Nevertheless, PNs are reported as being involved in research activities, such as the implementation of research intervention protocols (Austin et al., 2013; Baig et al., 2010; Cooper & Zimmerman, 2016, 2017; Kazmer et al., 2017; Mendelson et al., 2008; Newcomb et al., 2014; Shillam et al., 2013), participant recruitment (Grebeldinger & Buckley, 2016; King, 2011; King & Pappas-Rogich, 2011; Mock, 2017; Shillam et al., 2013; Van Dover & Pfeiffer, 2011; Ziebarth & Miller, 2010), and data collection (Monay et al., 2010; Shillam et al., 2013).

Role implementation. There is a large body of evidence ($n = 21$ studies) that provides insight into what and how the PN role is implemented (Austin et al., 2013; Bagley, 2011; Bokinskie & Kloster, 2008; Cooper & Zimmerman, 2016, 2017; Devido et al., 2017; Devido et al., 2018; Dyess, 2008; Dyess et al., 2017; Dyess & Chase, 2012; Gotwals, 2018; Grebeldinger & Buckley, 2016; Hixson & Loeb, 2018; Millerd, 2010; Mock, 2017; Pappas-Rogich & King, 2014; Rydholm et al., 2008; Shores, 2014; Solari-Twadell & Hackbarth, 2010; Young, 2015; Ziebarth, 2016b). We categorized this body of evidence into two sub-categories: barriers to PN role implementation and opportunities to enhance PN role implementation in two areas. They are reported below.

Barriers to PN role implementation. Eight studies identify barriers to PN role implementation (Bagley, 2011; Bokinskie & Kloster, 2008; Devido et al., 2018; Dyess et al., 2017; Mattingly & Main, 2015; McCabe & Somers, 2009; Thompson, 2010; Ziebarth, 2018). These barriers relate to time and scheduling challenges (Bagley, 2011; Bokinskie & Kloster, 2008; McCabe & Somers, 2009), insufficient financial support (Bokinskie & Kloster, 2008; Mattingly & Main, 2015; Mock, 2017), isolation from colleagues (Devido et al., 2018), poor systems for documentation (Dyess et al., 2017; Mattingly & Main, 2015), and lack of congregational, volunteer, and clergy support (Bokinskie & Kloster, 2008; McCabe & Somers, 2009; Mock, 2017; Thompson, 2010). Poor leadership, organizational change, and lack of strategic planning for PN programming can result in involuntary PN termination (Ziebarth, 2018).

Opportunities for PN education. Nine studies address gaps in PN education and offer opportunities for curriculum development (Bagley, 2011; Devido et al., 2017; Devido et al., 2018; Gotwals, 2018; Grebeldinger & Buckley, 2016; Newbanks & Rieg, 2011; Solari-Twadell & Hackbarth, 2010; Tormoehlen, 2009; Ziebarth & Miller, 2010). Among these, three studies examine PN perceptions of the quality of their basic course (Newbanks & Rieg, 2011; Tormoehlen, 2009; Ziebarth & Miller, 2010). The literature identifies the need to revise basic courses to better address curricular gaps, including confidentiality (Tormoehlen, 2009), spirituality and spiritual care practices (Bagley, 2011; Tormoehlen, 2009; Ziebarth & Miller, 2010), community nursing knowledge (Ziebarth & Miller, 2010), organizational leadership (Bagley, 2011), and caregiver self-assessment, goal setting, and monitoring (Grebeldinger & Buckley, 2016). Experiential learning needs include enhancements to role modeling, practice hours, and peer support (Ziebarth & Miller, 2010). Finally, the need for post basic training to increase PN self-efficacy in knowledge and counseling in health promotion and disease prevention is also identified (Devido et al., 2017; Devido et al., 2018; Gotwals, 2018).

Opportunities for enhanced PN ministry support. Seven studies (Bagley, 2011; Devido et al., 2017; Dyess et al., 2017; King & Pappas-Rogich, 2011; McCabe & Somers, 2009; Mock, 2017; Wordsworth, 2015) identify opportunities

Table 3. Quality Appraisal using Mixed Methods Appraisal Tool, 2018 version.

