Overview of the Content

The American Nurses Association (ANA) recognizes faith community nursing as a nursing specialty. Faith community nursing acknowledges spiritual care as an essential component of a specialized body of nursing knowledge and competencies. A faith community nurse (hereafter, referred to as FCN; plural FCNs) provides care to individuals, families, groups, communities, and populations with emphasis on promoting whole-person health. As professional registered nurses, FCNs are guided in their decision making and practice by the *Code of Ethics for Nurses*; *Nursing Scope and Standards of Practice,* Fourth Edition; and *Guide to Nursing's Social Policy Statement*: *Understanding the Profession from Social Contract to Social Covenant*. These three documents form the foundation of practice for all registered nurses. FCNs hold themselves accountable to the scope and standards of practice under any state, commonwealth, territory laws, statutes, and regulations related to nursing practice and federal regulations.

INTRODUCTION

The American Nurses Association (ANA) published the first *Scope and Standards of Parish Nursing Practice* in 1998. As the practice of parish nursing evolved and embraced multiple faith traditions, the title of the specialty practice was changed to faith community nursing with the publication of *Faith Community Nursing: Scope and Standards of Practice* in 2005. Since the publication of the third edition in 2017, there have been dramatic changes in health care as well as the nursing profession. *Faith Community Nursing: Scope and Standards of Practice,* Fourth Edition, describes the current specialty practice of faith community nursing for the nursing profession, faith community nurses (FCNs), other health care providers, spiritual leaders, employers, insurers, health care consumers, families, and members of faith communities. The scope of practice

statement presents the framework and context of faith community nursing. It accompanies the standards of practice and professional performance and their associated competencies. The scope and standards included in this document define the responsibilities of the FCNs and guide professional practice and performance.

The Standards of Practice Statement encompasses actions taken by registered nurses, which form the foundation of the nurse's decision-making, and expand for the graduate-prepared FCNs, including Advanced Practice Registered Nurses (APRNs). The standards of professional performance describe a competent level of behavior in the professional role, including activities related to ethics, advocacy, respectful and equitable practice, communication, collaboration, leadership, education, scholarly inquiry, quality of practice, professional practice evaluation, resource stewardship, and environmental health.

"The standards are authoritative statements of the actions and behaviors that all registered nurses, regardless of role, population, specialty, and setting, are expected to competently perform. These published standards may serve as evidence of the standard of practice, with the understanding that the application of the standard depends on context." (ANA, 2015, p. 4).

Changing patterns of practice and forced change, such as pandemics or clinical circumstances, may be harbingers of change for the profession, which continues to evolve and expand. It is for these reasons that periodic review and revision of the scope and standards must occur (ANA, 2021).

FUNCTION OF THE SCOPE OF PRACTICE STATEMENT OF FAITH COMMUNITY NURSING

"The scope of practice statement describes the who, what, where, when, why, and how associated with nursing practice and roles. Each question must be answered to provide a complete picture of the dynamic and complex practice of nursing and its membership and evolving boundaries . . . The why is characterized as nursing's response to the changing needs of society to achieve positive health care consumer outcomes in keeping with nursing's social contract and obligation to society. The depth and breadth in which registered nurses engage in the scope of nursing practice are dependent on their education, experience, role, and the population served. Formal periodic review and revision of the scope of nursing

practice statement ensure a contemporary description of nursing practice is in place" (ANA, 2021, p. 4). The scope of faith community nursing practice is specific to this specialty, but it builds on the scope of competent practice and professional performance expected of all registered nurses.

FUNCTION OF THE STANDARDS OF FAITH COMMUNITY NURSING PRACTICE

Standards are "authoritative statements of the actions and behaviors that all registered nurses, regardless of role, population, or specialty, are expected to competently perform" (ANA, 2021, p. 3). Standards reflect the values and priorities of the profession, provide direction for professional nursing practice, and introduce a framework for the evaluation of this practice. The ANA outlines 6 standards of professional nursing practice and 18 standards of professional performance. Competencies are included for each standard, which provide evidence of compliance for each. The standards included in this document define the responsibilities of the FCN and guide professional practice and performance.

Changes in health care and nursing practice may result in a new context for this nursing specialty. The competencies related to each of the standards reflect current practice and provide details for application of the standards. The competencies listing is not meant to be exhaustive.

