Parish Nursing in Saskatoon:
Discerning the Present, Exploring the Future

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A study commissioned by Interchurch Health Ministries Saskatchewan to assist in their future planning process

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SCOPE OF THE PROJECT

I was contracted by ICHM-SK in the fall of 2020 to gather data on ICHM-SK and the work of parish nurses in Saskatoon and to help ICHM-SK use that data to make plans for its future.

I completed interviews with thirty-three people: eleven with parish nurses, four with parish nursing instructors, two with community health nurses, eight with parish nurse program administrators and eight with parish nursing clients. I also made email contact with government officials.

This kind of research is "qualitative," intended to produce "grounded theory." So it is not a comprehensive survey of the experience of all those in the positions I just described. However it is a large sample of those in the ICHM-SK network.

This report should not be taken as an assessment of any particular parish nurse's competencies, or those of parish nurses in Saskatoon as a whole. Nor does it intend to assess the extent to which parish nurses trained by or connected to ICHM are adhering to professional nursing standards of practice—for example those of the Saskatchewan Registered Nurse Association,[1] the Canadian Association of Parish Nurse Ministry (CAPNM),[2] the Canadian Nurses Association, or any other body. Assessment of that sort is obviously outside my area of expertise. So, in the section on "Parish Nurse Roles" for example, I am only describing what parish nurses and their clients say the parish nurses *actually did*, and the *impact* they had on clients and others.

In regard to ICHM's structure, focus and funding, my observations of what is happening may carry a little more assessment/recommendation weight, since I have a fairly extensive background in working with non-profits in education and community development. But even so, the stakeholders of ICHM should weigh what is said against their own experience. They will be the ones taking action (or not).

This report will be shared first with the ICHM-SK board, then with those who have been interviewed, and then—revised with any feedback from those groups and as determined by the ICHM-SK board—made available to all stakeholders and any interested parties.

The report will also serve as the basis of a planning exercise that will be carried out by ICHM-SK and its stakeholders to set directions for the future of parish nursing in Saskatchewan, perhaps with wider implications for Canada.

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[1] See https://www.srna.org/wp-content/uploads/2019/09/RN-Practice-Standards-2019.pdf

[2] See https://www.capnm.ca/about/standards/

PARISH NURSE ROLES

Parish nursing seems to bridge two worlds. On the one hand it is a type of community health nursing.[3] The national Canadian Nurses Association says: "Community health nurses support the health and well-being of individuals, families, groups, communities, populations and systems. They practise in health centres, homes, schools and other community-based settings."[4] On the other hand, parish nurses also stand in the long religious tradition of ministers (called "diaconal" in some traditions) that serve the physical and emotional needs of a community as an expression of the religious organization's mission and faith.

In this project I didn't assume that the roles of the parish nurses I heard described in the interviews would be identical to those listed on their websites by ICHM-SK[5], ICHM-Canada[6], or the Canadian Association for Parish Nursing Ministry (CAPNM),[7] or to the roles originally imagined by Granger Westberg when he began the movement[8], or to those set out more recently for "faith community nursing" by the American Nurses Association.[9] I simply listened to the stories of what parish nurses in Saskatoon are *actually doing*. Not surprisingly, however, there is considerable overlap in content if not always in role titles.

It is worth noting that parish nursing has a very broad range of potential roles because it bridges the two worlds of congregational ministry and community health and it can be practiced in a variety of faith-based institutions. So Bulechek, Dochterman, Butcher, & Wagner,

[3]Community Health Nurses of Canada (CHNC) lists parish nursing as one expression of community health nursing in their 2009 vision statement. See https://www.chnc.ca/en/membership/documents/loadDocument?id=535&download=1#upload/membership/document/2016-07/2009englishchndefinition-visionstatement.pdf.

[4] https://cna-aiic.ca/en/policy-advocacy/community-health-care.

[5] https://www.ichm-sk.ca/parish-nursing/roles/.

[6] http://www.ichm.ca/our-ministry/.

[7] https://www.capnm.ca/resources/parish-nurse-fact-sheet/.

[8] Robyn Dandridge lists Granger's roles in "Faith Community/Parish Nurse Literature: Exciting Interventions, Unclear Outcomes," *Journal of Christian Nursing*, Vol 31(2):100-107, p.102: "When the parish nurse role was envisioned by Granger Westberg, the model was based on seven proposed functions: Integrator of Faith and Health, Personal Health Counselor, Health Educator, Trainer of Volunteers, Developer of Support Groups, Referral Agent, and Health Advocate."

[9] See *Faith Community Nursing: Scope and Standards of Practice,* 2nd ed., American Nurses Association, 2012.

in their sixth edition of *Nursing Interventions Classifications* list 38 key roles or types of interventions used by "faith community" (parish) nurses[10] and these aren't exhaustive.

Here are the parish nursing roles I heard described in the interviews:

Advocate: Parish nurses are accepted as medical authorities by virtue of their training, but because they are also church ministry staff their authority has an *ethical* weight as well. Interviewees told how parish nurses stood up for patients in hospital who were being inappropriately pressured by a doctor. They stood up for elders who were being abused by adult children. And often they had to stand up to clients for their own well-being: "I'll get a phone call from a wife whose husband will not go to the doctor. That's the advantage of being a parish nurse. She has more authority, assessment skills, they can point things out and tell them what they see."

Trail Guide: Parish nurses not only know the health resources available in their region, and help clients identify those most appropriate for them, but they also "clear the path" to get them into the right place in a timely way. Just as importantly, parish nurses (unlike nurses in most other settings) have the freedom to *accompany* the client through the health care system over long periods of time. This is particularly important because Canada's medical system is bureaucratic, specialized and often daunting for even the most knowledgeable to navigate when they are sick. I heard many stories of parish nurses driving elderly patients to a doctor's appointment, helping a new Canadian interpret and remember a doctor's instructions, checking up afterward to make sure they were taking prescribed medication. "We have the freedom to walk with them through the system" one parish nurse said. A client said "the parish nurse even stayed with my family member overnight till she could be hospitalized." This accompaniment can last for years in some cases. Clients spoke about how much they appreciated this *continuity of care:* "She [parish nurse] never left me hanging." [After a covid-19 diagnosis] "she brought groceries, medication, made regular phone calls, but then she kept checking in even after we recovered." "Years after my [spouse's] death I still regard her as a friend."

Spiritual Care-giver: Parish nurses said they see themselves as "called by God," doing their work on behalf of God: "We are the hands and feet of Jesus"; "I was there for them as a listening ear for Jesus," "I want to bridge people to God." So they feel that part of their role is

[10]G. Bulechek, J. Dochterman, H. Butcher, & C. Wagner "Core interventions for nursing specialty areas: Faith community nursing" in *Nursing Interventions Classification* (*NIC)*, 6th ed. 2013, (Mosby Inc: St. Louis, MO), p. 429: "Table 2: Nursing Interventions Classification: Core Interventions for Faith Community Nursing: • Abuse Protection Support • Active Listening • Anticipatory Guidance • Caregiver Support • Coping Enhancement • Crisis Intervention • Culture Brokerage • Decision-Making Support • Emotional Support • Environmental Management: Community • Family Integrity Promotion • Family Support • Forgiveness Facilitation • Grief Work Facilitation • Guilt Work Facilitation • Health Care Information Exchange • Health Education • Health Literacy Enhancement • Health System Guidance • Hope Inspiration • Humor • Listening Visits • Medication Management • Presence • Referral • Religious Addiction Prevention • Religious Ritual Enhancement • Relocation Stress Reduction • Self-Care Assistance: IADL • Socialization Enhancement • Spiritual Growth Facilitation • Spiritual Support • Surveillance • Sustenance Support • Teaching: Group • Teaching: Individual • Telephone Consultation • Touch • Values Clarification."

to bring a sense of Divine Presence to their healing work. The spiritual care they provide tends to be simple but effective. They generally didn't try to frame a client's suffering in theological terms (leaving that to clergy) but as one put it "I always say a prayer, offer to bring Jesus along if they want. I incorporate what they've been talking about in the prayers." Some brought rosaries or holy water, others participated with clergy in rituals of healing at worship services or in visits to bring communion to the sick. Some shared comforting Bible verses and poems. Parish nurses tried to incorporate the cultural traditions of their clients—for example, including smudging for cleansing when working with indigenous people.