Author	Study Type*	Quality 1	Quality 2	Quality 3	Quality 4	Quality 5
Devido et al. (2018)	1	Yes	Yes	Yes	Yes	Yes
Dyess (2008)	1	Yes	Yes	Yes	Yes	Yes
Dyess and Chase (2012)	1	Yes	Yes	Yes	Yes	Yes
Grebeldinger and Buckley (2016)	1	Yes	Yes	Can't tell	Yes	Yes
Kazmer et al. (2017)	1	Yes	Yes	Yes	Yes	Yes
King (2011)	1	Yes	No	Can't tell	Can't tell	Can't tell
Millerd (2010)	1	Yes	Yes	Yes	Yes	Yes
Mock (2017)	1	Yes	Yes	Can't tell	Yes	Yes
Newbanks and Rieg (2011)	1	Yes	Yes	No	No	Can't tell
Sheehan et al. (2013)	1	Yes	Yes	Can't tell	Yes	Can't tell
Shores (2014)	1	Yes	Can't tell	Yes	Yes	Yes
Van Dover and Pfeiffer (2011)	1	Yes	Yes	Yes	Yes	Yes
Ziebarth and Miller (2010)	1	Yes	Yes	Yes	Yes	Yes
Young (2015)	1	Yes	Yes	Can't tell	Can't tell	Can't tell
Baig et al. (2010)	2	Yes	Yes	Can't tell	Yes	No
Gotwals (2018)	2	Can't tell	Can't tell	Can't tell	Can't tell	Can't tell
Mendelson et al. (2008)	2	Yes	Yes	Can't tell	Can't tell	Can't tell
Austin et al. (2013)	3	Yes	Can't tell	No	No	Can't tell
Cooper and Zimmerman (2016)	3	Can't tell	Can't tell	No	No	Yes
Cooper and Zimmerman (2017)	3	No	Can't tell	Yes	No	Can't tell
Medley et al. (2018)	3	No	Yes	Yes	No	Can't tell
Shillam et al. (2013)	3	Can't tell	Can't tell	No	No	Yes
Bokinskie and Kloster (2008)	4	Yes	Yes	Can't tell	Can't tell	Yes
Hixson and Loeb (2018)	4	Yes	Yes	Yes	Can't tell	Yes
King and Pappas-Rogich (2011)	4	Yes	Yes	Can't tell	Can't tell	Yes
King and Tessaro (2009)	4	Yes	Can't tell	Can't tell	Can't tell	Yes
Mattingly and Main (2015)	4	Yes	Yes	Yes	Yes	Yes
McCabe and Somers (2009)	4	Yes	No	Can't tell	No	Yes
McGinnis and Zoske (2008)	4	Yes	Yes	Can't tell	No	Yes
Monay et al. (2010)	4	Can't tell	No	Can't tell	No	Yes
Pappas-Rogich & King, 2014	4	Yes	Yes	Can't tell	Yes	Can't tell
Reilly et al. (2011)	4	Yes	Yes	Can't tell	Yes	Yes
Solari-Twadell and Hackbarth (2010)	4	Yes	Yes	Yes	Yes	Yes
Thompson (2010)	4	Yes	No	Can't tell	No	Yes
Tormoehlen (2009)	4	Yes	No	Can't tell	No	Yes
Ziebarth (2018)	4	Yes	Can't tell	Can't tell	No	Yes
Bagley (2011)	5	Yes	Yes	Yes	Yes	Yes
Devido et al. (2017)	5	Yes	Yes	Yes	Yes	Yes
Dyess et al. (2017)	5	No	Yes	Yes	Yes	Yes
Newcomb et al. (2014)	5	No	No	No	Can't tell	No
Rydholm et al. (2008)	5	No	Yes	Yes	Yes	Yes
Wordsworth (2015)	5	Yes	Yes	Yes	Yes	Yes
Ziebarth (2016b)	5	Yes	No	No	Can't tell	Yes

to enhance support for PN ministries. Opportunities exist in five key areas including improved community support for PN programs (Mock, 2017), emotional support for PNs (McCabe & Somers, 2009; Mock, 2017), documentation technology and outcome tracking (Dyess et al., 2017), health promotion and disease prevention (Devido et al., 2017; King & Pappas-Rogich, 2011; McCabe & Somers, 2009), and volunteerism (Bagley, 2011; Wordsworth, 2015). With additional support, there are opportunities for PNs to promote more seamless and efficient health and transitional care services (Devido et al., 2017; King & Pappas-Rogich, 2011; Mock, 2017) and bereavement care (Mock, 2017).

Program evaluation and research. There are nine studies in the literature sample that report outcomes related to the implementation of various health promotion programs and interventions (Austin et al., 2013; Baig et al., 2010; Cooper & Zimmerman, 2016, 2017; Medley et al., 2018; Mendelson

Table 4. Summary of Quality Appraisal by Study Type and Question.

Study Type	Yes	No	Can't Tell
1. Qualitative ($n = 14$)			
Is the qualitative approach appropriate to answer the research question?	14	0	0
Are the qualitative data collection methods adequate to address the research question?	12	1	1
Are the findings adequately derived from the data?	8	1	5
Is the interpretation of results sufficiently substantiated by data?	11	1	2
Is there coherence between qualitative data sources, collection, analysis and interpretation?	10	0	4
2. Quantitative randomized controlled ($n = 3$)			
Is randomization appropriately performed?	2	0	1
Are the groups comparable at baseline?	2	0	2
Are there complete outcome data?	0	0	3
Are outcome assessors blinded to the intervention provided?	1	0	2
Did the participants adhere to the assigned intervention?	0	1	2
3. Quantitative non-randomized ($n = 5$)			
Are the participants representative of the target population?	1	2	2
Are measurements appropriate regarding both the outcome and intervention (or exposure)?	1	0	4
Are there complete outcome data?	2	3	0
Are the confounders accounted for in the design and analysis?	0	5	0
During the study period, is the intervention administered (or exposure occurred) as intended?	2	0	3
4. Quantitative descriptive ($n = 14$)			
Is the sampling strategy relevant to address the research question?	13	0	1
Is the sample representative of the target population?	8	4	2
Are the measurements appropriate?	3	0	11
Is the risk of nonresponse bias low?	4	6	4
Is the statistical analysis appropriate to answer the research question?	13	0	1
5. Mixed methods ($n = 7$)			
Is there an adequate rationale for using a mixed methods design to address the research question?	4	3	0
Are the different components of the study effectively integrated to answer the research question?	5	2	0
Are the outputs of the integration of qualitative and quantitative components adequately interpreted?	5	2	0
Are divergences and inconsistencies between quantitative and qualitative results adequately addressed?	5	0	2
Do the different components of the study adhere to the quality criteria of each tradition of the methods involved?	6	1	0

