Cultivating the Soul: A Model of Presence

by

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ABSTRACT

This grounded theory study answers the question "How do parish nurses (PNs) develop their spiritual nursing practice over time?" After research ethics board review, six PNs were interviewed. Data were coded and analyzed until all data fit. An emerging Basic Social Psychological Process (BSPP) called *Cultivating the soul to become a channel of God one moment in time* explains how PNs use a four-step iterative process to achieve six stages of presence. These include finding favourable environments, trusting in God, deciding to act, and taking a leap of faith. Stages include foundation of God-related beliefs and values, presence with self, presence with God, presence with others, presence with God and others, and channel of God. Memoing and establishing rigor criteria were applied throughout the analysis. Implications include developing spiritual care competencies for education curriculum, client–centered care, and regulation of nurses. **Key words**: Parish nurse, Spiritual care, Presence, Grounded theory.

DEDICATION

I dedicate this work to the glory of God and to all nurses who wish to enhance their spiritual nursing practice. May this work enlighten nurses and bring healing and spiritual well-being to all them that cross their paths.

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I acknowledge God Almighty, our heavenly Father, Creator and Preserver of all things and my Lord and Savior Jesus Christ who have provided me with the grace, guidance, wisdom, and strength to accomplish the work herein. I also acknowledge my husband, Anthony, and our children Jedidiah and Emanuel for their dedication, understanding and support. I am grateful to all my professors, supervisors, mentors and spiritual advisors who have taught me to value patience and perseverance. I acknowledge, with heartfelt gratitude, the six parish nurse participants who consented and entrusted me with their authentic experiences as this study and subsequent findings would not have been possible without their great generosity.

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Introduction of the Area of Interest

Several reasons bring me to study parish nursing, notwithstanding my personal knowledge, experience, and general interest in the subject. These include the phenomena of globalization, spirituality religiosity and health, holistic nursing, nursing workforce, nursing self-regulation, and the origin and history of parish nursing as foundational to the nursing profession.

Globalization

As we experience an increase in the globalization of religious conflict and the subsequent displacement and immigration of large populations, the faith-based plurality of the Canadian population will also increase (Reimer-Kirkham, 2014). Reimer-Kirkham et al. (2012) report that during personal trials and community tragedies, people tend to turn to their faith for strength and healing. For example, it is now recognized that global climate change is negatively affecting the health of vast populations especially the poor (Falk-Rafael, 2006; World Health Organization, 2014). Renowned scientists are sounding the alarm that the planet's ecology is in imminent danger, saying it can no longer sustain life as we know it for much longer (McKibbon, 2013). The public has often turned to nurses during such tragedies as nurses have a "duty to provide care during natural or human-made disasters" (Canadian Nurses Association, 2008, p. 9) and strive to adapt their practice to care for their clients' needs. I believe nurses can become better equipped to help meet the basic spiritual needs of people as we continue to face more and more large scale global challenges.

Spirituality, Religiosity and Health

It is commonly accepted that spirituality and religiosity have associated ties with health. While spirituality and religiosity are similar, according to Bjarnason (2007) religion is widely considered a "subset of spiritual phenomenon" (p.352). In a concept analysis conducted by Bjarnason (2007), religiosity had three key attributes including religious affiliation, activities, and beliefs, all of which had personal and public expressions. According to a scoping review conducted by Austin, MacDonald and MacLeod (2018), "spirituality is defined as a set of inner experiences and feelings through which a person inwardly seeks meaning and purpose as well as relationships to self, family, others, society, nature and the significant or sacred" (p.1-2). Brown (2010), also offers a definition,

> spirituality is recognizing and celebrating that we are all inextricably connected to each other by a power greater than all of us, and that our connection to that power and to one another is grounded in love and compassion. Practicing spirituality brings a sense of perspective, meaning and purpose to our lives (p. 145)

Mueller, Plevak, and Rummans (2001) conducted a literature review and meta-analysis on religious involvement, spirituality, and physical and mental health related to quality of life, and how physicians might assess and support the spiritual needs of clients. They reported that most persons regard their spiritual life as important as their physical health and want their spiritual needs assessed and addressed. "A majority of nearly 850 studies of mental health and 350 studies of physical health have found a direct relationship between religious involvement and spirituality and better health outcomes" (Mueller et al., 2001, p. 1230). Most of these studies found that religious involvement and spirituality were associated with less cardiovascular disease, hypertension, anxiety,

depression, substance abuse, suicide and with a greater sense of well-being, greater longevity, coping skills, health related quality of life, and health promoting behaviours (HPB). Thus, helping clients meet their spiritual needs may enhance recovery from illness (Mueller et al., 2001). That being said, Mueller et al. (2001) found a number of barriers that prevented the support of client spirituality, the most important being the bio-medical model. Current medical training does not address the effects of spirituality on health, which is compounded by the fact few physicians describe themselves as religious or spiritual, and regard themselves as ill-equipped to deal with some clients' complex or daunting spiritual needs. The lack of time, training, experience, confidence, and role uncertainty in spiritual matters limits medical professionals' abilities to offer spiritual care to clients in the current health care environment (Mueller et al., 2001). Similar issues within the nursing profession have been reported, which is understandable since the majority of nurses work within a bio-medical model (Canadian Institute for Health Information, 2015; Carr, 2010; Reimer-Kirkham et al., 2012). None of the studies reviewed by Mueller et al. (2001) suggested that physicians prescribe religious activities for their clients to engage in for fear of being perceived as proselytizing. According to Hackett (2014) proselytization is a "process whereby groups and individuals seek to attract others to their own religious orientation" (p. 456). However, Mueller et al. (2001) suggest proselytization can be prevented by acknowledging and supporting the client's own spiritual practices, and to do otherwise may "constitute a form of negligence" (p. 1231), especially during severe and terminal illnesses. According to Delgado (2015), "spiritual care practices can include actions that address a patient's concerns, as well as the patient's attention to the fulfillment of religious obligations" (p. 117). Various

spiritual assessment tools exist to take clients' spiritual history, which can help determine if clients are open to working with a member of the pastoral care department, chaplain, or parish nurse to help meet their spiritual needs (Blaber, Jones & Willis, 2015; Mueller et al., 2001).

Holistic Nursing

Nursing scholars, educators, and regulators all agree that holistic nursing is a professional expectation which involves caring for the body, mind, and spirit. However, spiritual nursing care is often misunderstood and absent in nursing education and practice (Carr, 2010; Reimer-Kirkham et al., 2012, Delgado, 2015). The subject of spirituality is often elusive, controversial, and confused with religiosity, which brings about ethical issues in nursing, such as proselytizing. This may happen when nurses attempt to offer spiritual care to their clients by using their own religious perspectives including prayers and rituals which may not coincide with their clients' own wishes and religion (Mueller, et al., 2001; Reimer-Kirkham, 2014; Delgado, 2015).

Parish nurses (PNs), through the Canadian Association of Parish Nursing Ministries (CAPNM), have collaborated with the Canadian Nurses Association (CNA) and the American Nurses Association (ANA) in preparing position statements, standards of practice, and core competencies on holistic and spiritual nursing care (ANA, 2012; CAPNM, 2015a; CAPNM, 2015b; CAPNM, 2015c; CNA, 2010). By studying the evolution of the roles and spiritual development of PNs, I believe we can bring new knowledge about spiritual nursing care, something which is currently missing in our health care system. I also believe PNs' fundamental holistic approach to nursing practice

and their focus on spiritual nursing care can be of great benefit to the nursing profession and to the populations that nurses serve.

Nursing Workforce

Alongside this obvious need for increased spiritual care is a new trend of nurses leaving the profession. In 2012, the average age of nurses in Canada was 45.2 years old and this number continues to increase (Canadian Institute for Health Information (CIHI), 2012). In 2014, we saw the first decline in the numbers of Registered Nurses (RNs) in Canada in over two decades with less entry nurses and more retirements (CIHI, 2015). Currently, over 65% of the RN workforce is 40 years and over (CIHI, 2015). As nurses age, they may fill management and other leadership positions and eventually retire (CIHI, 2015). Strangely though, nurses often enter the field of parish nursing during the latter years of their careers, and as PNs, continue to practice well into their 70s (Chase-Ziolek & Iris, 2002; King, 2011; McGinnis & Zoske, 2008; Messerly, King & Hughes, 2012; Tuck, Pullen & Wallace, 2001). While CNA (2015a) has called for the development of recruitment strategies and data collection to better understand why nurses are leaving the profession, it is important to tap the perspectives of PNs who join the ranks of parish nursing, often at post-retirement, from other settings in an attempt to help address community health needs.