Web-builder—Most of the parish nurses wove a relational network of support around clients, especially those who worked with pastoral care committees or health cabinets. One said, "I connected her with a woman from another town whose child died of the same thing. Sometimes you just need to know you're not alone in this." "I'm a big fan of support groups—I help to start them." Parish nurses mobilized clients' family, friends and congregational members to help them with transportation, food, caring conversation and more. Clients interviewed expressed deep gratitude, feeling that the parish nurse represented a web of community care that they could count on.

Gap Minder: Like London Tube riders, parish nurses "mind the gap." One said: "I think one of the most important things we do is care for the isolated, those you don't see in the pews." Another, "we help to bridge the gap between hospital and home and the church community." A health cabinet member said "During the pandemic they spent a lot of time contacting shut-ins to make sure nobody was falling through the cracks." Parish Nurses helped to start programs where there was a support gap in the community—in stroke rehabilitation in one case, for example, or hospice relief for families of handicapped children in another. They assisted congregations in forming partnerships with community programs to provide housing for low income and homeless people in their neighbourhood.

Detective: Parish nurses are constantly making in-home assessments. More than a few of these were life-saving. For example several interviewees shared stories of patients who came home from surgery. In one case a spouse felt the patient wasn't doing well, but couldn't put their finger on anything specific. They wouldn't call 911 or 811, but did call the parish nurse. She came immediately, assessed the patient and saw they were in critical danger, then cleared the way to get the patient immediately re-admitted to hospital. Other times, parish nurses prevented unnecessary hospitalization by noticing habits or conditions in the home that were causing the health problem and enabling the client to make simple adjustments.

Educator: Interviewees told how they gave (or received) instruction on health practices in the home, one-on-one and with families: "They've taught us how to care for family members better." "The parish nurse has taken me on hospital visits and I've learned how to minister to people in ways that I might not otherwise." They also worked with parish health committees and volunteers to put on exercise programs, blood pressure clinics, and information sessions on miscarriage awareness, prostate health, alzheimers, teen sexuality, post-menopausal women's

health, good nutrition, physician-assisted death, the impact on families of a child's chronic illness, pandemic safety and many other health topics.

Ecumenist: Parish nurses are trained with people of other religious traditions and learn how to work with them. That collegial relationship continues after graduation as they network in parish nurse special interest groups provincially and nationally. Working on the boundaries between church and a very diverse community, they engage, and generally work well, with people of all kinds of religious—and no religion—backgrounds. This is not to say, however that clergy and denominational leaders unfamiliar with parish nursing are quite as comfortable with this ecumenism. There have been occasions when individuals or congregations have reacted to ICHM's openness to a variety of faiths and theological positions by withdrawing support or involvement from ICHM.

Coach/Counsellor: Parish nurses were particularly helpful during and after traumatic events. "When I was going through tough cancer treatments the parish nurse was there to coach me." Another said, "When my partner died she helped me to calm down, focus on what I needed to do." "When I got the diagnosis I didn't know what to do next. My mind was in chaos." Parish nurses provided a calming presence for people bereaved, or shocked by an accident or bad health news. They assisted clients to inventory their resources, figure out what to do, who to see or call, and in what order. Clients said it was a great relief. "She's a one-stop-shop!"

Trust-Bearer: Parish nurses are able to carry out these roles particularly well because they have the trust of both the medical community and the parish. A client said, "I trust her because she works at church and is very gentle, compassionate, but also because of her technical knowledge, she is very competent in her field." Parish nurses said they tried to provide a "*safe* place" to talk about difficult or embarrassing health issues. Clients said they were able to broach health matters with their parish nurse that they wouldn't have felt comfortable bringing up to anyone else, even their doctors in some cases. In the case of work with indigenous people this trust is particularly important. For many of them churches are ambiguous: reminders of residential school trauma but also in some cases places of healing. The regular contact with a parish nurse in congregational life, supported by indigenous leaders, makes it easier to trust the nurse to visit in their home and help them with their health concerns.

Several things should be noted about parish nursing roles in Saskatoon:

1. ***Parish nurses are carrying out these valuable roles for pay that is far beneath the level of their training, even compared to other similarly educated church professionals.*** Most indicated low rates of hourly pay, many hours of "volunteer" work, and in many cases did not even have basic ministry expenses (example parking) covered. This is undoubtedly the biggest challenge to the sustainability of parish nursing as an occupation, and the recruitment of younger nurses who might long for the wholistic ministry parish nursing offers, but can't live on the income. Some suggestions for addressing funding are included in the section "ICHM Structure, Focus and Funding."

2. ***There seems to be a great deal of variability among parish nurses.*** While almost all of the above roles seem to be represented in the ministry of every parish nurse I interviewed, or interviewed others about, the role *emphasis* varied considerably. At times, some parish nurses were almost social workers, willing to find any way to provide for struggling clients' basic needs—even for housing and finances—while others at times had a ministry approaching that of pastors, with a heavier focus on spiritual care, even worship leadership. Some variability is natural, given the personal gifts and preferences of each parish nurse. However congregations didn't always establish a clear *process* for linking the roles available to their parish nurse with the congregation's overall mission plans/programs—or to civil health initiatives in their neighbourhood. No doubt these links exist but they seem to be, in most cases, informal.

   Without such links there may be some danger that a parish nurse's ministry loses focus and impact. When a parish nurse's roles are intentionally incorporated into the employing institution's formal planning processes it is much easier to sort out which roles should be given priority at a particular time. Otherwise it is left to the parish nurse to choose based on her own preferences and the daily expression of needs by individuals or families. This spontaneous response to need is similar to acute care nursing. However, in the long run it may not address the deepest health needs of a congregation/community and ultimately have less lasting impact. It can also then be seen by congregations as a "sideline" to their central mission, not well understood, and easily cut from the budget in tough financial times.

3. ***There may be a need for greater support, oversight and review of parish nurses in their roles.*** Parish nurse ministry in Saskatoon settings is very confidential. While some parishes shared information about clients within the "umbrella" of confidentiality among the professional team in the parish (on a "need-to-know basis"), in other congregations client information was so confined to the parish nurse that the nurse's work was almost invisible to the parish and she had a great deal of autonomy. This suggests that parish nurses may not always have the kind of supervised support available to nurses in other settings.