et al., 2008; Reilly et al., 2011; Sheehan et al., 2013; Shillam et al., 2013). The majority evaluate educational interventions about specific health concerns, such as: hypertension (Austin et al., 2013; Baig et al., 2010; Cooper & Zimmerman, 2016, 2017), diabetes (Austin et al., 2013; Sheehan et al., 2013), gestational diabetes (Mendelson et al., 2008), colorectal screening (Medley et al., 2018), infection prevention (Reilly et al., 2011), and polypharmacy (Shillam et al., 2013). Kazmer and colleagues (2017) report a cognitive-behavioural and spiritual counseling intervention for dementia caregivers. Five of the nine programs were implemented among sample populations aged 50 and older (Austin et al., 2013; Baig et al., 2010; Medley et al., 2018; Newcomb et al., 2014; Shillam et al., 2013). Age was not reported in three studies (Cooper & Zimmerman, 2016, 2017; Reilly et al., 2011).

Discussion

This scoping review of the international PN research reveals a significant gap in PN research from Canada and non-U.S. countries. It is also the only published review that reports the findings of a critical appraisal of the PN research. The only Canadian study found in the time period was an unpublished thesis (Millerd, 2010). Research that explores the roles of PNs and how they are implemented has continued. Our review specifically highlights the significant roles of PNs in facilitating spiritual care, providing wholistic nursing care, and in health promotion. It also suggests a gap in understanding how PNs engage in spiritual care and advocacy and how they apply ethics and evidence-informed decision-making in their practice. Similar to the findings of Dandridge (2014) review, research that reports the implementation and evaluation of health promotion interventions is prevalent in our literature sample.

Spiritual care

Spirituality is a broad concept that is recognized as a fundamental component of compassionate health care (Puchalski et al., 2009). It refers to the way individuals seek and express meaning and purpose and how connectedness to the moment, to self, to others, to nature, and to the sacred is experienced (Puchalski et al., 2009). Accumulating research evidence suggests that a person's belief in religion

or spirituality has a significant impact on health (Mueller et al., 2001). An estimated 5,000 articles are written every year on the positive impact of religion or spirituality on health (Lipton, 2015). Spiritual beliefs also have a direct, positive influence on the activity of the immune and endocrine systems that are important for health maintenance and disease prevention (Lipton, 2015). According to a systematic evidence-based analysis (Bonelli & Koenig, 2013), religious involvement is correlated with better mental health in the areas of depression, substance abuse, and suicide.

The focus on spiritual care practices distinguishes parish nursing from other nursing specialties. Facilitation of spiritual care is one of the CAPNM standards and its indicators describe care expectations (CAPNM, 2021b). In this review, 13 studies describe a range of PN spiritual care practices (Dyess & Chase, 2012; Grebeldinger & Buckley, 2016; Hixson & Loeb, 2018; Kazmer et al., 2017; King, 2011; McCabe & Somers, 2009; Millerd, 2010; Mock, 2017; Newbanks & Rieg, 2011; Shores, 2014; Solari-Twadell & Hackbarth, 2010; Van Dover & Pfeiffer, 2011; Ziebarth, 2016b). Although spiritual presence is noted as a practice (Grebeldinger & Buckley, 2016; Millerd, 2010; Shores, 2014), the *'what'* and *'how'* of spiritual care and its integration with other domains of PN practice has not been rigorously studied. A qualitative study by Canadian researchers (LeBlanc-Kwaw et al., 2020), published after our search, examines the process PNs use to develop the spiritual practice of presence. The basic social process involves cultivating the soul to become a channel of God through steps of presence that involve the self, God, and others (LeBlanc-Kwaw et al., 2020).

Health promotion

This review emphasizes the significant health promotion role of PNs within churches and communities. Promoting healthy lifestyles and healthy behaviors prevents health problems and reduces health risks and threats (Public Health Agency of Canada, 2017). In the PN research, health is largely promoted through activities of health screening, teaching, coaching, and referral, based on physical factors of health (Austin et al., 2013; Cooper & Zimmerman, 2016, 2017; Dyess, 2008; Gotwals, 2018; King, 2011; King & Tessaro, 2009; McGinnis & Zoske, 2008; Monay et al., 2010; Newcomb et al., 2014; Sheehan et al., 2013; Young, 2015; Ziebarth & Miller, 2010).