Self-Regulation

Nursing is a self-regulated profession, which remains a privilege given by government to ensure the public receives safe, compassionate, competent, and ethical care from qualified registered nurses (CNA, 2017). Nursing practice and boundaries are

well defined and the requirements and qualifications to practice are well stipulated through provincial legislation (CNA, 2007). The nursing profession self-governs through regulatory bodies and with the involvement of its professionals. Most nursing regulatory bodies have adopted a framework based on three principles to: promote good practice, prevent poor practice, and intervene in unacceptable practice (CNA, 2007).

However, nursing regulatory bodies alone cannot ensure the successful self-regulation of the nursing profession. According to Murray, Rosanbalm, Christopoulos, and Hamoudi (2015), "self-regulation is defined from an applied perspective as the act of managing cognition and emotion to enable goal-directed actions such as organizing behaviour, controlling impulses, and solving problems constructively" (p. 5). All practicing nurses participate in self-regulation when they accept responsibility to practice according to professional standards and their code of ethics, and offer expertise in establishing, promoting, and maintaining these standards (CNA, 2007). The Code of Ethics of registered nurses (CNA, 2017) states nurses must provide safe, compassionate, competent, and ethical care. This includes honoring clients' dignity by recognizing and respecting the intrinsic worth of each person. While caring for their clients needs, nurses must also assist people in meeting their goals of receiving culturally and spiritually appropriate care by taking into account their clients' values and spiritual beliefs without judgment or bias (CNA, 2017). Therefore, self-regulation on a personal level is a basic requirement to self-regulation in a professional role.

According to Pope Francis (2015), many of today's societal problems are connected with our modern self-centered culture of instant gratification and lack of self-control. By living a more spiritual life, we may become less consumed with ourselves,

demonstrate more self-control, engage in problem solving, and begin to be one with nature, others, and God (Pope Francis, 2015). Murray et al. (2015) point out that self-regulation can be strengthened and taught like literacy. However, I have not found any literature or nursing research in the area of spirituality and its role in professional self-regulation.

Origin and History of Parish Nursing

Although parish nursing is now practiced throughout the world and in many religions, parish nursing began and is still predominantly a Christian faith-based nursing practice with its origins dating 2000 years ago with Jesus Christ's ministry of healing the body, mind, and spirit

According to the CAPNM (2015b),

> Parish nursing is a heath ministry of faith communities, which emphasizes the wholeness of body, mind, and spirit. Rooted in the vision of Christ as Healer, this ministry grows out of the belief that all faith communities are places of health and healing and have a role in promoting wholeness through the integration of faith and health. (p.1)

VandeCreek and Mooney (2002) state that the profession of nursing is derived from a Christian worldview based on Jesus' teaching and example of caring for the sick. "The current parish nursing movement has grown out of this vision for nursing as a ministry of the Christian church" (VandeCreek & Mooney, 2002, p. 35). Christians have continued for centuries caring for the sick and needy. This Christian ministry began with deaconesses and wealthy Christian women who offered their homes and money to care for the sick and needy (Dolan, Fitzpatrick & Herrmann, 1983). For example, Phoebe, as a deaconness and benefactor of many early Christians in the first century, lived near

Corinth and was trusted by Paul to deliver his letters to the Romans (Bible Gateway, 2016; Romans 16:1,2, King James Version). Fabiola in the fourth century was a lady from a noble family in Rome and a follower of St. Jerome (Kirsch, 1909). When Fabiola became a widow, she joined the church, gave her wealth to fund the first Christian public hospital, and tended to the sick (Kirsch, 1909). For centuries after that, religious orders built and ran hospitals and offered health care to those in need (Bullough & Bullough, 1987; VandeCreek & Mooney, 2002). The Augustinian Sisters at the Hotel Dieu in Paris received their rule from Pope Innocent IV (1243-1254) and were among the first purely nursing order (Bullough & Bullough, 1987). Three nuns from the religious order of Hospitallers of Saint Joseph arrived in Montreal in 1659 and were the first religious order to offer health care in Canada along with Jeanne Mance, who arrived earlier in 1642 (Religious Hospitallers of Saint Joseph, 2015). Coincidentally, the first New Brunswick parish nurse, Sr. Ernestine LaPlante, is part of this same religious order and continued to practice and teach parish nursing in New Brunswick up until 2015 (Personal communication, Sr. Ernestine LaPlante, September 24, 2015). Today, throughout the world, we continue to see the existence of Catholic hospitals and the work of nursing religious orders.

Although Florence Nightingale is credited to have established the professional secular nursing practice, she continuously emphasized the spiritual aspect of nursing care (Coakley, 1989; VandeCreek & Mooney, 2002). Nightingale "had a deep, mystical relationship with God, whom she viewed as absolute perfection, wisdom, and love" (VandeCreek & Mooney, 2002, p. 41). Nightingale spoke about her calling from God to "service" and she responded to that call by becoming a nurse (Coakley, 1989).

Nightingale began her studies of nursing at the Institution of Lutheran Deaconesses in Keiserwerth, Germany and also visited with the French Catholic nuns at the Paris hospital (Coakley, 1989).

For the past two centuries, Nightingale's secular professional nursing has largely prevailed over the deaconess spirit of Christian service. According to VandeCreek and Mooney (2002), "the idea of nursing as 'service' is scorned by many because it implies that nurses must be subservient" (p. 43). Yet, the deaconesses and nuns, having a biblical office, were subservient only to God and humankind, and ran their hospitals independently from physicians, only calling upon them occasionally while paying them for their services (VandeCreek & Mooney, 2002). According to Hamilton (1994)

> While the professional nurses had a worldly vocation they envisioned that secular nursing would emulate the values of the religious sisters without accepting their rules, regulations, and cloistered life and believed compassion, once associated with God's authority, would be replaced with compassion based on commitment to the authority of humanity and its social progress. (p. 21-22)

However, the professional nurses' practice became more narrowly focused and limited to obeying the medical profession, and began to lose its spiritual dimension (VandeCreek & Mooney, 2002).

Parish nursing in North America, as we know it today, began in the late 1980s with Rev. Granger Westburg (1990), a Lutheran hospital chaplain in Chicago, Illinois. As the health care system was becoming more secularized and the nuns no longer the major care providers, Rev. Westberg noticed the health care system was lacking spiritual nursing care. Therefore, he recruited and trained six nurses to work in six different churches in the Chicago area, so they could begin offering holistic care with a focus on spiritual nursing care.

Based on a qualitative grounded theory study of PNs, Myers (2002) found PNs "believe that parish nursing has recaptured and reclaimed the 'kind of nursing that Nightingale had in mind' as well as the kind of nursing that brought them into the profession in the beginning" (p. 254). Myers (2002) added that parish nursing has the "potential to make nursing aware of itself and to reawaken nursing to its rich culture and heritage" and that nursing was "never intended to be a handmaiden profession to a highly technical profession such as medicine" (p. 255).

Contribution to Nursing Knowledge

By studying PNs and their spiritual nursing practice, we may be able to understand better how to integrate spiritual nursing care into nursing practice, policy, and education curricula. We may also learn and understand how the health care system can better partner with its community stakeholders to improve health promoting behaviours and monitor chronic health conditions. We may also learn how to keep experienced nurses in the workforce, and how to help all nurses be more satisfied in their practice which can ultimately improve retention and client satisfaction with nursing care. Patterson, Wehling, and Mason (2008) state that parish nursing "challenges the nursing profession to reclaim its spiritual dimensions of care, challenges the health care system to provide whole-person care, and challenges the faith community to revitalize its healing mission" (p. 40).