   However without good review and feedback on their work parish nurses may suffer in several ways. First, most of the parish cannot see the wonderful work they do, so their ministry may be poorly understood and not well-supported financially. Secondly, the nurses may find themselves vulnerable to abuse by, or enmeshment with, very needy clients. Thirdly, there is no clear parish-sanctioned process for identifying the stressors on the parish nurse (example leadership team conflict) and strategizing for relief. Finally, regular supportive review helps parish nurses to identify very specifically the areas they want to focus on in professional development.

In those parishes that have active health cabinets some of this review and feedback is happening. And a couple of parishes are making use of congregational surveys to help them identify health care needs. However all of them might benefit from building more active structures of support and accountability that assist the parish nurse in reviewing on a regular basis how they are meeting accepted standards of professional practice for parish nurses, and how their own goals and struggles are affecting their work.

RECRUITMENT

Effective recruitment requires understanding the motives people have for entering parish nursing. These should be addressed in recruiting conversations, information sessions and marketing materials, in training courses and in on-going support of parish nurses.

Some of the motives for entering parish nursing expressed during interviews included:

- ***Desire to grow professionally, being able to offer a wider, more inclusive range of care.***
    - For some, physical acute care alone "wasn't as satisfying as when I started" – so parish nursing becomes an attractive option later in career.
    - "we get to pray and bring spirituality into the care"
    - "we can care for the whole family"

- ***Desire to connect a nurse's wider world with their faith community***
    - "though churches want you to just deal with their members (because they are paying you) I have always dealt with people in that grey or area outside the church.
    - "connecting to people who don't come to church is one of the things I like best about this.

- ***Desire for greater recognition in their faith community***. Parish nurses said they want their work to be seen as "a job, rather than volunteering." The challenge is that not many Christian denominations have a credentialled "place" for parish nurses, and therefore do not have the pay grids, pensions, and public recognition that such places provide.

- ***Desire for greater impact*** **in their nursing:** "I wanted to work where I could reach more people" – for example in a community setting rather than the more restricted setting of acute care.

- ***Change in work status creates opportunity for something new:*** "I was in transition"; "my hospital hours were going down."

- ***Reciprocity:*** One parish nurse says she sees herself giving back to the faith community she grew up in "giving back to the people that gave to me."

- ***Desire for time to tend to patients wholistically:*** "I worked on a surgical floor but there was just no time for that stuff. But on that ward I got affirmation from a fellow who went for surgery. There was nothing that could be done (he was palliative) but I spent time with him and his wife and got a thankyou note. So I knew I needed to be nursing in a situation where I could do that kind of care."

- ***Desire to share healing from personal trauma***: Some parish nurses felt that their own experiences of trauma and loss gave them an empathy for others in the same situation. "I don't shy away from grief, because of my own experience."

- ***Flexibility of hours and roles:*** "If you are a parish nurse rather than an RN you don't get the pay and benefits, but the parish nurses have flexibility and that's super rewarding."

Recruitment ideas that emerged in interviews:

- "I'm going to write a letter to the SRNA to say that RN's living their faith are already doing a lot of what parish nurses do—it's not a far stretch to get the rest of [the parish nurse] training and start doing it in your own community"
- talk to gatherings of RN's who are already interested or involved in community health nursing, or public health nursing.
- partner with the University of Saskatchewan to place nursing students in parishes under a parish nurse as preceptor for their clinical/field work and service learning, so that they get a taste of parish nursing and may be disposed to see it as a career goal from the start.
- parish nurses could be visibly introduced as "parish nurses" at nursing (eg. SRNA) events, as well as at regional church gatherings.
- parish nurses should be encouraged to share the story of their journey into parish nursing with other registered nurses, as they encounter them in hospital, home care, long-term care and other settings.

PARISH NURSE TRAINING

The Current State of Training Programs in Canada

Parish nurse training across Canada has declined sharply over the last few years. ICHM-SK has had no candidates in 2020-21. Taylor College and Seminary in Edmonton formally ended their parish nurse training program in March 2021. The program at McMaster in Hamilton concluded a few years ago. The group in the Maritimes didn't really get off the ground training-wise. ICHM-Canada in Toronto and Waterloo are no longer offering training. Only St Peter's in London ON still has a few active candidates. There appear to be a variety of issues:

- the costs of maintaining a formal education program—both for the student and the school;
- a lack of understanding of parish nursing on the part of potential employers, especially those from faith communities that have not had a history of extensive involvement in health care (which, according to organizers at Taylor, may have been a key actor in the demise of their program, since they serve an evangelical community that is less familiar with health ministries in the church than mainline denominations);
- a sense among younger nurses with families to support that the education will not result in a salary that can begin to meet their needs;
- the lack of core funding for the administration of the programs, especially personnel to promote parish nursing and recruit students.

ICHM-SK's Training History and Current Situation

In spite of these challenges, ICHM-SK appears to have done an exceptional job of training candidates at relatively low financial cost to ICHM-SK and students over the past two decades. And they have done so while offering one of the longest and most intense training programs in Canada.

But this has only been possible because of very large amounts of time given as volunteers (or sometimes with honoria-level payment) on the part of staff, educators and working parish nurses. It is a model that often seems to work in the early days of a movement when energy is high. But eventually the early adopters move on, and it is difficult to find replacements willing to make the same sacrifices for long-term program maintenance.

Therefore one of the aims of this ICHM-SK project has been to identify essential elements of parish nurse training, perhaps to find whether it can be better focused and pared down to what matters most while still meeting core competencies required for parish nursing.

Feedback on ICHM-SK Training, from Interviews

On the one hand, I didn't find a clear consensus among interviewees as to which courses were most useful for ministry in all areas of parish nursing. On the other hand, most parish nurses

did concede that their RN training and experience had been light on emotional-psychological care (though I think this has changed somewhat for most RN training programs in Canada in recent years).

They noted that acute care nursing leaves little time for listening to patients' anxieties, especially as the record-keeping tasks have increased to consume more of a nurse's time. In addition, moving from acute care to parish nursing (which is a subset of community health nursing in general) requires the nurse to take much more initiative to assess, refer, organize and educate than the candidates were used to. One said "In [my previous nursing work] tasks were 'fed' to me—but here I had to take initiative." Another said, "Parish nursing is a *relational* thing and there is not always a right way to do it—but in critical nursing there *is* a *right* way to do things or you're in trouble. With parish nursing there is fluidity, flexibility—there is time to give people your ear."

So moving from acute care, or other forms of institutional nursing to parish nursing was a major shift. One said "I had to learn that our job is to walk alongside people—not fix everything for them." Modules that dealt with handling grief and loss, conflict resolution, mental illness and other aspects of emotional/cognitive care were generally appreciated, as were courses in professional ethics.

Beyond that however, there was not a lot of agreement about which elements of the curriculum became most valuable in their post-training ministry. This seems to be due in part to the fact that they serve in quite different settings, with differing needs/demands. Some sites are single-parish, others multi-congregational (even multi-denominational). Some are small, others large, some urban, suburban or rural. The cultural settings vary enormously. In some cases parish nurses are given a fair amount of autonomy regarding the focus of their work, with little in the way of a formal job description. Others slot their parish nurses into historically defined roles.

In addition, the medical and religious background training of parish nurses varies considerably. Some were trained in different eras with different emphases on RN education. Some received their training in other provinces, in the U.S. or overseas, with differing emphasis on public health care or community health-style nursing.