This is a narrow view of a PN's opportunities to promote health. According to the WHO (2021), health promotion "moves beyond a focus on individual behavior towards a wide range of social and environmental interventions" (para.1).

In Canada, the determinants of health include: income and social status, employment and working conditions, education and literacy, childhood experiences, physical environments, social supports and coping skills, healthy behaviors, access to health services, biology and genetic endowment, gender, culture, and race/racism (Government of Canada, 2020). A greater understanding of how these dimensions of health are being addressed by Canadian PNs would add value to the nursing literature and PN practice. Future exploration should employ more wholistic and population health definitions of health promotion and consider relevant frameworks, such as the Ottawa Charter for Health Promotion (WHO, 1986) and the Population Health Model (Hamilton & Bhatti, 1996).

Although advocacy is a key process for promoting health, the work of advocacy among PNs is not well reported. The Ottawa Charter for Health Promotion (WHO, 1986) states that the "fundamental conditions and resources for health are peace, shelter, education, food, income, a stable ecosystem, sustainable resources, social justice and equity" (p.1). It also states that health promotion must aim to make these conditions favorable through advocating for health, enabling people to control determinants of health, mediating between differing interests of society for the pursuit of health, building healthy public policy, creating supportive environments, strengthening community action, developing personal skills, and reorienting health services. These are ways in which PN ministries in Canada should seek opportunities to advocate for the health of faith communities and broaden the impact of parish nursing by implementing more upstream approaches to health promotion.

Recommendations for education and practice

The findings of this review reveal several areas which should be better addressed in PN certification and continuing education programs. As integration of spirituality into nursing care is integral to the PN's practice, more time needs to be given to the development of this skill in basic PN programs, mentoring programs, and continuing education courses. PN courses should include a focus on EBP. To enable PNs to more rigorously evaluate their interventions and programming, curricula in PN certification programs should foster competency in EBP, research, and quality improvement methods. Cultivating relationships with faculties/schools of nursing in Canada as well as health organizations that have resources to support EBP, such as libraries and health databases, would support PNs to remain up-to-date in best evidence and offer continuing education and research opportunities for Canadian PNs.

The review also highlights the need for increased support for PN ministries in Canada and internationally. Self-efficacy and empowerment as leaders were identified in several studies (Bagley, 2011; Devido et al., 2017; Devido et al., 2018; Gotwals, 2018). PNs identify participatory education, mentoring, and a relationship with a higher power as means for supporting their empowerment (Weis et al., 2006). Volunteerism is another area for PN ministry support. According to Wordsworth (2015), churches in the United Kingdom with PNs have twice as much volunteer

coordination and support and increased time to address the wholistic care needs of people who do not normally go to church, thus positively affecting the mission of churches. Finally, financial, clergy, and parish leadership support affirm the contributions of the PN and promote PN wellbeing (Bokinskie & Kloster, 2008) and are therefore, important for retaining PNs in the nursing workforce.

Recommendations for research

There is a need to support international research in parish nursing. Parish nursing is practiced in 29 countries around the world (Westberg Institute, 2021); yet, there is a dearth of research published outside of the United States. Funding to support PN research and collaborations with nurse researchers would advance PN research in Canada. More rigorous methods are also needed to evaluate the outcomes of PN interventions in populations across the lifespan, especially children and youth. There is no research that assesses the impact of parish nursing on healthcare system outcomes, such as primary care and hospital utilization. The cost effectiveness of parish nursing for faith communities, the broader community, and the healthcare system is also not known, although a model to measure its economic benefits in prevention has been proposed (Ziebarth, 2016a). Improved reporting of methods and findings would improve the credibility of PN research for evidence-informed practice. Publication checklists are readily available in the public domain from the UK EQUATOR Centre (n.d.) to support the reporting of various research study types. Because the economic value of a resource often helps organizations determine whether or not the resource is of value and should be maintained, these latter research foci would be helpful in demonstrating the importance of funding and retaining PNs in the community sector.

Research related to the ethical practices of PNs is lacking. Given the new and changing ethical issues in contemporary healthcare and the reality that many PNs practice in their own faith communities, it is expected that PNs experience ethical dilemmas in their practice. In Canada, the legislation of Medical Assistance in Dying (MAiD) necessitated the generation of guidelines for PN practice related to MAiD (CAPNM, 2017). Because federal legislation "does not change the PN's commitment to the people he/she cares for" (CAPNM, 2017, para. 1), it is important to explore how PNs navigate client and family decision making about MAiD and other ethical issues. Participation in client decisions and discussions about end-of-life and assisted dying are likely to have a direct personal and professional impact on PNs. They can lead to moral distress (Rice et al., 2008) and moral residue (Kopchek, 2020) among nurses and have a potentially negative influence on PN retention in the nursing workforce.