Personal Knowledge on the Subject

As a nurse with over 30 years of experience, I have had the opportunity to work in nursing administration, consultation, and regulation. I have also been married to an

Anglican priest for over 15 years, and have had the opportunity to be part of several faith-communities. I have met many PNs, some of whom have practiced parish nursing for nearly 20 years post-retirement, and I have discussed their roles and practices with them. My strong spiritual faith has directed my nursing career for many years. In September 2015, I enrolled in a 14-month faith community nursing education program from the New Brunswick Parish Nursing Ministries (CAPNM, 2015d), coordinated by Sr. Ernestine LaPlante, and which I completed in November 2016.

This interest in parish nursing was sparked by the opportunity I had to help develop a parish-nursing ministry and provide parish nursing services in an informal way in two separate parishes. I personally experienced the impact a parish nurse's practice can have on one's own life as a nurse, and on the life and overall health of many individuals in a parish community. It is uplifting to see how, under the leadership and guidance of a parish nurse, an individual and a whole community can gain hope, develop synergy and passion, and then come together to mobilize their resources to support one another. I am interested in learning more about how PNs develop their spiritual nursing practice, especially considering the limited initial and continuing spiritual education opportunities they have.

Formulating the Research Problem

Based on my personal experience and deep interest in parish nursing, I am interested to learn more about the experiences of PNs working in faith-based communities. I wish to understand the process PNs go through over time to specialize in providing spiritual nursing care. Questions to address include: How do PNs develop their

practice over time? How do PNs perceive the effectiveness of their practice on their clients' and faith-community's health and wellbeing over time? I believe by interviewing PNs about their authentic experiences, through guiding and probing questions, I may develop an understanding of these processes. I want to be able to understand the experiences of PNs in building their spiritual nursing practice, while identifying any pre-requisites, enablers, and obstacles.

Ultimately, I am interested in learning how PNs move from being a proficient or expert nurse in a secular nursing practice, where spiritual nursing is almost non-existent, to a nurse who has developed excellence in spiritual nursing care in a faith-based community. Can we simply educate nurses in spirituality or is teaching and learning spirituality a personal journey that depends on certain pre-requisites and experience? Therefore, my research question is "How do PNs develop their spiritual nursing practice over time?" I believe the findings based on this research question may help inform curricula, continuing education programs, and policies which can enable all nurses to provide spiritual nursing care to their clients regardless of the practice setting.

Chapter 2 Literature Review

In consultation with a librarian, I conducted two literature reviews related to the subject of parish nursing. I began with a scoping review on standards and policies related to parish nursing, followed by a more focused systematic review on PNs' spiritual nursing practice. In both instances, an adaptation of Arksey's and O'Malley's (2005) method was used with the following steps: Identification of the research question; location, screening, and selection of relevant publications; charting and organizing results; and summarizing and reporting the results.

Scoping and Systematic Reviews Search Method

The first literature review conducted was a scoping review by seeking to answer the following question "What literature is available regarding policies in parish nursing?" A systematic literature review was conducted in order to search for more depth and breath on the spiritual nursing practice of PNs by answering the question "How do PNs develop their spiritual nursing practice over time?" The databases searched included Cumulative Index to Nursing and Allied Health Literature (CINAHL), and all other associated EBSCO databases, PubMed, MEDLINE, and all other associated OVID databases, Johanna Briggs Institute EBP database, ProQuest Nursing and Allied Health Source. Key words were used with truncation and Boolean operators in both reviews. Key words for the scoping review included: law, bylaws, policy, guidelines, standard, regulation, parish nurse, faith-based nurse, faith-community nurse. Key words for the systematic review included: parish nurse, faith-based nurse, faith-community nurse, spiritual, spiritual care, spiritual nursing care, (w)holistic, faith-based practice, practice,

program, development, implementation, growth, success, trend, utilization, transition, promotion, management, initiate. Both searches were limited to peer-reviewed and academic journals with no date restrictions. All abstracts were read. Editorials and news briefs were excluded because of their limited or repetitive information. Book chapters were also eliminated, as no new meaningful information would be offered compared to more current and peer-reviewed articles. Articles restricted to community nursing or spiritual care that did not mention parish or faith-based nursing were also excluded. Two articles were unavailable from the scoping review (one was in Dutch, and the other was requested but unavailable). A manual bibliography search followed and resulted in two additional literature reviews published between 1995 and 2014. Three relevant organizations' websites were also added to the review: Canadian Association of Parish Nurse Ministry (CAPMN, 2015b), Church Health (CH, 2018), and Health Ministries Association (HMA, 2015).

The scoping review produced a total of 40 usable articles from 1995 to 2014 including three literature reviews, one concept analysis, 14 research articles, one of which was a secondary analysis of a previously published research project, 17 descriptive articles, and five articles describing anecdotal experiences. The literature contained the definitions and demographics of parish nursing, its history, models, delivery of care, scope, roles, and standards of practice. Specific spiritual nursing interventions, as core to PNs' practice, were also identified. Other topics included issues in documentation and use of nursing classification systems, development of parish nursing ministry, reasons why senior nurses are attracted to parish nursing, and descriptions of advanced practice nursing for PNs.

Once the systematic review was conducted and duplicates were removed, a total of 42 usable articles remained, nine of which were duplicates from the first scoping literature search for a total of 33 new articles. Among the 33 articles published between 1998 and 2015, there were three literature reviews, 11 qualitative research studies including two with grounded theory methods, five quantitative research including one with mixed methods (quantitative and qualitative), and 14 anecdotal descriptive articles. The literature described the phenomena of parish nursing, roles of PNs, and the relationships and partnerships PNs developed within their practice. The literature also identified and described the following: various programs PNs offered; the importance PNs put on holistic care and faith integration with health; spirituality and spiritual interventions as core to parish nursing practice; the processes PNs used to offer spiritual care and their role in supporting health promoting behaviours; the process of developing a parish nursing ministry and its various models; motivational factors that influence PNs' practice; faith community practice setting and its social influence model; clergy and client perspectives of PNs practice; various educational curriculums, educational requirements, and support PNs need in developing and maintaining their practice; and identified practice and client outcomes.

The search has been updated using the same key words, limiting it to English peer-reviewed articles between 2015 and 2018. Only one additional research article was found, a case study by Finocchiaro (2016), which described the experience of one PN caring for a young dying client. The PN described using the spiritual assessment tool HOPE (H = sources of Hope strength comfort and meaning, O = role of Organized religion in the clients life, P = Personal spirituality and practice, E = effect on medical

care and end of life decisions) to determine the relevant spiritual comfort and support measures the client wished for as death drew near. The PN used presence by being there to share the journey, used guided imagery and meditation, and listened to the client's life story as she helped foster forgiveness. A second article, an anecdotal paper by Ziebarth (2016), described the research gaps in parish nursing, which included the need to test models and theories in parish nursing.

Phenomenon of Parish Nursing

Parish nursing is a relatively new area of nursing practice having been developed in the USA by Reverend Granger Westberg in 1984 (Westberg, 1990). The International Parish Nursing Resource Center (IPNRC) developed a philosophy of parish nursing as described by Patterson, Wehling, and Mason (2008):

> The spiritual dimension is central to parish nursing practice. Personal spiritual formation is an intentional process of intimacy with God to foster spiritual growth. It is an ongoing, essential component of practice for the parish nurse and includes both self-care and hospitality, through opening the heart to self and others. The parish nurse role reclaims the historical roots of professional nursing… Each parish nurse practices under the scope and standards of practice and the ethical code of nursing as set forth in their country…*Shalom*, God's intent for harmony and wholeness, serves as a foundation for understanding health. (p.39)

Parish nursing has four foundational concepts including professionalism, Shalom, community, and spiritual formation (Patterson et al., 2008). Professionalism includes the fact PNs are registered nurses who meet all the regulatory and ethical obligations of the nursing profession. Shalom speaks to wellness and the holistic practice of caring for and healing of the body, mind, and spirit. Community relates to the PNs' work setting and context of care within a faith-community and the service they offer to their greater

community; and spiritual formation speaks to the essential part of PNs' practice which focuses on spiritual care (Dyess, Chase & Newlin, 2010; Patterson et al, 2008). This latter concept is the focus of my research project.