APPLICATION OF THE SCOPE AND STANDARDS

This fourth edition of the *Faith Community Nursing Scope and Standards of Practice* provides a valuable resource for FCNs to use in decision-making and when expanding, validating, or analyzing their professional practice. The document can be used to guide the development and evaluation of many aspects of faith community nursing practice, including

- Initial preparation and ongoing educational programs,
- Role description and performance evaluations,
- Policies and procedures,
- Quality improvement programs, and
- Processes for certification.

SUMMARY

The scope and standards of practice for faith community nursing reflect the commitment of the Health Ministries Association (HMA) in partnering with the ANA to promote an understanding of faith community nursing as a specialized practice in the interprofessional practice of diverse faith communities. Due to the multiformity of participating faith communities, it is important to identify inclusive terminology to describe the beliefs and practices related to faith traditions. Terms used in this document indicate an effort to include many faith traditions and not to promote any one faith in particular. *Faith Community Nursing: Scope and Standards of Practice,* Fourth Edition, reflects current faith community nursing practice from a national perspective, the professional and ethical standards of the nursing profession, and the legal scope and standards of professional nursing practice. The standards are dynamic and subject to testing and change.

ADDITIONAL CONTENT

For additional appreciation of the history and context related to *Faith Community Nursing Scope and Standards,* Fourth Edition, the reader will find additional useful content in Appendix A.

Scope of Faith Community Nursing Practice

DEFINITION OF FAITH COMMUNITY NURSING

The American Nurses Association (ANA) states professional nursing "integrates the art and science of caring and focuses on the protection, promotion, and optimization of health and human functioning; prevention of illness and injury; facilitation of healing; and alleviation of suffering through compassionate presence. Nursing is the diagnosis and treatment of human responses and advocacy in the care of individuals, families, groups, communities, and populations in recognition of the connection of all humanity" (ANA, 2021, p. 1).

Faith community nursing is a specialized nursing practice that emphasizes intentional care of the spirit, the promotion of whole-person health (body, mind, and spirit), and the prevention or minimization of illness within the context of a faith community and other community settings. Faith community nurses (FCNs) are professional registered nurses (RNs) who are actively licensed in the state in which they practice. FCNs include nurses with diplomas, and both associate-prepared and baccalaureate-prepared RNs; more recently, graduate-prepared RNs and advanced practice registered nurses (APRNs) have been joining the ranks of RN prepared FCNs. The FCN may serve in a leadership role or as a staff member of a faith community, a health care system, or another community setting. Faith community nursing promotes the health and wholeness of individuals, groups, families, and faith communities through the practice of nursing. FCNs follow their state nursing regulatory body and the standards set forth in this document. The FCN uses their knowledge as both a

professional nurse and a spiritual care provider to promote whole-person care across the life span. The FCN builds relationships and provides care during multiple encounters with health care consumers over extended periods of time. These may include stages of healthy growth and development as well as life transitions such as illness, loss, grief, and changes in day-to-day functioning.

The FCN provides spiritual care in the faith community as well as in the broader community. The FCN regularly practices the following skills:

- Integrating the art and science of caring nursing
- Protecting, promoting, and optimizing health and human functioning
- Preventing illness and injury
- Facilitating healing
- Alleviating suffering through compassionate presence

Faith community nursing incorporates the diagnosis and treatment of human responses and advocacy in the context of the values, beliefs, and practices of a faith community (churches, congregations, parishes, synagogues, temples, mosques, or faith-based community agencies). *Health care consumers* are defined by the ANA as "patients, persons, clients, families, groups, communities, or populations who are the focus of nurses' attention. Health care consumers receive nursing services as sanctioned by the state regulatory bodies. The more global term 'health care consumer' is intended to reflect a proactive focus on health and wellness care, rather than a reaction to disease and illness" (ANA, 2021, p. 2). In narratives within the specialty of faith community nursing, other terms such as parishioner, congregant, or faith community member may also be included as descriptive terms. The term health care consumer may refer to the faith community or broader community, or to groups, families, and individuals.