Limitations

This scoping review focused on available English articles through the searches identified. There is a possibility that the authors have not identified published material that was available through other data sources; therefore, they are missing from this review. We eliminated nine articles that did not meet methodological screening criteria and that may have added useful information to this review. The elimination of these articles points to further methodological weaknesses in PN research than documented in this review. Although the authors of the MMAT (Hong et al., 2018) provide clear quality criteria/indicators, and we implemented a two-reviewer scoring process, we acknowledge that there was subjectivity and therefore bias in our scoring.

Conclusion

This scoping review of the PN research literature highlights the specialized practice of PNs. There is a significant gap in PN research in Canada and in high quality research internationally. The literature is organized around three themes: practice roles of the PN, role implementation, and program evaluation research. PN practice roles include professional practice and accountability, wholistic nursing care, facilitation of spiritual care, health promotion, advocacy and ethics, communication, collaboration, and evidence-informed practice. Role implementation opportunities exist for PN education and ministry support. Health promotion is a dominant research area, particularly the evaluation of PN educational interventions programs related to health education and screening for chronic disease. Researchers undertaking PN research should consider using more rigorous methods where appropriate and reporting checklists to increase the validity and reliability of research for evidence-informed PN practice. PN alignment with ethics boards and university researchers could advance PN research. Research into the cost effectiveness, healthcare outcomes, and the economic value of PN practice is needed.

Acknowledgments

The authors acknowledge the following members of the original CAPNM research team: Rosalyn Thompson, BN, RN, Cheryl Gibson, PhD, RN, and Claudia McCloskey MEd, RN, for their contributions to the original analyzes of articles. Keith Thompson helped to manage the numerous articles by merging the original literature spreadsheets.

Committee member Laura Van Loon supported our analysis work and reminded the team of the importance of this research. The documentation support of Faith Cormier, CAPNM Board Member Liaison, kept us on track, always with her signature wit and humour.

This scoping review and the work behind it would not have been possible without the spiritual support and direction from Mark Miller, PhD. He often provided the 'big picture' motivation we needed to navigate through the details and keep our eyes on the goal.

Declaration of Conflicting Interests

The author(s) declared no potential conflicts of interest with respect to the research, authorship, and/or publication of this article.

Funding

The author(s) received no financial support for the research, authorship and/or publication of this article.

ORCID iDs

Elsie Millerd https://orcid.org/0000-0002-3729-4538
Andrea Fisher https://orcid.org/0000-0002-6978-8882
Jeanne M. Lambert https://orcid.org/0000-0003-3675-2418
Kathryn A. Pfaff https://orcid.org/0000-0001-9124-0365

References

Arksey, H., & O'Malley, L. (2005). Scoping studies: Towards a methodological framework. *International Journal of Social Research Methodology*, *8*(1), 19–32. https://doi.org/10.1080/1364557032000119616

Austin, S., Brennan-Jordan, N., Frenn, D., Kelman, G., Sheehan, A., & Scotti, D. (2013). Defy diabetes! a unique partnership with faith community/parish nurses to impact diabetes. *Journal of Christian Nursing*, *30*(4), 238–243. https://doi.org/10.1097/cnj.0b013e3182a35fcb

Bagley, C. (2011). *Parish nurse practice implementation: Opportunities and barriers* [unpublished doctoral dissertation]. Walden University.

Baig, A. A., Mangione, C. M., Sorrell-Thompson, A. L., & Miranda, J. M. (2010). A randomized community-based intervention trial comparing faith community nurse referrals to telephone-assisted physician appointments for health fair participants with elevated blood pressure. *Journal of General Internal Medicine*, *25*(7), 701–709. https://doi.org/10.1007/s11606-010-1326-9

Bokinskie, J. C., & Kloster, P. K. (2008). Effective parish nursing. *Journal of Christian Nursing*, *25*(1), 20–25. https://doi.org/10.1097/01.cnj.0000306000.35370.71

Bonelli, R., & Koenig, H. (2013). Mental disorders, religion and spirituality 1990 to 2010: A systematic evidence-based review. *Relig Health*, *52*(2), 657–673. https://doi.org/10.1007/s10943-013-9691-4

Canadian Association of Parish Nursing Ministry. (2021a). *Parish nursing*. https://www.capnm.ca/

Canadian Association of Parish Nursing Ministry. (2021b). *Standards*. https://www.capnm.ca/about/standards/

Canadian Association of Parish Nursing Ministry. (2017). *Guidelines for parish nurses on Medical Assistance in Dying (MAiD)*. https://www.capnm.ca/wp-content/uploads/2019/05/maid-guidelines-appendix-d.pdf

Clark, M. B., & Olson, J. K. (2000). *Nursing within a faith community: Promoting health in times of transition* (1st ed.). Sage Publications, Inc.