Parish nursing is recognized in many countries including Canada, the United States, the United Kingdom, Australia, South Africa, South Korea, Finland, Ukraine, Georgia, and Germany (Church Health, 2018; Wordsworth, 2014). Although the concept of parish nursing was initially based on the Christian faith and on caring for the body, mind, and spirit, many other religions, including Islam and Judaism, now have PNs within their congregations (American Nurses Association, 2012; International Parish Nurse Resource Center, 2011). The American Nurses Association (ANA, 2012) and the Canadian Nurses Association (CNA, 2010) have recognized parish nursing as a nursing specialty. The ANA in collaboration with the Health Ministries Association has developed scope and standards of practice, and core competencies for faith community nursing (ANA 2012).

Models of Parish Nursing

There are three prominent parish-nursing models: health service parish nursing, volunteer, and nurse parishioner (Anderson, 2004). Hospitals have developed the health service parish nursing model in an attempt to do community outreach. It includes providing and paying for a nurse to work in collaboration with a congregation to offer community nursing services and programs to its members (Anderson, 2004; Miskelly, 1995; Ruesch & Gilmore, 1999). Nurses in this model offer very little spiritual intervention (Anderson, 2004; Miskelly, 1995). The volunteer model is used when a

church approaches a hospital to help them find and support a nurse who is willing to volunteer for the parish (Anderson, 2004). The parish nurse works with the congregation in meeting their particular health needs, while offering existing community health programs (Anderson, 2004). The nurse parishioner model is used when nurses, who happen to be parishioners, offer their services, either remunerated or not, to work with a church health committee to help bring health and wholeness to a congregation's members (Anderson, 2004; CAPNM, 2015e). The nurse in this model works most effectively when supported by a strong and vital parish health ministry team (Patterson, Wehling & Mason, 2008). PNs who work in a nurse parishioner model do not perform any hands-on care nor do they duplicate any existing community health programs or services; rather, they focus on offering spiritual care (Anderson, 2004; Patterson et al., 2008; Trofino et al, 2000). The first two models are more prominent in the United States, while the latter model is more common in Canada (Anderson, 2004; CAPNM, 2015e).

Parish Nurses

A parish nurse is defined as a "registered nurse with specialized knowledge, who is called to ministry and affirmed by a faith community to promote health and wholeness" (CAPNM, 2015e, p.1). As of 2011, there were approximately 15,000 PNs in the USA (IPNRC, 2011), and each cared for between 40 and 1700 congregants (Nelson, 2000).

Based on a national survey conducted in the US by Solari-Twadell and Hackbarth (2010), the average age of entry into parish nursing is 55 years, and nearly half of PNs have over 30 years of nursing experience. Sixty-eight percent (68%) of PNs were unpaid, and over half had an undergraduate or graduate degree in nursing (Solari-Twadell &

Hackbarth, 2010). Research by McGinnis and Zoske (2008) found most PNs have no intention of leaving their position despite their age and non-remuneration. Factors that encouraged PNs to stay included flexible hours, reduced work intensity, broader community health domain, autonomous role, high correlation between their beliefs and practice, and working in a favourable setting that encourages holistic health by helping people make body, mind, spirit, interpersonal, and environmental connections (McGinnis & Zoske, 2008; Patterson, et al., 2008; Solari-Twadell & Hackbarth, 2010).

Providing nursing care in a congregational setting is distinctive from other settings as PNs report having been able to make a difference and having unique opportunities and challenges (Chase-Ziolek & Iris, 2002). Making a difference involved working with clients towards health promotion, advocacy, health education, and health counseling (Chase-Ziolek & Iris, 2002). Parish nurses found opportunities for establishing practice autonomy and long-term relationships, while integrating faith and health in a psychosocial environment (Chase-Ziolek & Iris, 2002). Most PNs face several challenges in their practice, including client autonomy, specific religious beliefs, and feeling always "on-call" (Chase-Ziolek & Iris, 2002). PNs reported their clients had more autonomy to accept or reject their health recommendations compared to other work settings, which created some level of frustration (Chase-Ziolek & Iris, 2002). Some PNs felt specific religious beliefs, such as a strong conviction that God was a healer and having a fatalistic pre-destination, sometimes got in the way of their clients' ability to accept care that would facilitate healing (Chase-Ziolek & Iris, 2002). Other PNs reported they felt they could not fully experience the worship service themselves, and felt overwhelmed when trying to find a balance between time spent for parishioners, and time

spent for personal and professional commitments and responsibilities (Chase-Ziolek & Iris, 2002).

Despite these challenges, PNs identified motivational factors for their volunteering, which included strengthened relationships, provision of valuable service, support for personal spiritual growth, and integration of faith with nursing practice (Chase-Ziolek & Iris, 2002). PNs establish long-term trusting relationships with their clients by being present, accessible, and by advocating for clients (Chase-Ziolek & Iris, 2002). The clients also appreciated the relaxed environment, the convenience and time for interaction, and the opportunity for, and guidance with, reflection and integration of faith with their health (Chase-Ziolek & Iris, 2002).

Roles of Parish Nurses

Westberg (1990) originally identified seven functions of the parish nurse as integrator of faith and health, health educator, health counsellor, referral advisor, health advocate, developer of support groups, and volunteer coordinator. As integrator of faith, PNs help remind people to draw on their faith while seeking to connect their faith issues with daily-lived experiences (Chase-Ziolek & Iris, 2002; Clark & Olson, 2000). PNs help guide their clients in strengthening their spiritual life as one way of becoming and remaining more whole and healthy (Chase-Ziolek & Iris, 2002; Clark & Olson, 2000). This role refers in part to the spiritual care PNs provide to their clients. As health educator, the parish nurse offers workshops and organizes small group discussions on various health topics based on a congregation's needs (Clark & Olson, 2000). The parish nurse's easy accessibility before, during, and after church service helps build trusting

relationships with individuals, families, and groups, which facilitates the role of health counselor (Clark & Olson, 2000). By offering private or group counseling sessions, the parish nurse assists people in modifying their lifestyles and increasing their coping skills during short and long-term illness and distressing situations (Clark & Olson, 2000). The parish nurse also acts as a referral advisor by becoming familiar with various congregational and community resources, and by helping to direct and assist clients to various resources (Clark & Olson, 2000). By being a health advocate, the parish nurse helps others navigate through the health care system by attending medical appointments with clients and being the voice of a client who may seem to have no voice at that time (Clark & Olson, 2000). By working with others, the parish nurse helps develop support groups by formalizing the social, emotional, and informational support groups that may already exist within a congregation (Clark & Olson, 2000). The parish nurse also acts as a trainer and coordinator of volunteers who helps carry out the health ministry by offering various services such as transportation, visitation, and peer support (Clark & Olson, 2000).

Solari-Twadell and Hackbarth (2010) critiqued these seven functions as being too restrictive. I agree with Solari-Twadell and Hackbarth (2010) who offer a broader definition of PNs' roles emphasizing coping assistance, lifestyle change, and spiritual care, while including the client, family, congregation, and the health care system. Other PN roles include (a) an expanded role of advocacy through working in collaboration with various communities to raise awareness of legislative issues that affect health and (b) an emphasis on the relationship with clients spanning over time to encompass optimal health functioning within a global context (Nelson, 2000; Patterson, 2007; Ziebarth, 2014a).

PNs are trusted professionals who foster long-term relationships with clients, and help them take a more active role in their health (Nelson, 2000).

Myers (2002) developed a mid-range theory of "authenticating self through holistic theocentric interconnecting" to describe the process through which RNs became PNs. The theory entailed six phases that progressively showed "a history of reclaiming, reworking, and making sense of the culture and heritage of nursing through parish nursing with a resultant unification of symbolic and conceptual meaning" (Myers, 2000, p. 98-99). The first phase depicted PNs struggling between their personal philosophy of nursing and their lived contradiction in their nursing environment whereby they felt dissatisfied being unable to provide the care they felt was important to their clients (Myers, 2002). The second phase was a consciousness of suffering in others and a perceived moral obligation to respond compassionately to social injustice and pain (Myers, 2002). The third and fourth phases included reflective self-consciousness and renewed awareness, which made them realize things can become different. This new awareness enables PNs to attempt to integrate their personal philosophy of nursing with their professional lived nursing experience (Myers, 2002). The fifth phase was PNs braving disparity in making the choice to actually become a parish nurse despite the perceived or real obstacles (Myers, 2002). Finally the sixth phase was harmonizing self with the experience of becoming a parish nurse. This phase made the PNs feel more whole since they felt they succeeded in integrating the entire process of becoming a parish nurse (Myers, 2002). Although Myers' (2002) theory explains much on how and why PNs become PNs, it does not go far enough in explaining how they develop their spiritual nursing practice and competencies over time.