Religious training was not uniform either. For example, Roman Catholic nurses said they had background in the use of healing rites and rosaries, while evangelical nurses had memorized Bible verses and were comfortable with spontaneous prayer and Lutheran nurses had more background in theological reflection on the meaning of illness. The spiritual competencies and gaps were not remotely uniform.

As a result, a particular course hosted by ICHM-SK (or other training program) may have felt redundant to one student but was often seen as essential to another.

The student practicum experience was much appreciated by parish nurses, especially when they were placed in a congregation that already had embraced health ministry as a core part of its congregational mission.

Some interviewees said that the 3-year length of the ICHM training program was quite intimidating for various personal and financial reasons and that many good potential recruits were turned away as a result.

Listening to the historical development of the ICHM curriculum it is possible that the curriculum may have become somewhat overloaded with courses ICHM wanted to be affiliated with the Parish Nurse Resource Centre in the U.S. and each affiliate had to agree that they would not leave anything out of the approved curriculum. But the American affiliates at that time were not doing congregational and community development—students were assigned from a Lutheran hospital. So the addition of Canadian-appropriate, congregation and community-focused courses on top of the required American ones up-sized the curriculum. Plus they had to keep up with any additions to the American curriculum.

At this point, being in step with the U.S. may not be as significant for ICHM as it once was. Moving forward then, it may be useful to reduce the course load and practicum length in the initial training by customizing it to fit each students' actual learning needs (based on an initial assessment).

Some Options for a Sustainable Training Program (if one assumes that the current model isn't sustainable):

Note regarding terminology: It is important to distinguish between *educational* and *professional* certification. Training schools provide a degree, or graduate certificate, which certifies that a student has completed a training regimen and achieved a certain set of "core competencies" or learning outcomes. Professional bodies certify that a member of their body is authorized/recognized to engage in a particular type of professional work as long as they adhere to a "standard of practice" which outlines boundaries and ongoing expectations of a professional in their work. An educational certificate is given once. Professional certification often must be renewed on a regular basis and is dependent upon the member continuing to adhere to the standard of practice.

A. KAIROS. **Key sources:** Greg Henson, KAIROS lead (Sioux Falls Seminary, Sioux Falls Iowa), and Heather Breitkreuz (Taylor Seminary, Edmonton AB). This model is somewhat similar to the classic UK model where the emphasis is not (as in North America) on students taking a course of instruction, but rather being able to demonstrate competence after accessing available learning opportunities.

1. Connect with the "KAIROS" network of seminaries (of which Taylor in Edmonton is part). In addition to the usual masters programs the consortium schools offer a "graduate

certificate" which can be customized for any discipline/focus.[11] Each student's training would be overseen by a three person "mentoring team" consisting of:

   a. A faculty mentor assigned by the school (usually in consultation with other schools to identify experts in the field).
   b. A vocational mentor chosen by the student. This is someone—such as a clergy person or parish nurse colleague—who works in the same local context as the student does/will.
   c. A personal mentor chosen by the student. This is someone who has a close relationship with the student and from whom they wish to learn.

2. After an initial assessment of the student's current level of skills (compared, for example, to the core competencies laid out by CAPNM[12], with a special focus on those most needed in the context/site in which they plan to serve), the student and mentoring team would create a customized set of learning experiences to fill in the gaps.
3. The learning experiences might include formal courses (online or in-person) in community health nursing, biblical theology, spiritual practices, grief and trauma care and/or developing training and education events in a parish. But the mentoring team might also design more informal learning activities (eg a project within a practicum/learning site).
4. Students would pay $300 tuition per month to their KAIROS school of registration until their mentoring team was satisfied that they had met the agreed standards. During this time they can take formal courses (for audit or credit) from any of the Kairos schools for no extra cost beyond the $300 per month. Or they could enroll in courses from any school (for extra cost) that met their learning needs.
5. The mentoring team would assess students' progress. When the team feels that the student has met the competency goals, the student would be given a set of tests (context-dependent, focused on the skills and knowledge most needed in their local sites) to assess their competence. If they passed, they would be issued a graduate certificate with a focus in parish nursing.
6. A professional nursing association (eg Community Health Nurses of Canada, provincial nurses associations such as the Saskatchewan Registered Nurses Association, or perhaps even the national Canadian Nurses Association) might be persuaded to recognize these graduate training certificates and provide professional certification for parish nurses who are willing to adopt their standard of practice.

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[11] See for example the Kairos Project guide on the Sioux Falls Seminary website, at https://sfseminary.edu/assets/users/general/KairosProject_Guide_01_11_2019.pdf.

[12] As noted earlier, besides CAPNM there are several North American bodies have identified core competencies for parish nurses, including ICHM-SK, ICHM Canada, the American Nurses Association and the Westberg Institute for Faith Community Nursing. Given the small size of Canada's training program it may be useful to adopt/adapt one set, such as CAPNM's, as the Canadian norm. That way, congregations can be confident that no matter where in Canada parish nurses are trained, they are all competent to do the work of a parish nurse.

B. *SASKATOON THEOLOGICAL UNION.* **Key sources:** Dr. Gordon Jenson (Lutheran Theological Seminary, Saskatoon) and Patricia King (U of S College of Nursing).

1. ICHM- SK hands the training process over to one of the following schools:
    a. The Saskatoon Theological Union (STU) as a whole.
    b. One of the STU schools: Emmanuel-St Chad, Anglican; Lutheran Theological Seminary, Lutheran; St Andrew's College, United Church; Horizon College and Seminary, Pentecostal/Evangelical (affiliate school).
    c. St Thomas More College (Roman Catholic) at the University of Saskatchewan.
    d. A specialized group comprised of representatives from some combination of the above. It would not be accredited and degree-granting, but would be able to grant a graduate certificate indicating that they have been trained for the core competencies required for parish nursing ministry.
2. The training body would complete a prior assessment of a parish nurse candidate's skills at the beginning of the program. They would then work to develop the student's skills toward the accepted list of "core competencies," but emphasizing those needed in the student's particular ministry site.
3. Students would pay a "program fee" to the training body and would audit courses available through the STU, the University of Saskatchewan, and other online sources that provide courses in parish nursing, community health nursing or spiritual/theological training.

C*. ICHM-SK*. Key sources: Dr. Gail Brimbecom (ICHM-Canada, Bowmanville ON) and Rev. Harold and Elaine Hesje (ICHM-SK, Saskatoon).

1. ICHM-SK develops its own "mentoring team(s)" who would oversee parish nurse candidates. Again, prior assessment would be done and training would be focused on "gap-filling" to develop core competencies. However ICHM-SK would not offer its own courses, but rather provide mentoring teams with a menu of courses useful for parish nurses which are offered online from other institutions (eg. the Westburg Institute in Faith Community Nursing, or St Peter's seminary in Ontario or other seminaries and nursing colleges). Mentoring teams would again be encouraged to develop their own learning activities/courses/projects based on the student's actual learning needs. They might draw from the ICHM-SK menu, or find their own courses, and/or design their own learning projects.
2. The mentoring team would assess the student's progress and would report completion to ICHM-SK, who would then offer the parish nurse educational certificate. As in the other models, professional certification would be provided by a provincial or federal nursing body.

3. Students would pay a program fee to ICHM-SK (perhaps $50-$100 month?) which would primarily cover the mentoring team member's costs/time. Fees for any courses they take from institutions would be above that (but could be taken as "audits" to reduce costs).