DESCRIPTION OF FAITH COMMUNITY NURSING PRACTICE

Faith community nursing is dynamic and evolves with changes in knowledge, the health care environment, and society to achieve positive health

care consumer outcomes while keeping with nursing's social contract and obligation to society (ANA, 2021, p. 3). The preferred minimum preparation for an RN or APRN entering the specialty of faith community nursing is a baccalaureate degree in nursing. The depth and breadth of the FCN's scope of practice is determined by the nurse's education, experience, practice setting, role, and the specific population served. RNs at all levels, including those identified as graduate-prepared nurses or APRNs, function within the independent scope of their licensure and incorporate the FCN specialty focus into their practice within their state-specific nursing regulating body. FCNs are autonomous, independent practitioners who often function in a consultative role. When functioning in this autonomous role, FCNs are responsible for carrying their own professional liability insurance. FCNs may also be cross trained to work in clinics or in faith-community-sponsored free clinic nursing roles. However, clinics of any type require a different skillset and may require provider oversight per state regulations.

THE SPECIALTY OF FAITH COMMUNITY NURSING

The FCN uses the nursing process to assess and address the spiritual, physical, mental, and social health of the individual health care consumer, faith community, or broader community. With an intentional focus on spiritual health, the FCN primarily uses evidence-based practice interventions such as health education, counseling, prayer, compassionate presence, active listening, advocacy, referrals, and a wide variety of other available community resources.

The FCN may also provide education and supervision to volunteers from the faith community. As an actively licensed RN, the FCN provides nursing care based on standards, professional experience, legal expectations, and education. The FCN focuses on the assets and needs as defined by both the faith community and the health care consumer population. The FCN may serve within or collaborate with interprofessional teams in a variety of settings to enhance nursing care and promote quality outcomes in response to the changing needs of society. These settings may include health care systems and organizations which focus on integrative

health, mental health, social work, long-term care, and end-of-life care. They may also include denominational faith-based organizations and other community agencies.

FCNs advocate for public policy and social change that addresses health disparities and promotes health and wellness (ANA & HMA, 2017, p. 3). The FCN may advocate for appropriate levels of care and access to care for single parents, the elderly, the unhoused, communities of color, and other vulnerable or marginalized populations. FCNs also advocate for health care consumers by initiating referrals for community services, promoting health literacy, and providing health education to empower people to optimize their own health and human functioning.

DISTINGUISHING TENETS OF FAITH COMMUNITY NURSING

The specialty practice of faith community nursing includes the application of nursing science and practice across the lifespan within the context of a faith community, the wider neighborhood, and the community at large, which has expanded through virtual communications. The differentiating factor from general nursing practice is the specific attention that is given to the intentional care of the spirit. The FCN delivers care which

- Promotes whole-person health and well-being,
- Establishes a therapeutic relationship that acknowledges caring as a sacred practice, and
- Focuses on the relationship between faith, health, and shalom. *Shalom* is defined as harmony and wholeness.

An individual's faith beliefs, rituals, spiritual practices, ethnic culture, worldview, and lived experience shape their concept of health. The faith community nurse provides whole-person care as a central focus in establishing rapport and building positive relationships with others. Through therapeutic use of self, the FCN is instrumental in assisting health care consumers in making health care decisions based upon their own personal faith practices and beliefs. The FCN respects that a health care consumer's source of spiritual well-being may or may not include religiosity.

Health care consumers who self-identify with a particular faith tradition exist along a spectrum of religiosity. The FCN should assess each person individually.

Reverend Granger Westberg, the founder of faith community nursing, often discussed this wholistic approach to care. He described *wholistic* or *whole-person* care as care that is supportive of the mind–body–spirit connection, or the whole person, as opposed to focusing in on a diagnosis, a deficit or a "hole" in a person (Westberg, 2015, n.d.). Since the current mainstream usage of holistic and wholistic are often presented as interchangeable, clarity in framing these concepts for FCNs may be helpful. *Holistic* is commonly used in relation to complementary treatments such as yoga, massage, and acupuncture, whereas *wholistic* may be thought of as a philosophy of life. In this document, *whole-person* seems to be a good fit, and a term which may preclude any confusion.

The FCN engages in intentional conversations with health care consumers about how their unique combination of beliefs, rituals, and traditions interplay with their sense of well-being and inform their health care decision-making. "Use of compassionate listening and reflective open dialogue enables individuals to express their understanding of how healing happens for them and how they can be supported" (ANA & HMA, 2017, p. 3). The interventions of active listening, prayer, and therapeutic touch are intentionally incorporated into the FCN's caring presence. This specialty practice holds that all persons are sacred and must be treated with dignity and respect. The foundations of this specialty are in accordance with the ANA's statements about nursing and the essence of the practice.