Clergy and Client Perceptions of the Role of Parish Nurses

Studies show that clergy acknowledge the important role of PNs as they prayed with individuals, shared their personal faith in God, facilitated forgiveness and grieving processes, instilled hope, and provided spiritual care and support (Raley & Weinhold, 2001; Shores, 2014). Although the majority of clergy surveyed by Thompson (2010) had adequate knowledge of the role and activities of parish nurses as well as positive attitudes and opinions towards them, Thompson (2010) reported most clergy did not identify spiritual counseling as a function of the parish nurse because they felt nurses were not sufficiently trained in spiritual care.

According to members of the congregation, PNs were present, listened, prayed, gave spiritual care and counseling, facilitated spiritual growth, led devotionals, and facilitated participation in religious services or activities (Shores, 2014). In particular, members reported PNs "provided their services with God's Holy Spirit showing through them" (Shores, 2014, p. 303). In a qualitative descriptive research study conducted by King (2011), clients chose to receive their health care services from PNs because they expected or could easily request them to provide spiritual care, something clients felt was not available elsewhere. These participants received holistic care from PNs as described by ANA (2012) practice standards which included education, personal counseling, screening, spiritual support, referrals, and advocacy (King, 2011).

Spiritual Care

The literature shows that spiritual care is core to PNs' practice. While research in parish nursing is limited, research in spiritual care has resulted in the analysis of this

concept as well as the identification of its barriers, processes, and outcomes. However, little is known on how PNs develop their spiritual nursing practice.

Concept analysis of spiritual care.

Ramezani, Ahmadi, Mohammadi, and Kazemnejad (2014) analyzed the concept of spiritual care in nursing using the Walker-Avant method and identified six antecedents. These antecedents included the following: Transcendent awareness (an acknowledgement that human beings are spiritual beings); self-awareness of personal beliefs, values, attitudes, and critical analysis of self and experiences; religious affiliation; professional commitment, responsibility, and accountability; sensitivity; and intentionality, whereby the nurse has a focused consciousness on the client patterns and cues (Ramezani et al., 2014). Current requisite skills and abilities for students entering the nursing profession do not include all these antecedents, which begs the question "how do nurses acquire these antecedents and develop spiritual nursing care competencies (Nurses Association of New Brunswick, 2014)?"

Defining attributes (essential characteristics) of spiritual nursing care include healing presence, therapeutic use of self, intuitive sense, exploration of the spiritual perspective, client-centeredness, meaning-centered therapeutic intervention, and creation of a spiritually nurturing environment (Ramezani et al., 2014). Healing presence was described as offering a fully caring presence or altruism, while therapeutic use of self was defined as active listening, establishing a therapeutic relationship, being non-judgmental, and offering unconditional acceptance of the other (Ramezani et al., 2014). Intuitive sense was defined as the ability to "sens[e] into one's own being [and] recognize the

opportunity for spiritual conversation with the client" (Ramezani et al., 2014, p. 214). Exploring the spiritual perspective meant assessing the spiritual needs and wellbeing of the client as well as the clients' source of strength and hope (Ramezani et al., 2014). Spiritual care focused on client-centeredness, which recognizes the uniqueness and lived reality of each individual (Ramezani et al., 2014). Meaning-centered therapeutic intervention was central to spiritual nursing care in that it helped develop meaningful relationships by instilling hope and offering religious intervention or complementary therapy meaningful to the client (Ramezani et al., 2014). The creation of a spiritual nurturing environment included respecting the client's spiritual, religious, and cultural beliefs and values, while safeguarding the capacity of caregivers to provide ethical care (Ramezani et al., 2014). Since most of these attributes form part of the Code of Ethics and the basic entry-level competencies of registered nurses, why then do most nurses not offer spiritual nursing care (CNA, 2008, 2015b; Nurses Association of New Brunswick, 2013; Reimer-Kirkham et al. 2012)? Six consequences or outcomes of providing spiritual nursing care were identified as "healing, promotion of spiritual well-being, psychological adaptation, and feelings of satisfaction for the client, and promotion of spiritual awareness, and job satisfaction for nurses" (Ramezani et al., 2014, p. 214).

Empirical referents (measurable indicators) of spiritual care in nursing were identified as encouraging clients' self-care, helping clients re-establish relationships with self, family, friends, and a Supreme Being, and helping clients emphasize the positive aspects of situations (Ramezani et al., 2014). While these may be useful in identifying indicators for standards of spiritual nursing practice, I believe Ramezani et al. (2014) have not identified how spiritual care competencies can be developed and acknowledge

the need for more qualitative research to help define other empirical referents of spiritual care in nursing based on different contexts, situations, and cultures.

Barriers to spiritual nursing care.

Carr (2010) identified several barriers to providing spiritual nursing care in general institutional and community settings, which include professionalism and organizational culture. According to Carr (2010), these barriers create a "lived space" that is uncaring, a "lived time" that is too tight and the "lived body" of the client being objectified for technical interventions while the "lived other [the client]" is experienced at a distance rather than "up close and personal" by the nurse "for fear of crossing professional distance boundaries [and] threaten[ing] the preferred image of expert knower" (p.1387). These barriers must be recognized and addressed by nursing administrators and regulators who seek to promote holistic nursing care and create environments conducive to quality client care (Carr, 2010). Further research is required to find solutions to address these barriers (Carr, 2010). Conducting a qualitative grounded theory study on the process through which PNs develop their spiritual nursing practice, may help uncover potential environmental factors and solutions used by PNs to successfully overcome some of these barriers.

Process of providing spiritual nursing care.

In a qualitative grounded theory research study, van Dover and Pfeiffer (2006) identified the process PNs used to provide spiritual care to parishioners as "Bringing God near." Nurses' focus was on both the client and God. PNs felt they were there to convey the love and power of Jesus and not simply do something spiritual such as prayer, or

other ritualistic interventions (van Dover & Pfeiffer, 2006). Rather, "the parish nurse spiritual challenge is to respond to what God is directing the nurse to be and do to strengthen people spiritually" (van Dover & Pfeiffer, 2006, p. 213).

Five distinct phases of "Bringing God near" were trusting God, forming relationships with client and family, opening to God, activating nurturing faith, and recognizing spiritual renewal and growth. Trusting God was the "spiritual foundation for the entire care-giving process" (van Dover & Pfeiffer, 2006, p. 217). This phase included the development over time of a relationship with God and the ability to recognize Him at work in their own lives and in the lives of others (van Dover & Pfeiffer, 2006). The phase of forming relationships included "being available and present, and collaborative assessment done by the nurse and the client together [which] led to naming and validating clients' spiritual concerns" (van Dover & Pfeiffer, 2006 p. 217). Opening to God meant inviting God into the nurse-client encounter and then becoming aware of His presence. The phase of activating or nurturing faith, was asking and providing the clients with spiritual interventions such as prayer, scripture reading, or music based on what would be meaningful to them (van Dover & Pfeiffer, 2006). Recognizing spiritual renewal and growth in the client and the nurse was demonstrated by positive changes in attitudes, emotions, and faith responses as well as a sense of thanksgiving for all that was experienced (van Dover & Pfeiffer, 2006). Van Dover and Pfeiffer (2006) stated the nurses' personal faith journey was highlighted in the phases of trusting God and opening to God. "This idea that a transcending God informs and guides spiritual care given by nurses is unique in the nursing literature" (van Dover & Pfeiffer, 2006, p. 218). Van Dover and Pfeiffer (2006) described the process PNs use to provide spiritual care.