D. ST. PETER'S SEMINARY, LONDON ON. Key source: https://www.stpetersseminary.ca/Our-Programs/Parish-Nursing/21.

1. St Peter's offers a parish nurse training program that normally has both in-person and virtual components: a one-week in-person (virtual though for 2021) intensive at St Peter's in Parish Nursing Foundations, followed by a paper and a one-year practicum during which students would take two 5-day online courses from the Dayton Virtual Learning Community for Faith Formation in Dayton Ohio.
2. The two online courses would be "The Parish Nurse as Counsellor and Spiritual Companion" (https://vlcff.udayton.edu/courses/course_details.php?course=157) and "The Parish Nurse: Facilitating Wholistic Health Through the Lifespan" https://vlcff.udayton.edu/courses/course_details.php?course=160.
3. At present this is the only program in Canada with active candidates for parish nurse ministry. While it is briefer than ICHM-SK's current curriculum this program might serve as the basis for an first level educational certificate, followed by a second level after three or four years of ministry (see below). It wouldn't offer the same customization as the above options but would remove ICHM-SK's responsibility at least for the basic training. Again professional certification would be offered by federal or provincial professional nursing bodies.

Other Training Considerations

A. *BASIC AND SECOND-LEVEL CERTIFICATION?*

With any of the above options it might shorten the initial training period and encourage a parish nurse's professional development if there were two levels of training certificates for parish nurses. The first would focus only on the most basic skills required for parish nursing in the local context. However, ICHM-SK could offer a second level certificate to a parish nurse who has been in ministry for three or more years. This second level would focus on a specific need in the parish nurse's context (eg. gerontology, addictions, nurse-family partnerships with young single moms, etc) and/or the parish nurse's own professional development goals. Again, a mentoring team could help the nurse design the learning process to build the needed competency in the area of focus and determine when that competency had been achieved.

B. *ICHM-SK's ROLE*

In models A, B and D above, ICHM-SK might be involved in recruiting students, and/or recommending mentoring team members, but would not oversee the training program. Its

primary role could become one of promoting parish nurse ministry to potential candidates (eg in community health nursing circles), promoting congregational health ministries—which might become parish nursing sites, and working with CAPNM and the SRNA parish nursing special interest group to provide resources to assist active parish nurses in Saskatchewan.

C. FUNDING FOR PARISH NURSE STUDENTS

While ICHM-SK's program has been—compared to any other graduate training program—very affordable, it may be that the parish nurse training program will need to be more expensive financially, but less expensive time-wise, if it is to be sustainable and still attractive to candidates. If it is more expensive financially, however, additional resources will need to be identified for scholarships and bursaries. Some of these may be available through religious/denominational foundations, for example:

- The Anglican Foundation of Canada-- https://www.anglicanfoundation.org/bursaries-awarded-for-theological-studies/
- Presbyterian Bursaries—see list at https://presbyterian.ca/wp-content/uploads/Bursaries-for-candidates-for-ministry-and-doctoral-students-2018.pdf. Some of these may be applicable to non-Presbyterian students
- The United Church of Canada Foundation (eg. the Ann Jentzsch-Bill endowment-- https://unitedchurchfoundation.ca/wp-content/uploads/2018-Jentzsch-Application.pdf
- The Evangelical Lutheran Church in Canada "Women of Faith Fund" -- https://elcic.ca/Womens-Desk/FaithFund.cfm

Other bursaries/scholarships are provided through the schools in which parish nurse candidates may be registered. In addition, bursaries are available through provincial nursing bodies for continuing education. CAPNM lists some of these at https://www.capnm.ca/education/financial-assistance/. ICHM-SK could perhaps help parish nurse candidates to find new sources of funding for their studies.

FUNDING PARISH NURSE POSITIONS

It was clear from the interviews that parish nursing may not be sustainable over the long-term if funded solely by congregations since it requires adding additional staff beyond a pastor. And it may never be available to smaller churches (especially rural who at best often have part-time pastors) for that reason.

Below are a few of the arguments that could be made for funding support by the provincial government (perhaps federal in the case of indigenous ministries). Patricia King, University of Saskatchewan nursing instructor, an active Catholic, and on the board of Community Health Nurses of Canada (CHNC), suggested the best way of making this case to the federal and provincial governments may be to have CHNC and the Canadian Association for Parish Nurse Ministry (CAPNM) jointly present the ministers with narrative stories of how parish nurses have saved the acute care system money by their unique opportunity to be regularly in people's homes, intervening at the "ground level" to prevent serious illness and injury. Unfortunately, at the present even community health nurse positions are not well-funded. But that needs to change.

The demand for ***non***-acute, *community-based* health care in Canada is rising for several reasons:

1. Canada's population is aging. A Sept 2020 Conference Board of Canada paper "Health Care Cost Drivers in Canada" says that "On its own, the aging of Canada's population is projected to add nearly 1.1 per cent per year to health care costs between 2019-20 and 2030-31." Many of the conditions associated with old age are chronic and better (and more cheaply) treated by community-based health than our acute care system.[13]

2. We are just coming out of a pandemic in which perhaps two million or more Canadians will have contracted the disease, and more than 25,000 will have died. Studies are showing that about a third of those who recover have persistent symptoms, becoming covid "long-haulers" suffering from fatigue, cognitive impairment (or "brain fog"), difficulty breathing, headaches, difficulty exercising, depression, sleep problems and loss of the sense of taste or smell. Some also develop new symptoms such as hair loss, rapid heart rates, or anxiety. Then of course, there is the mental/emotional damage suffered by those grieving the many who died in 2020-21 (not just from covid) without family present and normal funeral rites, and the wider population struggling with the impacts of a year and a half of isolation. Mental illness and addiction rates are rising sharply,

[13] Frank T. Denton and Byron G. Spencer, "Chronic Health Conditions: Changing Prevalence in an Aging Population and Some Implications for the Delivery of Health Care Services," *Canadian Journal on Aging / La Revue Canadienne Du Vieillissement* 29, no. 01 (2010): Abstract summary, doi:10.1017/s0714980809990390.

along with associated deaths. All of these are best treated by increased support of community services, even if that means shifting funding from acute care.

3. There is evidence that even though patients are being released from acute care hospitals earlier, acute care expenses are still rising in Canada. Yet the number of dollars invested in community support services for those patients who are being released earlier, and for those with chronic conditions, has not increased or even declined. This is creating a vicious circle where patients released without adequate community support have to be re-admitted, increasing acute care costs, thereby pressuring hospitals to release even earlier.

4. Parish-medical partnerships have a long history of success in Saskatchewan and around the world. For more than a thousand years, religious groups have been instrumental in establishing hospitals, clinics, long-term care homes and other forms of medical intervention. Most of their founding stories are related to healing. Christians of every stripe, Muslims, Jews, Chinese Buddhists, Indian Hindus have centuries of practice in working with governments and businesses to bring health care to their people.[14] And there is a substantial body of evidence that involvement with a religious community decreases morbidity, mortality and disability in population-wide studies[15] (consistent with other studies on the social determinants of population health[16]). Perhaps in light of the emergent need for better community health practices, it is time to strengthen and rebuild those partnerships.

Clearly then, there is a valuable role for parish nurses to play as agents of preventative health, in-home intervention, and health education in Canada's aging, pandemic- society. To this point they have cost the national health care system virtually nothing in terms of salary and benefits, since these have been paid by churches. Yet they have saved the system a great deal by providing care in the community and preventing unnecessary hospital admissions or re-admissions.