Colquhoun, H. L., Levac, D., O'Brien, K. K., Straus, S., Tricco, A. C., Perrier, L., Kastner, M., & Moher, D. (2014). Scoping reviews: Time for clarity in definition, methods, and reporting. *Journal of Clinical Epidemiology*, *67*(12), 1291–1294. https://doi.org/10.1016/j.jclinepi.2014.03.013

Cooper, J., & Zimmerman, W. (2016). The evaluation of a regional faith community network's Million hearts program. *Public Health Nursing*, *33*(1), 53–64. https://doi.org/10.1111/phn.12222

Cooper, J., & Zimmerman, W. (2017). The effect of a faith community nurse network and public health collaboration on hypertension prevention and control. *Public Health Nursing*, *34*(5), 444–453. https://doi.org/10.1111/phn.12325

Craiger, B. (2006). *Walking alongside: The essence of parish nursing*. Trafford Publishing.

Dandridge, R. (2014). Faith community/parish nurse literature. *Journal of Christian Nursing*, *31*(2), 100–107. https://doi.org/10.1097/cnj.0000000000000063

Devido, J. A., Doswell, W. M., Braxter, B. J., Spatz, D. L., Dorman, J. S., Terry, M., & Charron-Prochownik, D. (2017). Experiences of parish nurses in providing diabetes education and preconception counseling to women with diabetes. *Journal of Obstetric. Gynecologic & Neonatal Nursing*, *46*(2), 248–257. https://doi.org/10.1016/j.jogn.2016.10.010

Devido, J. A., Doswell, W. M., Braxter, B. J., Terry, M., & Charron-Prochownik, D. (2018). Exploring the experiences, challenges, and approaches of parish nurses in their community practice. *Journal of Holistic Nursing*, *37*(2), 121–129. https://doi.org/10.1177/0898010118801414

Dyess, S. (2008). *Living in abundance: The experience of living with chronic illness for adults affiliated with a community of faith with access to a faith community nurse* [Unpublished doctoral dissertation]. Florida Atlantic University.

Dyess, S., Callaghan, D., & Opalinski, A. (2017). Exploration and description of faith community nurses' documentation practices and perceived documentation barriers. *International Journal of Faith Community Nursing*, *3*(1). https://digitalcommons.wku.edu/cgi/viewcontent.cgi?referer=&httpsredir=1&article=1040&context=ijfcn

Dyess, S., & Chase, S. K. (2012). Sustaining health in faith community nursing practice. *Holistic Nursing Practice*, *26*(4), 221–227. https://doi.org/10.1097/hnp.0b013e318258527c

Dyess, S., Chase, S. K., & Newlin, K. (2010). State of research for faith community nursing 2009. *Journal of Religion and Health*, *49*(2), 188–199. https://doi.org/10.1007/s10943-009-9262-x

Gotwals, B. (2018). Self-efficacy and nutrition education: A study of the effect of an intervention with faith community nurses. *Journal of Religion and Health*, *57*(1), 333–348. https://doi.org/10.1007/s10943-017-0465-2

Government of Canada. (2020). *Social determinants of health and health inequalities*. https://www.canada.ca/en/public-health/services/health-promotion/population-health/what-determines-health.html

Grebeldinger, T. A., & Buckley, K. M. (2016). You are not alone. *Journal of Christian Nursing*, *33*(1), 50–56. https://doi.org/10.1097/cnj.0000000000000242

Hamilton, N., & Bhatti, T. (1996). *Population health promotion: An integrated model of population health and health promotion*. http://www.phac-aspc.gc.ca/ph-sp/php-psp/index-eng.php

Hixson, L. B., & Loeb, S. J. (2018). Promoting successful aging through faith community nursing. *Journal of Christian Nursing*, *35*(4), 242–249. https://doi.org/10.1097/cnj.0000000000000528

Hong, Q., Fàbregues, S., Bartlett, G., Boardman, F., Cargo, M., Dagenais, P., Gagnon, M.-P., Griffiths, F., Nicolau, B., O'Cathain, A., Rousseau, M.-C., Vedel, I., & Pluye, P. (2018). The mixed methods appraisal tool (mmat) version 2018 for

information professionals and researchers. *Education for Information*, *34*(4), 285–291. https://doi.org/10.3233/efi-180221

Kazmer, M. M., Glueckauf, R. L., Schettini, G., Ma, J., & Silva, M. (2017). Qualitative analysis of faith community nurse–led cognitive-behavioral and spiritual counseling for dementia caregivers. *Qualitative Health Research*, *28*(4), 633–647. https://doi.org/10.1177/1049732317743238

King, M. A. (2004). Review of research about parish nursing practice. *Online Brazilian Journal of Nursing*, *3*(1). https://doi.org/10.17665/1676-4285.20044896

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

King, M. A., & Pappas-Rogich, M. (2011). Faith community nurses: Implementing healthy people standards to promote the health of elderly clients. *Geriatric Nursing*, *32*(6), 459–464. https://doi.org/10.1016/j.gerinurse.2011.09.007

King, M. A., & Tessaro, I. (2009). Parish nursing. *Journal of Christian Nursing*, *26*(1), 22–24. https://doi.org/10.1097/01.cnj.0000343922.78680.fb

Kopchek. (2020). *How do palliative care registered nurses apply concepts of ethical decision-making when caring for patients who request medical assistance in dying? An interpretive descriptive qualitative study* [unpublished thesis]. University of Windsor.