However, what remains unclear is how do PNs obtain the required competencies to offer spiritual care and develop their spiritual nursing practice over time.

Spiritual interventions.

Spiritual nursing care is core to PNs' practice. Therefore, PNs are particularly well positioned to offer core spiritual interventions, such as prayer, presence, touch, spiritual support, spiritual growth, and hope instillation (Solari-Twadell, 2010; Tuck et al., 2001). Other core interventions used by PNs include active listening, emotional support, facilitation, and hospital or home visitation (Solari-Twadell, 2010; Tuck et al., 2001). Religious interventions performed by PNs include ministering, offering communion, laying of hands, and anointing (Tuck et al., 2001). Spiritual interventions are broader than religious interventions where the latter are particular rituals, hymns, and doctrines used in specific religions. Other spiritual interactions that can also be specific to each religion include discussing, singing, and reading (Tuck et al., 2001).

Outcomes of spiritual nursing care.

Ramezani et al. (2014) in their concept analysis identified six outcomes of providing spiritual nursing care as "healing; promotion of spiritual well-being; psychological adaptation and feelings of satisfaction for the client; and promotion of spiritual awareness and job satisfaction for nurses" (p. 214). PNs' focus on relationship-building and collaborative work with others, within a setting provides opportunity for dialogue on health issues and relationship building, which help increase trust (Anderson, 2004). Prayer was identified as a way to access the connection between body, mind, and spirit, and the PNs' strong nurturing role, motivated by intrinsic values associated with

the role of spirituality, was critical to promoting holistic health (Anderson, 2004; Connor & Donohue, 2010).

Research studies reveal that providing and receiving spiritual nursing care results in a feeling of empowerment (Falk-Rafael, 2001; van Dover & Pfeiffer, 2011; Weis, Schank and Matheus, 2006). According to Weis et al (2006), "empowerment is a reciprocal process between the parish nurse and clients characterized by recognition of a higher power…that resulted in an enhancement of the nurse-client relationship (p. 17, 24). Six themes of empowerment for PNs were identified as being valued, role implementation, a higher power, experience and education, reciprocal interactions, and mentors (Weis et al., 2006). Clients identified sources of empowerment for themselves that included focusing on their own agendas, trust, presence and listening, information giving, relating to God, and connections and linkages to resources (Weis et al, 2006). Outcomes for clients who received such care reported having enhanced self-confidence, acquired and utilized new knowledge, and reinforced personal faith (Weis et al., 2006). This latter finding was further emphasized in a grounded theory study by van Dover and Pfeiffer (2011) who reported that "clients of PNs experienced a renewed spiritual identity [that brought] them a new equilibrium in faith" (p. 1824).

Falk-Rafael (2001) echoes these same findings in a qualitative study and reported "nurses themselves were empowered through their client's empowerment in a reciprocal effect" (p.6). Falk-Rafael (2001) continues by saying that client-centered care required nurses to be flexible in "meeting them where they are at…following client's agenda" (p. 6). Interestingly, Connor and Donohue (2010) report that in a faculty model where

student nurses had clinical experiences working with homeless people "a reciprocity of caring emerge[d] where both nurse and client are changed and healed" (p. 131).

I believe that PNs' unique relationships with their clients can help monitor changes in their client's health and wellbeing and can help strengthen the clients' coping skills while working to promote health and healing. This unique nurse-client relationship positions the PNs to become valuable partners within the health care system. PNs can become the link to other health care professionals and help the clients integrate their health care needs with their lifestyles.

Educational Preparation

Since most nurses enter into parish nursing later in their careers, they bring a wealth of nursing knowledge and experience. However, most PNs begin their independent practice by becoming affirmed in a faith-community and obtaining a minimal amount of formal training in parish nursing (CAPMN, 2015d; CAPNM, 2015e; Pappas-Rogish & King, 2013; Ziebarth, 2014b). There are core competencies and established standards of practice for PNs as well as many types of online and onsite education programs for parish nursing ranging from a few weeks to university credit courses (ANA, 2012; Clark & Olson, 2001; IPNRC, 2011; CAPNM, 2015a; CAPNM, 2015c; CAPNM, 2015d). However, Ziebarth and Miller (2010) reported that successful transition in the role of parish nurse requires the development of new training models, educational objectives, competencies, and orientation and mentoring programs because there are no current standards of education for entry into parish nursing practice.

While spiritual care and counseling are core to the PNs' practice, not all PNs are comfortable in offering spiritual care since few receive any type of recognized spiritual training such as clinical pastoral education (Brudenell, 2003; Clark & Olson, 2001; Derrickson, 2001; Glueckauf et al, 2009; King , 2011; Newbanks & Rieg, 2011; Pravecek, 2005; Thompson, 2010; Ziebarth, 2014b; Ziebarth & Miller, 2010). Clinical pastoral education (CPE) is a required training program for those seeking to work as hospital chaplains and other spiritual leaders. Therefore, it is imperative that PNs obtain the required training, support, resources, and mentoring in pastoral counseling or lay ministry to help advance their professional spiritual nursing practice (King, 2011). Unfortunately, PNs find that these educational programs and support are not always available and begin their ministry without formal spiritual education (Brudenell, 2003; Chase-Ziolek & Iris, 2002; Clark & Olson, 2001). Most PNs have access to the Church Health (2018) website, which includes as part of their ministry the Westberg Institute (CH, 2018). The Westberg Institute is a renowned leader in faith community nursing (FCN) and has provided excellent resources for education, consultation, and research for the past 30 years (CH, 2018).

Two examples were found in the literature describing successful spiritual education programs specially developed and offered to PNs following their requests for more training. First, Derrickson (2001) developed a clinical pastoral education (CPE) based on Erikson's (1963) psychosocial developmental stages and Pruyser's (1976) spiritual diagnostic categories. Erikson (1963) identified eight stages related to various psychosocial crisis and eight basic virtues associated with overcoming these crisis including hope, will, purpose, competency, fidelity, love, care, and wisdom. Pruyser

(1976) identified diagnostic variables related to pastoral care including awareness of the Holy, providence, faith, understood subjectively, grace or gratefulness, repentance, communion, and vocation. Some adjustments to the program were necessary to meet PNs particular needs, such as congregational dynamics, how to gain credibility within their congregation, and negotiating their role with clergy as well as their need "to fix" anything that needed fixing (Derrickson, 2001). Overall the CPE standards used to design the curriculum were met and included personal assessments, autobiography, and didactic presentations following client visitations by the parish nurses (Derrickson, 2001). These CPE standards were adequate to meet the educational needs of parish nurses as they reported being very satisfied with the curriculum (Derrickson, 2001).

Second, Glueckauf et al. (2009) conducted a pre-post clinical trial on cognitive behavioural spiritual counseling (CBSC) provided by 21 parish nurses to caregivers of dementia patients. For their training, the parish nurses were given two 2½-day weekend workshops over a 10-month period. The CBSC consisted of 12 one-hour bi-weekly sessions over six months in the caregiver's home. The parish nurses received bi-weekly consultation and mentoring either by telephone or email from the researchers. These sessions included continuous training and mentoring on CBSC methods as well as strategies on how to deal with difficult situations such as caregiver ambivalence and relapse. Results showed statistically significant improvement in caregiver's problems and reduction in depression. Findings also showed that parish nurses' satisfaction with the training was high, and that post-training significantly increased the parish nurses' counseling comfort and perceived efficacy. These findings are to some extent similar to Tuck et al.'s (2001) report that parish nurses show statistically significant high scores on

four spiritual and religious well-being scales, with statistically significant higher scores in the older age group of parish nurses.

In a qualitative research study with PNs, Newbanks and Rieg (2011) reported that further study was required to determine whether the catalyst in incorporating spiritual care in their practice was PNs' awareness prior to attending a basic program or their previous spiritual training and experience. While spiritual educational opportunities for PNs are limited, PNs continue to offer spiritual care, which has been proven to be beneficial to them and to their clients. As experienced nurses, PNs seek to gain and maintain competencies in their clinical area of practice.