Essential to the practice of faith community nursing is a caring relationship that promotes trust and the understanding of health as a dynamic process. This process embodies the spiritual, physical, mental, emotional, social, and relational dimensions of the person. In addition, the impact of the social determinants of health should not be minimized. Faith community nursing practice is influenced by the theoretical principles of effective caring to promote health in individuals and families (however a person defines their family unit) as well as their perceived place in the community. Every human experience has mind–body–spirit components. Attention to identified human responses is accomplished by practicing an

approach to health promotion and wholeness that recognizes that the mind, body, and spirit are intertwined. Emphasis is placed on the spiritual component, particularly as it relates to whole-person health, as initially developed by the International Parish Nurse Resource Center in 2001.

In addition to the intentional care of the spirit, the FCN builds community through population-focused care. The focus population is usually targeted within the context of the faith community or other organizations in which the FCN serves. As virtual communication brings change to the practice, population care may extend beyond the boundaries of brick-and-mortar organizations. Collaboration with others increases opportunities for successfully achieving measurable positive health outcomes.

Research provides evidence that supports the value of faith community nursing in today's competitive market and expands the unique body of knowledge required to define the profession. The collection and analysis of data to distinguish this important specialty is essential as we continue to define faith community nursing in a changing climate.

FOUNDATIONS OF PRACTICE

The practice of faith community nursing is based on the following assumptions:

- Health and illness are both individual and universal human experiences which are influenced by multiple factors, including culture, worldview, beliefs and values, and faith traditions
- Health is the integration of the spiritual, physical, psychological, and social aspects of the person, while also promoting a sense of harmony with self, others, the environment, and a higher power
- Health may be experienced in the presence of disease or injury
- Healing is the process of integrating the body, mind, and spirit to create wholeness, health, and a sense of spiritual well-being, even when the health care consumer's illness is not cured (HMA/ANA, 2017, p. 87)
- Illness does not preclude health, nor does optimal health preclude illness

- An illness may not be cured, but even at end-of-life, healing may lead to a peaceful death

This specialized practice is continually evolving, requiring the integration of new knowledge and awareness of ever-changing resources to achieve desired outcomes. FCNs utilize nursing practice standards, position statements, and evidence-based publications from peer-reviewed professional journals for optimal application in their practice.

The philosophy of faith community nursing embraces four major core concepts. These concepts were developed by the International Parish Nurse Resource Center's Philosophy of Parish Nursing in 2001 and have been adapted for inclusion in the Westberg Institute for Faith Community Nursing curriculum.

1. **Spirituality**: An ongoing, essential component of practice that includes both self-care and hospitality through opening the heart to self and others as well as an intentional process of fostering spiritual growth. It is important for the attainment of an overall sense of health, wellbeing, and quality of life.
2. **Professionalism**: The FCN practices within the following parameters as defined by
   - *Nursing: Scope and Standards of Practice,* 4th Edition (ANA, 2021),
   - *Faith Community Nursing: Scope and Standards of Practice,* 4th Edition,
   - *Code of Ethics for Nurses* (ANA, 2025), and
   - State nurse practice acts.
3. **Whole-person health**: The FCN promotes shalom as a foundation for *wholism*, or whole-person health and healing. Health promotion, education, and the dissemination of information are tailored to individual and population needs as assessed by the FCN. Wholistic health includes addressing other life issues, such as suffering, grief, loss, and violence.
4. **Community**: A group with common interests which may include members of vast diversity. An effective faith community nursing practice requires collaboration with other community partners,

wise use of resources, and creativity of thought to foster health and wellness (Westberg Institute, 2014/2020, p. viii).

SETTINGS

Faith community nursing practice is focused on the intentional care of the spirit and is practiced within the context of a faith community, a faith-based organization, or the wider community. The settings may be composed of diverse people of all ages who represent a wide range of cognitive and functional abilities.

The FCN assesses needs and then creates and facilitates a plan of care that incorporates communal and individual spiritual beliefs and practices. This assessment provides direction for the FCN's subsequent intervention. The FCN may see health care consumers in an onsite office or visit members in a health care facility, private home, or other community setting. The FCN may also assist health care consumers as they navigate health services within the community and beyond. The integration of faith and health provides a supportive, healing presence for the health care consumer, caregiver, and others during these encounters.