LeBlanc-Kwaw, D., Weaver, K., & Olson, J. (2020). Becoming a channel of God: How faith community nurses develop their spiritual practice. *Journal of Holistic Nursing*, *39*(3), 239–253. https://doi.org/10.1177/0898010120977326

Lipton, B. (2015). *The biology of belief*. Hay House Inc.

Martin, L. B. (1996). Parish nursing: Keeping body and soul together. *The Canadian Nurse*, *92*(1), 25–28.

Mattingly, C. M., & Main, M. E. (2015). Examining faith community nurses' perception and utilization of electronic health records. *International Journal of Faith Community Nursing*, *1*(1). https://digitalcommons.wku.edu/ijfcn/vol1/iss1/2/

McCabe, J., & Somers, S. (2009). Faith community nursing: Meeting the needs of seniors. *Journal of Christian Nursing*, *26*(2), 104–109. https://doi.org/10.1097/01.CNJ.0000348271.20300.b0

McGinnis, S. L., & Zoske, F. M. (2008). The emerging role of faith community nurses in prevention and management of chronic disease. *Policy, Politics. & Nursing Practice*, *9*(3), 173–180. https://doi.org/10.1177/1527154408322560

Medley, L. B., Smith, L., & Blankenship, M. (2018). Colorectal cancer screening education in faith-based communities. *International Journal of Faith Community Nursing*, *4*(1). https://digitalcommons.wku.edu/cgi/viewcontent.cgi?article=1043&context=ijfcn

Mendelson, S., McNeese-Smith, D., Koniak-Griffin, D., Nyamathi, A., & Lu, M. C. (2008). A community-based parish nurse intervention program for Mexican American women with gestational diabetes. *Journal of Obstetric. Gynecologic & Neonatal Nursing*, *37*(4), 415–425. https://doi.org/10.1111/j.1552-6909.2008.00262.x

Miller, L. W. (2004). *Faith and health: A framework for christian nurses*. Trafford Publishing.

Millerd, E. (2010). *Walking on holy ground: The experience of spirituality for parish nurses* [unpublished thesis]. Wilfred Laurier University.

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

Monay, V., Mangione, C. M., Sorrell-Thompson, A., & Baig, A. A. (2010). Services delivered by faith-community nurses to individuals with elevated blood pressure. *Public Health Nursing*, *27*(6), 537–543. https://doi.org/10.1111/j.1525-1446.2010.00881.x

Mueller, P. S., Plevak, D. J., & & Rummans, T. A. (2001). Religious involvement, spirituality, and medicine: Implications for clinical practice. *Mayo Clinic Proceedings*, *76*(12), 1225–1235. https://doi.org/10.4065/76.12.1225

Newbanks, S., & Rieg, L. S. (2011). Are parish nurses prepared to incorporate the spiritual dimension into practice? *Journal of Christian Nursing*, *28*(3), 146–151. https://doi.org/10.1097/cnj.0b013e3182203ef1

Newcomb, P., Canclini, S., Cauble, D., Raudonis, B., & Golden, P. (2014). Pilot trial of an electronic family medical history in US faith-based communities. *Journal of Primary Care & Community Health*, *5*(3), 198–201. https://doi.org/10.1177/2150131914524441

Noble, H., & Smith, J. (2018). Reviewing the literature: Choosing a review design. *Evidence Based Nursing*, *21*(2), 39–41. https://doi.org/10.1136/eb-2018-102895

Olson, J., Clark, M., & Simington, J. (1999). The Canadian experience. In *Parish nursing: Promoting whole person health within faith communities* (pp. 277–286). Sage Publications, Inc. https://doi.org/10.4135/9781452232874

Pappas-Rogich, M., & King, M. (2014). Faith community nursing. *Journal of Christian Nursing*, *31*(4), 228–234. https://doi.org/10.1097/cnj.0000000000000104

Public Health Agency of Canada. (2017). *How healthy are Canadians? A trend analysis of the health of Canadians from a healthy living and chronic disease perspective*. https://www.canada.ca/en/public-health/services/publications/healthy-living/how-healthy-canadians.html#s2

Puchalski, C. M., Ferrell, I. B., Virani, R., Otis-Green, S., Baird, P., Bull, J., Chochinov, H., Handzo, G., Nelson-Becker, H., Prince-Paul, M., Pugliese, K., & & Sulmasy, D. (2009). Improving the quality of spiritual care as a dimension of palliative care: The report of the consensus conference. *Journal of Palliative Medicine*, *12*(10), 885–904. https://doi.org/10.1089/jpm.2009.0142

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

Rice, E. M., Rady, M. Y., Hamrick, A., Verheijde, J. L., & Pendergast, D. K. (2008). Determinants of moral distress in medical and surgical nurses at an adult acute tertiary care hospital. *Journal of Nursing Management*, *16*(3), 360–373. https://doi.org/10.1111/j.1365-2834.2007.00798.x

Rydholm, L., Moone, R., Thornquist, L., Alexander, W., Gustafson, V., & Speece, B. (2008). Care of community-dwelling older adults by faith community nurses. *Journal of Gerontological Nursing*, *34*(4), 18–29. https://doi.org/10.3928/00989134-20080401-09