Community Partnerships and Programs

Magnet hospitals recognize the importance of providing spiritual nursing care and may actively develop programs in collaboration with faith-community nurses and nursing faculty members that help offer spiritual care to clients (Lashley, 2006; Messerly, King, & Hughes, 2012). Partnerships between a parish nursing program, a faculty of nursing, and a community-based outreach organization have been developed to help clients living with substance abuse draw on their faith to acquire health-promoting behaviours (Connor & Donohue, 2010). Integrating faith beliefs and practices with the provision of care, enabled clients to begin to recognize and draw on their faith, find purpose and meaning in life, and improve their health by adopting health-promoting behaviours (Connor & Donohue, 2010). Students and faculty reported that offering spiritual care and providing simple intentional comfort to this population of persons recovering from substance abuse

was primarily why they were drawn to the profession of nursing (Connor & Donohue, 2010).

Health-Promoting Behaviours

The practice of health-promoting behaviours (HPBs) such as eating a healthy diet, doing physical activity, having adequate sleep, and using stress management strategies are believed to increase lifespan (Mueller et al. 2001). While an individual's perception of health and motivation for HPB is multi-dimensional, determinants of HPBs vary in degree of importance from person to person depending on the influences of the individual's past behaviours and beliefs, current bio-psychosocial status, and level of health knowledge (Boland, 1998). Social and spiritual beliefs were consistently found to be vital to HPB (Boland, 1998). In a meta-analysis, Sirois, Kitner, and Hirsch (2015) found that HPBs were positively associated with self-compassion, and suggested it "may be an important quality to cultivate for promoting positive health behaviours" (p. 661). Brown (2010) states that

> When we become more loving and compassionate with ourselves and we begin to practice shame resilience, we can embrace our imperfections. It is in the process of embracing our imperfections that we find our truest gifts: courage, compassion and connection (p. 122).

Since social and spiritual dimensions of health are foundational to parish-nursing practice, Boland (1998) suggested parish nursing as a model for implementation of successful interventions toward HPB. PNs are seen as an extension of the church and are easily accepted by all members of the congregation. This puts PNs in an excellent position to enhance healing, support HPBs, and help clients cope with and maintain functioning in the face of substance abuse, chronic illness, and homebound status

(Drayton-Brooks & White, 2004; Hurley & Mohnkern, 2004; Lashley, 2013; Matteson, Reilly & Mosely, 2000). PNs' practice includes several factors identified as important in planning HPB interventions such as trusting relationships; open communication; safe comfortable, and familiar environment; context and support of a faith-community; and prayer (Drayton-Brooks & White, 2004).

In a study by Hughes, Trofino, O'Brien, Mack, and Marrinan (2001), PNs hired by a hospital to work as primary health care providers in a church setting limited their spiritual nursing care to prayer upon request since they did not feel competent to offer any other types of spiritual care. However, Hughes et al. (2001) reported that the church setting and the church community became and functioned as a support group within a supportive environment, which created a positive social influence and helped enable HPB by fostering hope in those who sought care. These results can be an indication for further research to help identify environmental factors that enable the provision of spiritual nursing care as well as to help understand barriers to providing spiritual care in other settings as described by Carr (2010). It goes without saying that in order to be able to provide spiritual nursing care in any setting, one must first understand how to develop these competencies.

Developing Parish Nursing Ministry

In a literature review conducted by Dyess et al. (2010), the major content areas identified in parish nursing ministry were development and implementation of parish nursing practice, roles and activities of PNs, evaluation and documentation of parish nursing practice, and congregational perceptions of parish nursing programs. While the

literature review from Dyess et al. (2010) provided ample descriptive information on parish nursing, no information was retrieved related to the development of the PNs' spiritual nursing practice.

In a qualitative grounded theory research study on parish nursing, Brudenell (2003) sought to answer the questions: How do faith-community nurs[es] form parish nursing programs? What is the effect of parish nursing programs on health outcomes? The basic social process was identified as "Knowing the congregation and community" with four phases of finding out/thinking about parish nursing, knowing the faith community, being accepted as part of the congregational ministry, and becoming an ongoing ministry (Brudenell, 2003). The results showed that less time and effort are required to develop a parish-nursing ministry under a collaborative volunteer model of parish nursing compared to the hospital type model because of the many various stakeholders involved (Brudenell, 2003). The PNs' presence was considered essential to establishing and maintaining an ongoing ministry.

Knowledge Gaps

Parish nursing is a relatively new area with limited available research (Patterson et al., 2008). The gaps in knowledge I identified from examining the available literature include limited outcome measurements of PNs' interventions, education programs, and support groups; pre-requisites, enablers, and barriers to developing competence in spiritual nursing practice and effective spiritual nursing care; and cost-benefit analysis of spiritual care for PNs. Concept analyses for two key concepts of parish nursing − spiritual formation and Shalom have not been found. Literature reviews are limited on

parish nursing interventions such as prayer, presence, touch, and visitation. I was unable to find any research studies of the role of spirituality on self-regulation in the nursing profession. Further, there is a limited amount of qualitative research on the meaning and experiences PNs have of parish nursing and their impact on the clients' health promoting behaviours. Limited research is available on theories to guide parish nursing, spiritual assessment, decision-making processes, and outcomes, which are all necessary in developing best practices in spiritual nursing care.

Shores (2014) suggested developing instruments to evaluate the impact of parish nursing intervention on clients. While research on client outcomes of spiritual care is important, it will be difficult for researchers to measure and reproduce these outcomes if spiritual nursing care provision is limited to only a few PNs. Similarly, the other gaps identified are important; yet, without knowing how PNs as specialists in spiritual nursing care develop their spiritual nursing practice, a limited number of nurses will be trained in spiritual nursing care. This limited sampling base will make it difficult to conduct more meaningful research. From literature reviewed, I believe what remained unclear was how PNs develop and maintain their spiritual wellbeing, spiritual nursing competencies, and spiritual nursing practice. I determined the need for research designed to better understand how PNs develop their spiritual nursing practice over time. Therefore, I believe focusing on the process of developing spiritual nursing practice is a key research question needing to be addressed. Hence, my research question was to identify what process do PNs use to develop their spiritual nursing practice so we are better informed on how to incorporate their knowledge into future nursing education curriculum, standards, best practice guidelines, and continuing competence.

Summary of Literature Reviewed

While parish nursing has been in existence in Canada for several years, there has been limited documented research on parish nursing. There is a need for research that explores the development of spiritual nursing practice from the Canadian perspective of PNs, since it is a relatively new nursing specialty in Canada. Such research can add to nursing knowledge by understanding the social psychological process PNs go through in developing their spiritual nursing practice and offering spiritual nursing care to the clients. This type of research can help inform best practices in spiritual care including educational strategies to prepare nurses for the spiritual component of nursing practice, and can help identify future research priorities in spiritual nursing.

Chapter 3 Method of Conducting Grounded Theory Research

To conduct this research, I used an interpretive paradigm, relativist ontology, interactive or inter-subjective epistemology, a qualitative research methodology and the Glaserian grounded theory method. According to Weaver and Olson (2006), the interpretive paradigm is based on relativism with the goal to understand meaning rather than to predict a phenomenon. Relativist ontology is the philosophical study of being and truth and views the truth as subjectively perceived with many possibilities (Weaver & Olson, 2006). According to Lincoln and Guba (1989), an interactive epistemology is required of the researcher choosing relativist ontology. Interactive epistemology or knowledge is drawn from those who are experiencing the phenomenon directly and by interacting with them to ensure that their description and meaning are accurately understood (Weaver & Olson, 2006). The researcher who engages in inter-subjectivity shares an awareness and understanding with the research participants (Weaver & Olson, 2006). The researcher engages with the participant while exploring, finding meaning of, and understanding a phenomenon or culture in its natural setting (Earle-Foley, 2011). The researcher co-discovers and co-creates the truth, as the participants perceive it (Killam, 2012). "It is precisely their interaction that creates the data that will emerge from the inquiry" (Lincoln & Guba, 1989, p. 88).