Unfortunately, this arrangement has not turned out to be sustainable. Church membership and income is dropping across the country and fewer can afford the costs of parish nurses without help. And what they can afford is not enough to attract younger nurses, who often have families to support. So the number of parish nurses in Canada is declining and the average age is increasing. Parish nurses could be part of the community solution to a long-term sustainable

[14] See Jeff Levin's excellent review in "Partnerships between the faith-based and medical sectors: Implications for preventive medicine and public health," in *Preventive Medicine Reports*, Vol 4 (Dec 2016), pp. 344-350, https://doi.org/10.1016/j.pmedr.2016.07.009.

[15] Koenig H.G., King D.E., Carson V.B., *Handbook of Religion and Health* (second ed), Oxford University Press, New York (2012).

[16] See E.L. Idler (Ed.), *Religion as a Social Determinant of Public Health*, Oxford University Press, New York (2014).

health care system in Canada, but that will only happen if there is some form of funding partnership between governments and charitable non-profits such as churches.

Medical historian Mark Honigsbaum asks the hard post-pandemic question: "The real question, politically, is will we invest more in public health so that we never again have to fear there won't be enough beds in ICUs to cope with all the sick people? Will we invest more in health and social care so that elderly people aren't left exposed in privatized care homes, far from clinical help?" [17]

FUNDING OPTIONS FOR PARISH NURSE POSITIONS: Pursue govt-church (public-private) partnerships through CHNC and CAPNM. If government funding is dependent on parish nurse ministry not being restricted to a single religious denomination several options could be explored, for example:

1) Have 2-6 churches of different denominations in a neighborhood or rural community share 1-3 parish nurses, who would also have a public profile and ministry to non-parish members in the neighborhood;

2) Identify, from parish nurse records, the percentage of time the nurse spends in physical-social care as opposed to spiritual care and religious rites. Have the parish(es) fund the spiritual portion and the government fund the physical/social.

3) Have parish nurses work under the aegis of a charity (example Catholic Family Services) that already receives government funding (either as grants or as core funding).

4) Have the parish nurses in a region form a charitable, non-denominational, not-for-profit corporation that provides services to "member" (i.e. substantially contributing) congregations, with support from government for wider community outreach.

5) Ask denominational judicatories (regional offices of religious groups) to consider funding a "circuit-riding" parish nurse who would serve rural communities out of offices in their local churches with government help.

[17] Mark Honigsbaum, *The Pandemic Century — A History of Contagion from the Spanish Flu to COVID-19,* Penguin Random House, UK (2020).

ICHM-SK STRUCTURE, FOCUS, FUNDING AND LEADERSHIP

STRUCTURE

To this point ICHM has been structured primarily as a volunteer-run organization. It is quite remarkable that it has operated essentially without paid staff considering its substantive responsibilities in curriculum development and delivery, practicum oversight, professional development of parish nurses, new congregational site development, fund-raising, marketing and recruitment. But to do that ICHM-SK has needed its parish nurses and health cabinet members to volunteer on ICHM committees in addition to their congregational work (which itself is often poorly paid or volunteer).

At the same time, parish nurses participate in a number of other organizations: 1) their provincial registered nurses association; 2) their provincial parish nurses special interest group; 3) the Canadian Association for Parish Nurse Ministry; 4) their own denomination's roster of paid ministers; 5) their local congregation's health board and other committees; 6) the staff of the congregation they serve, 7) community/city health initiatives. Add to these, connections to related nursing organizations (eg. Community Health Nurses of Canada—which could be a fruitful connection for recruiting) and it is easy to see where a parish nurse's energy and attention to outside connections can become fragmented.

The parish nurses of Saskatoon have been remarkably generous with their volunteer time. However I have watched similar volunteer-run non-profits burn out from "networking fatigue." It often happens at the beginning of a movement. A variety of groups will pop up to address a societal need. As they do so, they begin to form productive connections with each other. But sometimes these multiply until organizations get overwhelmed. So then they start to isolate from each other to conserve enough energy to carry out their primary mission. But the isolation then results in a great deal of redundant "re-inventing the wheel." And funders—corporate, foundation, government—may become confused as to which group they should support and withdraw altogether. It can lead to the early demise of a movement.

The fact that of six parish nurse training locations in Canada (Toronto, Waterloo, London, Hamilton, Saskatoon and Edmonton) only one (St Peter's, London ON) is still active, may in part be a reflection of this phenomenon. Of course, as mentioned in other sections, core funding for the training and oversight organizations, lack of funding for parish nurse salaries, churches' failure to fully recognize parish nursing as a core ministry, and other factors have contributed as well (see sections on "Funding Parish Nurse Positions," "Parish Nurse Roles," and "Recruitment").

FOCUS

ICHM might be more effective in the long run, and more financially sustainable, if it reduces/rationalizes its functions:

1. Training responsibilities could be reduced or eliminated. With a vast number of theological/biblical studies, parish nursing, and community health nursing courses accessible on-line (see Appendix "Training Resources") it should be possible for parish nurse candidates to get the graduate training they need from several institutions, with simple coordination and a graduation certificate being provided by a school/consortium (see options in "Parish Nurse Training" section). If ICHM-SK wants to keep its oar in training, a reduced role (as described in "Parish Nurse Training") could be considered.
2. Parish nurse professional certification, mutual support and professional development could be provided by a strengthened version of the SRNA parish nursing special interest group, CAPNM, Community Health Nurses of Canada, and/or the Canadian Nurses Association.

This would allow ICHM to focus on three elements that, in my assessment, are even more key to the long-term sustainability of parish nursing in Canada than training structures:

1. ***Building congregational interest in health ministri****es*. Hearing from clergy and health cabinet members, it seems that parishes which continuously hire parish nurses are those that have a heavy "buy-in" to health ministry as such. This was one of the founding principles of ICHM—that health ministry belongs to congregations *as a whole*, to *caring communities*. It is not just the ministry of a single professional. American studies of sustainability in parish nursing point to "the inclusion of the concept of 'health' as part of the mission and vision of the faith community"[18] as a vital element in the long-term viability of a parish nurse ministry. Stories of the early years of parish nursing in Saskatoon suggest that congregational buy-in to health ministry requires strong support and nurturing from clergy. And clergy tend to take their cues (more or less depending on denomination) from regional judicatories. So ICHM may find it fruitful to, for example, approach Saskatchewan Roman Catholic Bishops in company with a Roman Catholic parish nurse and supportive priest to talk about ways in which the diocese could promote health ministries in its parishes.

2. ***Catalyzing our governments and some key foundations to provide long-term core funding for parish nursing positions***, as a legitimate and critically valuable expression of community health nursing. For suggestions, see section "Funding Parish Nurse Positions."

[18] P. Ann Solari-Twadell and Deborah Jean Ziebarth, "Long-term Sustainability of Faith Community Nursing Programs," in *Faith Community Nursing: An International Specialty Practice Changing the Understanding of Health,* Springer (2020): 275-286, p.282.