The settings for faith community nursing continue to expand as the needs of populations grow and change. While the traditional setting is often a community of faith—such as a church or congregation, a synagogue, temple, or mosque—nontraditional settings may also include faith-based health clinics, day shelters, public and private schools (in coordination with the school nurse), long-term care facilities, and other community settings. Faith-based community sites for underserved populations that provide food, housing, and resources may also incorporate FCNs for chronic disease management, screenings, health education, spiritual support, and ongoing whole-person care (Balint & George, 2015). FCNs may serve in a variety of non-profit or for-profit organizations. The FCN in these unique settings complements other professionals as an important team member.

FCNs collaborate with colleagues in nursing schools to provide lectures on spirituality and health, serving as clinical preceptors for com-

munity health nursing students. They also partner with health care and community organizations to provide educational presentations to nursing colleagues such as those working in transitional care, home health, and hospice settings.

FCNs practice in urban, suburban, and rural settings and may impact health care in a proactive manner. They also link individuals and families to resources within their faith and surrounding community. Each setting is unique. FCNs recognize that physical and spiritual health is impacted by violence, chronic diseases, persistent mental illness, and disabilities. Accessibility to care and health equity are major focuses of faith community nursing practice. The size, concerns, assets, and expectations of the community will help define and guide the focus of the FCN's care. Frequent areas of concern may include access to health resources and care, transportation, health literacy, safety and environmental concerns, effective emergency medical system resources, access to mental health care, social isolation, and financial concerns.

Depending on the setting of practice, the FCN may be in a paid or in an unpaid position. Available resources and creative partnerships may determine the FCN position description. The FCN is most often supported and guided by a committee of community leaders and assisted by lay volunteers. With education and supervision provided by the FCN, these volunteers may assume tasks that support individuals and groups in the faith community and in the wider community. FCNs may be managers of health and wellness programs with responsibilities such as budget preparation and oversight, strategic planning, coordination with other initiatives of the faith community or other health care systems, and both supervision and performance evaluations of volunteers.

EVOLUTION OF FAITH COMMUNITY NURSING

Nursing has its historical foundation deeply rooted in faith and health, as well as in the ancient and recent traditions of many religions. Faith traditions established public health practices, including caring for the wounded in wartime, visiting the sick, and caring for infants, the elderly, and the

dying as a religious duty. This sense of duty often focused on caring for strangers, which became a hallmark of a faith-based ministry. The link between faith and health evolved and has been influenced by cultural, political, social, and economic events. Religious groups founded hospitals to care for vulnerable populations. In the early 12th, 13th, and 14th centuries, religious orders provided care for persons with physical and mental illnesses. These were precursors to nursing practice, especially in the realm of spiritual care.

A TIMELINE OF EVOLUTION (OR DEVELOPMENT) OF FAITH COMMUNITY NURSING

Circa AD	Phoebe is the first known Christian nurse, mentioned in Romans 16:1, who was sent by St. Paul to Rome as the first documented visiting nurse.
620 AD	Rufaida Al-Aslamia, a companion of the Prophet Muhammad (Peace Be Upon Him) and a pioneering figure in the field of Islamic medicine, surgery, and social work, is widely acknowledged as the first Muslim nurse in Islamic history. Rufaida is credited as designing the first code of ethics for nurses.
1200 AD	Religious orders provided care for vulnerable populations in Europe.
1800s	Religious orders were called upon to serve vulnerable populations as a vocation.
1859	Florence Nightingale received training from the Deaconess Institution in Germany. She felt called to serve the sick and wrote *Notes on Nursing: What It Is and What It Is Not.* Nightingale was a social activist for health issues.
1950s	Halbert Dunn, a physician, developed a public health concept that he called high-level wellness. His perspective on health promotion and wellness influenced the development of faith community nursing. In the 1970s, Dunn's writings were a catalyst for wellness centers.
1973	Reverend Dr. Granger Westberg, in conjunction with the W. K. Kellogg Foundation and the Department of Preventive Medicine and Community Health of the University of Illinois College of Medicine, opened the first medical clinics in the neighborhood churches of marginalized communities, which he termed wholistic health centers. "Parish nurses" served in these wholistic health centers. This resulted in establishing a collaboration of health care professionals and clergy delivering whole-person care in faith settings.