Sheehan, A., Austin, S. A., Brennan-Jordan, N., Frenn, D., Kelman, G., & Scotti, D. (2013). Defy diabetes! impact on faith community/parish nurses teaching healthy living classes. *Journal of Christian Nursing*, *30*(4), 244–247. https://doi.org/10.1097/cnj.0b013e3182a364b9

Shillam, C. R., Orton, V. J., Waring, D., & Madsen, S. (2013). Faith community nurses & brown bag events help older adults manage meds. *Journal of Christian Nursing*, *30*(2), 90–96. https://doi.org/10.1097/cnj.0b013e3182831eff

Shores, C. (2014). Spiritual interventions and the impact of a faith community nursing program. *Issues in Mental Health Nursing*, *35*(4), 299–305. https://doi.org/10.3109/01612840.2014.889785

Solari-Twadell, P., & 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

Thompson, P. (2010). Clergy knowledge and attitudes concerning faith community nursing: Toward a three-dimensional scale. *Public Health Nursing*, *27*(1), 71–78. https://doi.org/10.1111/j.1525-1446.2009.00828.x

Tormoehlen, L. (2009). *A learning needs assessment of parish nurses* [Unpublished doctoral dissertation]. Ball State University.

UK EQUATOR Centre. (n.d.). *Reporting guidelines for main study types*. https://www.equator-network.org/about-us/uk-equator-centre/

Van Dover, L., & Pfeiffer, J. (2011). Patients of parish nurses experience renewed spiritual identity: A grounded theory study. *Journal of Advanced Nursing*, *68*(8), 1824–1833. https://doi.org/10.1111/j.1365-2648.2011.05876.x

Weis, D., Schank, M. J., & Matheus, R. (2006). The process of empowerment: A parish nurse perspective. *Journal of Holistic Nursing*, *24*(1), 17–24. https://doi.org/10.1177/0898010105282522

Westberg Institute. (2020). *Celebrate the legacy of Granger Westberg*. [video]. https://www.youtube.com/watch?v=FVtHVrUQ8zI&feature=youtu.be&ct=t(EMAIL_CAMPAIGN_2_18_2020_15_59_COPY_01)&goal=0_f14b402807-1a02c15f38-309196773&mc_cid=1a02c15f38&mc_eid=81274e55f6

Westberg Institute. (2021). International parish/faith community nursing. https://westberginstitute.org/international-faith-community-nursing/

Wordsworth, H. A. (2015). *Rediscovering a ministry of health: Parish nursing as a mission of the local church*. Wipf And Stock Publishers.

World Health Organization. (1986). *Ottawa charter for health promotion*. https://www.euro.who.int/__data/assets/pdf_file/0004/129532/Ottawa_Charter.pdf

World Health Organization. (2017). Enhancing the role of community health nursing for universal health coverage. *Human Resources for Health Observer*, *18*, 1–32. https://www.who.int/publications/i/item/9789241511896

World Health Organization. (2021). *Health promotion*. https://www.who.int/westernpacific/about/how-we-work/programmes/health-promotion

Young, S. A. (2015). Urban parish nurses: A qualitative analysis of the organization of work in community-based practices. *Journal of Nursing Education and Practice*, *6*(2), 19–26. https://doi.org/10.5430/jnep.v6n2p19

Ziebarth, D. (2018). Job termination survey: Faith community nurses. *International Journal of Faith Community Nursing*, *4*(1). https://digitalcommons.wku.edu/ijfcn/vol4/iss1/4/

Ziebarth, D. (2016a). Altruistic and economic measurements used for prevention health services: Faith community nursing program. *Evaluation and Program Planning*, *57*, 72–79. https://doi.org/10.1016/j.evalprogplan.2016.02.004

Ziebarth, D. (2016b). *Transitional care interventions as implemented by faith community nurses* [Unpublished doctoral dissertation]. University of Wisconsin - Milwaukee.

Ziebarth, D. J., & Miller, C. L. (2010). Exploring parish nurses' perspectives of parish nurse training. *The Journal of Continuing Education in Nursing*, *41*(6), 273–280. https://doi.org/10.3928/00220124-20100401-01

Author Biographies

Elsie Millerd is a registered nurse in Ontario and the Education Coordinator for the Foundations in Parish Nursing Program at St. Peter's Seminary in London, Ontario. She is a longstanding CAPNM member and has served as a parish nurse and in many parish nursing leadership roles.

Andrea Fisher is a registered nurse, a care manager at NurseOnBoard in Orleans, Ontario and a volunteer parish nurse.

Jeanne M. Lambert is a registered nurse and faith community nurse in the Bishop's Mills, Ontario area. She is the Chair of the CAPNM Research Committee and an executive member of the Registered Nurses' Association of Ontario Faith Community Nursing Interest Group.

Kathryn A. Pfaff is an Associate Professor of Nursing at the University of Windsor and volunteers as a parish nurse at her church in Kingsville, Ontario.