3. ***Recruiting parish nurse candidates.*** Recruitment is heavily dependent on the two above. There is good indication from my interviews of leaders in the community health field that parish nursing would be quite attractive to many nurses who have strong roots in a religious tradition (see section "Recruitment"), but they need to see a way forward that is efficient and affordable on the training side (see section on "Parish Nurse Training") and is decently paid on the employment side. Nurses who are early in their careers want to know that the extra education required to become a parish nurse will lead to positions in congregations that are well-recognized, with salaries that are sufficient to support their families and pay off student loans.

ICHM-SK FUNDING

As far as funding the operations of ICHM itself, it may be that a more focused and scaled-down ICHM could attract foundation grants to work on building clergy, judicatory and congregational interest in health ministry (eg. the "Seeds of Hope" grant provided by the United Church Foundation). Post-pandemic there is a great opportunity make an appeal to foundations based on the value of preventive and community health. The whole emphasis in 2020-21 seemed to be on keeping people healthy so they didn't overstress the acute care system. So foundations that fund grants for health care are likely to be amenable to the sort of application that ICHM would submit.

Another funding option would be to choose a "focus" element (such as one of the above, or another such as "fostering mental health through church health ministries") and use it as a means for developing a pilot project for congregations. Pilot projects (which have lots of spin-off or multiplication potential) are often attractive to funders, even govt funding. According to my interviewees, Manitoba has seen a number of non-profit health-related organizations get picked up by government funding (much like The Open Door Society has done in Saskatoon in its work with new immigrants).

LEADERSHIP

These kind of changes however will require significant time and energy on the part of ICHM-SK leadership at a time when its founders and many of its parish nurses are retiring. ICHM-SK faces something of a chicken and egg problem: it needs active, paid, committed leadership to secure grants needed for re-organization and new initiatives (since not many granting agencies will provide substantial, core funding if an organization doesn't have paid leadership who they can hold accountable for proper use of the funds). But ICHM may not be able to acquire paid leadership without getting a grant.

OPTIONS FOR ICHM-SK TO MOVE FORWARD

1. Slim down, or hand off, training of parish nurses (see options in the section on "Parish Nurse Training."

2. Encourage and assist the SRNA parish nursing special interest group to build a more intentional structure for supporting Saskatchewan parish nurses.
3. Work with ICHM-Canada, CAPNM (and perhaps Community Health Nurses of Canada) to get a grant that would provide some core funding for re-imagining and re-invigorating parish nurse ministry in Canada.
4. Use that grant to hire a Canadian co-ordinator, and pay for the costs of drawing key leaders together from AB, SK, ON and other provinces together (on zoom) to collaborate on an approach to parish nursing in Canada that:
    a. promotes parish-based health ministry to congregations and government bodies;
    b. makes parish nurse training efficient, contextually appropriate and affordable;
    c. recruits and supports parish nurses on a steady, sustainable basis.

APPENDIX: ONLINE COURSES IN COMMUNITY HEALTH NURSING AND PARISH NURSING

This is a sample of online and intensive courses related to community health that could plug into a custom curriculum for parish nurse training based on individual candidate's learning needs:

Note: this list does not include the vast number of online courses in theology, spiritual care, biblical studies etc offered by seminaries across the world.

Athabasca University NURS 434 "Community Health Promotion". Delivery mode is individualized study online with e-textbook. Asynchronous at student's own pace (within the course contract period). https://www.athabascau.ca/syllabi/nurs/nurs434.php

University of Lethbridge courses in nursing: eg. Nursing 3020 – Community Health Nursing, or 3021 "Community and Population Health" or Nursing 4520 "Community Health Nursing Practice", Nursing 2268 "Disruptions in Health 1" Nursing 2421 "Health of Families", Nursing 3125 "Mental Health Nursing", etc (large selection).

Taylor Seminary (E.P Wahl Center)—Parish Nursing Institute – 8 days on-campus. Also, through their arrangement with 3 or 4 other seminaries (the "Kairos Project") students can take on-line/distance courses, working with a mentoring team.

St Peter's Seminary (Roman Catholic) in Waterloo ON—has a summer residency (July 4-10, 2021)- 8 days, covering:

- Scriptural foundations of whole-person health care
- History of Christian healing
- Understanding spiritual nursing practice
- Roles of the parish nurse
- Professional practice and legal issues
- Values and ethics in health decisions
- Working in a ministry team
- Prayer, devotions and worship leadership
- Theological reflection
- Establishing a parish nursing ministry

University of Dayton Ohio (https://vlc.udayton.edu) offers 2 online courses each year in parish nursing (can be taken during practicum): The courses are 5 weeks long. . Students affiliated with St Peter's pay $50 a course, those not affiliated with St Peters (eg. ICHM-SK) pay $105 plus a one-time $25 affiliation fee. The 2021 courses were*:*

1) ***Parish Nursing: Facilitating Wholistic Health Through the Lifespan*** Five Week Course Consists of the following topics: Session One: Wholistic Health of Children, Adolescents, and Young Adults; Session Two: Wholistic Health of Middle and Older Adults; Session Three: Caring for Families in the Faith Community; Session Four: Impact and Management of Chronic Illness on Families; Session Five: End of Life Transitions

2) The Parish Nurse as Counsellor and Spiritual Companion Five Week Course consists of the following topics: Session One: Pastoral Care / Spiritual Care Giving; Session Two: Counselling in Parish Nurse Ministry; Session Three: Wholistic Health Promotion: The Parish Nurse as Facilitator of Wellness; Session Four: Mental Health and the Parish Nurse; Session Five: Grief, Loss and Suffering

LUTHERAN THEOLOGICAL SEMINARY, SASKATOON

5 Courses in their "Master of Theological Studies in Health Care and Parish Nursing":

- Faith & Community Health Issues,
- Health and Healing in the Bible,
- Health Practice in Faith Communities,
- Health Promotion within Faith Communities
- Moral Problems in Medicine

WESTBERG INSTITUTE FOR FAITH COMMUNITY NURSING –ONLINE WEBINARS – ESP USEFUL FOR THE ICHM PARISH NURSING COORDINATOR (RON)

Module 1: Introduction to the Leadership and Coordination Series

This module introduces the participant to the specific roles of the professional as a leader of faith community nurses and/or health ministers. The material addresses the expectations of the coordinator as the supervisor, supporter and sustainer of faith community nurse programs, whether as a network, a segment of a larger institution, or a leader of health ministers in a large faith community. It incorporates information for the coordinator on leadership skills, professional expectations, and staff support strategies.

Module 2: Spiritual Leadership

This module assists the participant to distinguish multiple aspects of providing spiritual care to nurses practicing in diverse settings and faith traditions with the goal of promoting holistic health for faith community nurses as caregivers. Cultural competency, partnering with chaplains, clergy, other spiritual care providers and spiritual care organizations, along with spiritual assessment as part of the coordinators role to provide Intentional care of the spirit for faith community nurses is included.

Module 3: Marketing and Promoting FCN Practice

This module assists the participant to select opportunities to promote FCN practice from a wide range of options applicable to both institutional and independent practice. Development of concise descriptions of practice, telling the story, and the use of social media and other options for coordinators working with public relations, marketing departments or independently is included. Emphasis is placed on promoting faith community nursing practice and recruiting registered nurses into the specialty practice.