1986	The Parish Nurse Resource Center (PNRC) was established through the sponsorship of Lutheran General Health System, currently known as Advocate Care, in Chicago, IL. The faith community nursing specialty embodies whole-person health and wellness. The word "wholistic" care has been associated with the vision of Dr. Granger Westberg. See the glossary for clarification.
1989	Health Ministries Association (HMA), a non-profit membership organization, was established to provide communication and networking among FCNs. This initiative was supported by a grant from the Kellogg Foundation.
1990	HMA received a grant from the Kellogg Foundation through the Northwest Aging Association to establish staff and begin programming. HMA also received a grant from the Wheat Ridge Foundation to begin 70 health ministry programs in faith communities.
1991	HMA's First Annual Meeting and Conference was held in Chicago, IL. HMA continues to host an annual meeting including continuing education (CE) unit offerings for attendees.
1991	FCN education became formalized in 1991. The Wisconsin model was the first basic preparation CE course taught by Rosemarie Matheus, MSN, RN.
1991	PNRC developed a standardized curriculum for parish nurses, educators, and coordinators.
1991	The first Master of Science degree in Parish Nursing was started at Georgetown University in Washington, D.C., by Norma Small.
1997	Parish Nursing is recognized as a professional nursing specialty of the American Nurses Association (ANA).
1998	ANA accepted and published HMA's *Scope and Standards of Parish Nursing Practice*.
2001	PNRC renamed to International Parish Nurse Resource Center (IPNRC) after expansion to countries outside of the United States. The Westberg Symposium is offered annually for CE and networking opportunities to FCNs and others interested in spiritual care.
2001	From 2001–2009, Duke University offered a master's degree in health and nursing ministries.
2002	IPNRC moved to St. Louis, MO under the management of the Deaconess Foundation.
2002	The Wilkerson-Droege Award in honor of Sister June Wilkerson and Reverend Thomas Droege was first awarded.
2005	The title "parish nursing" in the *Scope and Standards of Practice* was changed to "faith community nursing" to be inclusive of nurses in all faith traditions.

2007	HMA began collaborating with the American Nurses Credentialing Center (ANCC) to develop board certification in faith community nursing.
2010	HMA's first National Summit was held. A white paper, *Now More Than Ever*, was published.
2011	IPNRC moved to Memphis, TN, under the management of the Church Health Center.
2012	The Westberg Faith Community Nursing Leadership Award was first presented.
2012	*Faith Community Nursing: Scope and Standards of Practice,* Second Edition was revised by the HMA and published by the ANA.
2013	Faith Community Nurses International (FCNI) was created as the international professional membership organization for FCNs. FCNI developed a peer-reviewed journal, *The International Journal of Faith Community Nursing (IJFCN).*
2014	The ANCC began offering certification by portfolio in faith community nursing.
2015	The HMA established the Faith Community Nursing Society. This society recognized nurses who achieved board certification by portfolio in faith community nursing. This society encourages FCNs to share their talents and skills in leadership positions to mentor new FCNs.
2016	IPNRC changed its name to Westberg Institute for Faith Community Nursing.
2017	The HMA joined the ANA as an organizational affiliate with voting privileges in the ANA's membership assembly. The ANA discontinued all board certifications by portfolio, including faith community nursing.
2020	The Westberg Institute moved to merge under the umbrella of the Spiritual Care Association of New York, NY.

Note: Historical milestones of faith community nursing in the United States are summarized in Appendix A.

There has been significant evolution and growth in faith community nursing while remaining grounded in evidence-based practice and whole-person care. "The 'how' of nursing is defined as the ways, processes, means, methods, and manner the registered nurse practices" (ANA, 2021, p. 32). Early literature identified seven responsibilities as the original "functions" or "roles" of the FCN (Hickman, 2005; Westberg & McNamara, 1990):

1. Integrator of faith and health
2. Personal health counselor
3. Health educator

4. Health advocate
5. Referral agent
6. Coordinator of volunteers
7. Developer of support groups

According to Smucker and Weinberg (2009), transitioning to the FCN role requires a shift from passively doing to being fully present. They also describe a model for Jewish congregational nursing. More recently, these traditional roles have been analyzed and attributes of FCNs continue to be collected in descriptive studies (Solari-Twadell & Ziebarth, 2020).

When implementing the nursing process, FCNs use a whole-person-centered approach in their dynamic process of assessment, diagnosis, identification of outcomes, planning, implementation, and evaluation. The FCN's practice is determined by the assets and needs of the faith community. Nurse-led programs within faith communities continue to grow and evolve. FCNs impact the health and wellness of individuals, families, communities, and populations. The common expectation across faith traditions is that the professional RN functioning as an FCN possesses a unique depth of understanding of the faith community's traditions, while remaining just as competent as an RN.

FOCUS ON SPIRITUAL CARE

Nurses have long observed that when illness or brokenness occurs, health care consumers often turn to their source of spiritual strength for support, healing, and hope. *Nursing: Scope and Standards of Practice,* Fourth Edition, reaffirms that spiritual care is integral in all nursing practice. The art of nursing focuses on compassionate care through balancing the body, mind, and spirit of the health care consumer (ANA, 2021, p. 5). In faith community nursing, the social dimension of the human being is also extremely important, and relationship-building fosters healing through connectedness with others and a higher power, regardless of faith tradition. The human experience is contextually and culturally defined, and the presence of illness does not preclude health (ANA, 2021, p. 5). One's culture and ethnicity can impact their health and may prevent social isolation. Honoring cultural traditions provides a sense of history, identity,

purpose, and meaning. The FCN believes that every person has a spiritual dimension that may be observed along a spectrum of religiosity or be based on spirituality alone.

In the 2021 revision of *The Essentials: Core Competencies for Professional Nursing Education*, the presence of spiritual care and spiritual assessment in nursing curriculum was expanded to ensure that the basic education programs prepared nurses to conduct spiritual assessments and provide spiritual care (American Association of Colleges of Nursing, 2021). The specialty practice of faith community nursing emphasizes the intentional care of the spirit as an essential domain requiring additional education and skill beyond the spiritual care provided in the general practice of an RN.

The FCN identifies a nursing diagnosis and plans interventions to address the identified health needs. Interventions always focus on spiritual care for individuals, families, communities, and populations. Diagnosis terminology is applied across the general nursing profession with standardized terminology, coming from organizations such as the North American Nursing Diagnosis Association-International.

A comprehensive list of nursing diagnoses exists, including diagnoses on spiritual, physical, and emotional health. Nursing diagnoses related to spirituality may include such topics as: spiritual distress, grieving and loss, spiritual well-being, and caregiver role strain. FCNs may use recognized classification systems for documentation of spiritual care. Some recognized nursing diagnosis classification systems include

- North American Nursing Diagnosis Association International,
- National Interventions Classification (NIC),
- National Outcomes Classification (NOC),
- The Omaha System, and
- Clinical Care Classification (CCC) System.

This evidence-based language validates the specialty and benchmarks faith community nursing practice against other nursing specialties. By using a nursing diagnosis classification system, FCNs are paving the way for standardized data collection. This approach empowers FCNs to build

on the unique body of knowledge necessary to define the specialty practice.

Once the FCN identifies a nursing diagnosis, intervention planning to address the identified health needs follows, with special focus on spiritual care. Examples of intervention classifications applicable to faith community nursing's focus on spiritual caregiving may include hope instillation, spiritual support, religious ritual enhancement, and spiritual growth. Whole-person care is not limited to only spiritual care; however, spiritual health affects all other domains and requires a balancing of the body, mind, and spirit while facilitating connectedness.

The FCN's interventions should be realistic and provide individualized, person-centered care, particularly in serious illness. For example, hope for a cure from an advancing disease may be replaced by hope for a pain-free day or quality time with loved ones. Treatment may or may not cure an affliction. However, it is still possible for a person to experience healing through care of the spirit even if a cure—physical restoration—does not occur. A person may be dying of cancer, but if a broken relationship between family members has been reconciled or the person is at peace with the circumstances, this may be considered healing. This broader viewpoint of healing is embraced by FCNs and makes the specialty of faith community nursing unique.

In addition to individualized person-centered care, the FCN cares for entire populations. FCNs treat the whole faith community as a health care consumer. Assessment and interventions focus on identifying the educational and supportive needs of the whole faith community.

Some health care consumers will require support for basic needs, so they have the time and space to reflect on spiritual issues. Basic needs such as nutritious food, clean air and water, clothing, shelter, access to health care, medications, and transportation, are the social determinants of health. Evidence demonstrates that these factors influence or even drive health outcomes, and they may be altered by interventions. For others, spiritual care will be the direct response. The form of spiritual care will depend on the beliefs and practices of the faith community; the goals of the faith community, group, or individual; the skills of the FCN; and collaboration with other staff members and volunteers.