Module 4: Human Resource Management

This module assists the participant to follow best-practice standards related to aspects of human resource management for both paid and unpaid positions. Guidelines, standards and requirements of state nurse practice acts, Scope & Standards of practice, Nursing code of ethics or the international equivalent along with suggested policy and procedures are discussed. Emphasis is placed on orientation including boundaries and self-care strategies, communication including giving and receiving feedback, and conflict management from a servant leadership perspective. Documentation and recordkeeping is included as appropriate throughout the series with supplemental resources, guidelines and activities in Westberg's Knowledge Sharing Platform online files.

Module 5: Growing and Sustaining the FCN Practice

This module assists the participant to further develop health ministry mission and vision at the coordinator level. Included is network development and sustainability strategies, choosing and establishing partnerships locally, nationally, and internationally, developing budgets and long-term plans including succession planning. Emphasis is placed on coordinator professional development, self-care, organizing live and technology-based meetings and retreats, guidelines for assisting FCNs to develop and grow and suggestions for overcoming challenges of time and organizational changes. Online resources include but are not limited to tools for quality assurance, outcome measurement, data collection, planning and program support.

Module 6: Relationships: Faith, Culture, and Geography

This interactive module explores the heart of faith community nursing practice by encouraging the participant to focus first inward at personal beliefs and viewpoints and then to consider aspects of culturally competent care, diverse faith traditions, cultures and tradition, faith community nursing practice and holistic health from a worldview. Also included is a look at hierarchal structure of religions and denominations in general and suggestions for supporting faith community nurses who are working across borders and with at-risk populations including refugees and the displaced.

Module 7: Functioning as an FCN Coordinator in Leadership and Management Roles

This module assists the participant to compare various aspects of the role of a leader/manager/supervisor/coordinator related to faith community nursing practice. Included are assessment activities to discern management types and leadership preferences. Emphasis is placed on servant leadership development and competency in secular and sacred faith community nurse health ministry settings.

Module 8: Documentation

This interactive webinar focuses on the multiple aspects of documentation for FCN coordinators in both sacred and secular settings. Along with access to various templates, forms, and examples, this webinar discusses the documentation responsibilities of a FCN coordinator, various elements of documentation systems, methods for using quality improvement tools, and methods for utilizing documentation outcomes for reports, funding and sustainability.

UNIVERSITY OF ALBERTA FACULTY OF NURSING

Joanne Olson has taught INT D577 "Spiritual Assessment in the Promotion of Health"

As an element of whole person health assessment, spiritual assessment is of interest to a broad spectrum of health as well as ministry professionals. Emphasis is placed on consideration of theories and skills needed for the practice of spiritual assessment. The course provides a context for interdisciplinary reflection on understandings of the human person, health, health promotion, spirituality, spiritual needs, and spiritual care. Students are invited to explore their own spirituality and various approaches to assessing the spiritual based on a variety of definitions and understandings of spirituality. Specific models and tools for spiritual assessment will be considered, two will be looked at in depth, and students will have opportunities to bring theory as well as experience together in both group and individual exercises of spiritual assessment rooted in their ministry/health practice.

MACEWAN UNIVERSITY, EDMONTON

Online course: Community Health, NURS 0165

This course contains three units that build on previously presented concepts within the Fundamentals of Nursing course. Unit 1 introduces the concepts of community health, including definitions of public health, global health, primary health care, and community health nursing. Unit 2 highlights community health nursing practice beginning with determinants of health and a description of the population health approaches, followed by health indicators and strategies for improving the health of various populations. Unit 3 focuses on specific aspects of community nursing. This unit highlights some crucial areas of practice, including the theoretical base for family nursing, communicable disease control, diverse populations, First Nations, Inuit, and Métis health, substance abuse, family violence, mental health, and the nursing skills required for home care nursing. Hours: 15 Prerequisites:NURS 0166 or RN, RPN, LPN, or consent of the program. $140.
https://www.macewan.ca/wcm/SchoolsFaculties/CentreforProfessionalNursingEducation/Courses/NURS0165

WESTBERG INSTSITUTE FOR FAITH COMMUNITY NURSING: has agreements with a number of universities to offer 2 online courses in faith community nursing: Egs:

Foundations in Faith Community Nursing – is offered by Eastern Mennonite University in Lancaster Virginia; Northside Hospital Gwinnett in Lawrenceville, Georgia; St Anthony College of Nursing in Rockford Illinois; etc etc, (see
https://westberginstitute.org/calendar-month-view/?tribe_event_display=list&tribe-

bar-date=2021-02-16) , with varying costs and time involvement (some have zoom sessions at the beginning and end, with asynchronous online work in the middle, over a semester-length period).

Transitional Care for Faith Community Nurses (designed to provide the faith community nurse with background knowledge on the needs of community members who are in the process of transitioning in care. This might include from the hospital to home, from the hospital to the nursing home, from the hospital to home with hospice and many other transitional times. The course uses the national Transitional Care Training Program through the Westberg Institute**.)** Offered through the West Virginia University School of Nursing.

LAKEHEAD UNIVERSITY THUNDER BAY ON: Courses from their Master of Public Health with Specialization in Nursing. Eg of courses offered online: HESC 5210 "Health Promotion and Illness Prevention"; HESC 5013 "Social and Ecological Determinants of Health"; HESC 5010 "Foundations of Public and Population Health"; HESC 5070 "Epidemiology I";

NIPISSING UNIVERSITY, NORTH BAY ON (E-campus Ontario) NSGD 3007: "Community Health Nursing" online asynchronous. "This course studies communities and populations, with a focus on identifying and assessing populations at risk, and intervention at the primary care level. Theories of nursing, community health, and the role of the community health nurse will be explored." NURS 209: "Gerontological Nursing"; PAL 110 "Orientation to Palliative Care" (This course will provide an overview of Palliative Care and coping with death, dying and grief. The focus is to provide you with a review of the concepts of Palliative Care, the multidiscipline team, hospice, current approaches to care, roles issues and expectation. Identify what resources are available and discuss home care vs. institutional care.")

QUEEN'S UNIVERSITY KINGSTON ON: NURS 325: "Psychiatric Mental Health Nursing" "This course is about critical psychosocial and mental health issues that impact individuals, families, and groups in Canadian society. The nursing care of clients with mental illnesses, including mood and thought disorders, addictions, and significant mental health challenges across the lifespan are addressed. Advanced communication processes, nursing strategies, and therapeutic processes used in working with clients with complex psychosocial issues, such as suicide, family violence, aggression, end-of- life decisions and abuse, are explored. This theory course addresses critical psychosocial and mental health issues that impact on the health of individuals, families, and groups in Canadian society. Topics include nursing care of clients with major mental illnesses including mood and thought disorders, and addictions, and significant mental health challenges related to children, adolescents and the older adult. Addresses therapeutic processes used in working with clients with complex psychosocial issues such as suicide, family violence, aggression, end-of-life decisions and abuse. Advanced communication processes and strategies used by nurses are a major focus of the course"

E-CAMPUS ONTARIO: Has a number of fully online courses in areas related to nursing, from dozens of colleges in Ontario. Courses in mental health nursing, community nursing, gerontological nursing, grief/trauma/end of life, spirituality (eg. at Queen's AGHE 812: "Religion, Spiritual Health and Aging"), nursing ethics, ethical and spiritual concerns in palliative care (eg. Fleming College-HLTH 329 or Confederation College OL 476).

Other Training Resources:

For the Practicum**:** *Guidelines for Quality Community Health Nursing Clinical Placements* https://casn.ca/wp-content/uploads/2014/12/CPGuidelinesFinalMarch.pdf.