The relativist ontology and interactive or inter-subjective epistemology are congruent with a qualitative research methodology since they require the researcher to become the research instrument (Lincoln & Guba, 1989). Qualitative research aims at generating insight, describing, and understanding the nature of reality in human experiences (Williamson, 2009). Qualitative research is favored when concepts are

complex, ill defined, and confusing, and where not much information is available on the issue at hand (Melnyk & Fineout-Overholt, 2015).

The purpose of using grounded theory (GT) is to "generate a substantive theory that accounts for a pattern of behaviour, which is relevant or problematic for those involved" (Glaser, 1978, p. 93). GT is used to answer questions related to processes- the "How?" of things, and is not concerned with mere description, but with conceptualization by reducing the data into themes to produce a theory (Glaser & Holton, 2004; Walker & Myrick, 2006).

GT techniques used include: (a) Developing data by conducting, recording, and transcribing interviews; (b) doing open coding on the data line by line; (c) selective coding these data by sorting and categorizing; (c) discovering a core variable or Basic Social Psychological Process (BSPP); (d) memoing; (e) doing theoretical sampling; (f) doing theoretical coding and sorting; (g) ensuring theoretical sensitivity; (h) generating a theory; (i) achieving saturation and rigor; and (j) writing up the findings. I demonstrated theoretical sensitivity by immersing myself in the data for long periods, doing line-by-line coding and suspending my own prior thoughts so to be true to what the data were saying. While conducting the study I applied GT rigor criteria of fit, grab, work, modifiability, generality, and traction as well as Lincoln and Guba's (1985, 1989) four trustworthiness criteria of credibility, transferability, dependability and confirmability. I used the latter because it is well understood and used by many qualitative researchers. While being cognizant that Glaser (2004) renounced using the Lincoln and Guba criteria with GT because of the possibility of reducing the theory to a more descriptive exercise and imposing a pre-existing (Lincoln and Guba) paradigmatic framework that could

further limit what would be seen in the data, I was careful to ensure the theory was brought to a higher level of conceptualization through theoretical coding, sorting, and sensitivity.

Grounded Theory: Two Separate Approaches

As the two original authors of GT, Barney Glaser and Anselm Strauss (1967), began to diverge on certain aspects of the GT method, this created two separate approaches to GT. When Strauss (Strauss & Corbin, 1990, 1998) began proposing a more complex and structured approach to initial coding of data with subsequent verifications, Glaser (1992) interpreted Strauss's technique as "forcing" the data and vehemently refuted this change in the GT method. Glaser remained true to the original method, whereby the theory is generated by constantly comparing data to data, data to concepts, and concepts to concepts, and is organized around the emergence of a core category or variable called "basic social psychological process" (Glaser, 1978). According to Glaser (1978), the rigorous analytical process of constant comparison requires no further verification, correction, or saturation. Walker and Myrick (2006) described the main differences between the two approaches as "the researcher's role, activity, and level of intervention in relation to the procedures used within the data analysis process… specifically addressing the issues of coding, forcing versus emergence, and verification" (p. 547-548). I chose to use the Glaserian approach to GT as it seemed simpler for me to understand and apply. However, I realized I had to remain vigilant to ensure that the perceptions of PN participants would remain uninfluenced by my previous knowledge of the subject, so not to force the data. Although Glaser (1998)

suggested not recording interviews as it may limit the ability to conceptualize the data, I recorded the interviews to remain completely engaged in the interview process, rather than relying on taking copious notes, thus ensuring the data truly reflected the participants' experiences as they described it.

Glaserian Grounded Theory Method

Following the two literature reviews, no information was available to answer the research question, "How do parish nurses develop their spiritual nursing practice over time?" A qualitative exploratory method was thus required. GT was an appropriate and preferred method to answer the research question, which related to a process. This method helped discover the process PNs go through to cultivate their souls and helped develop a model that could help others better understand the complexities of this process.

Data Developing

After the University of New Brunswick Research Board reviewed the study, I began the initial step of data gathering by recruiting participants (Glaser & Strauss, 1967). I sought the assistance of the leaders of the New Brunswick Parish Nursing Ministries (NBPNM) and the Alberta Association of Parish Nurses Ministries (AAPNM). Both leaders emailed their respective members using the invitation letter (see Appendix A) inviting those interested to contact me by email or telephone for more information.

Sample

The criteria for sampling consisted of eligible parish nurses who: (a) received certification in parish nursing; (b) resided in New Brunswick, Nova Scotia, Prince

Edward Island or Alberta; (c) had a minimum of two years of experience in providing spiritual nursing care, while working as a parish nurse and; (d) were willing to participate in a confidential interview for approximately one hour. All those interested received detailed invitation and information letters (see Appendix B) by email informing them of the purpose of the research and their rights as participants. Snowball approach to sampling was also introduced to all participants. However, only one PN came forward from this method and was sent a Snowball invitation letter (see Appendix C), but did not meet the selection criteria of years of experience. Two other PNs, who contacted me, also did not meet the criteria of having a minimum of two years of experience as a PN. Three more PNs who contacted me chose not to participate after receiving the research information letter.

Sample selection

Six participants were selected after establishing eligibility for the study. Each participant had rich personal experiences in providing spiritual nursing care, which made them subject matter experts (Cleary, Horsfall & Hayter, 2014). Each participant received a participant information letter (Appendix B), signed a consent form (Appendix D) and completed a demographic questionnaire (Appendix E). Once the signed consent was received by email or by mail, an interview was scheduled at a mutually agreeable time. Interviews were conducted according to logistics and participants' preferences, which included by Skype (one), telephone (four) and face-to-face (one). Each interview began by restating the purpose of the study, explaining the participants' rights, and informing them that interviews and recordings may be stopped at any time as they wished. The

interview began once the participants' verbal consent was received, and lasted between 50 to 75 minutes.

As illustrated in Table 1, homogeneity of the sample was achieved as all participants were female, of Christian faith including: United, Baptist, Presbyterian, and Other non-identified Christian faith, and ranged in age between 55 and 71 years and over. Participants' highest level of education included three with RN diplomas, and three with Bachelor in Nursing degrees. All participants received certification in parish nursing, albeit from different parish nursing programs over the past 20 years with and without clinical practicum.

One participant also had Clinical Pastoral Education (CPE) and another had a degree in religious studies. Two participants were currently retired from parish nursing after several years in practice, one participant was still working between 10-19 hours per week, and the three others worked less than 10 hours per week. One participant had a paid position, and the three others worked on a volunteer basis, one of which had expenses reimbursed. Five of the six participants had between six and ten years of experience as parish nurses offering spiritual care, while one had between three to five years of experience. All participants gave rich explanations of their experience in developing their spiritual nursing practice over time, while working as PNs in Alberta, Nova Scotia, and New Brunswick.

Table 1. Demographics of PN participants

PN	Gender	Age Range	Religion	Highest Education	PN Education	Status PN Employment	Hours/Week	Salary	PN years of Experience
1	F	55-64	United	RN Dip	Certif.	Part-time	Less than 10	Expenses	6-10
2	F	65-70	United	RN Dip	Certif.	Part-time	10-19	Paid	6-10
3	F	55-64	Presbyterian	RN Dip	Certif. with Cl.	Part-time	Less than 10	In-kind	3-5
4	F	71+	Baptist	BN	Certif. with Cl.; CPE	Retired	10-20	n/a	6-10
5	F	55-64	Other	BN	Certif.	Retired	n/a	n/a	6-10
6	F	71+	Baptist	BN /RS	Certif. with CL	Part-time	Less than 10	n/a	6-10

Note: Participants include six female PNs, age between 55-71+ years, of Christian faith, most having 6-10 years experience as PNs
PN=Parish Nurse; Dip= Diploma; Certif=Certificate; Cl=Clinical practicum; CPE= Clinical Pastoral Education

Interviews

The interviews were recorded for the purpose of ensuring accuracy of data produced. By being free to listen carefully to the participants, rather than taking copious notes, I was able to pay attention, be present, and interact with the participants to help create data. Having data recordings enabled me to listen to the data over and over again, which helped me find common themes and nuances among participants that may have been missed otherwise. This also provided me the opportunity to do line-by-line coding that would not have been possible otherwise. Line-by-line coding is a purposeful way to attain theoretical sensitivity by immersing into the data, and generating a theory that does not need further verification (Glaser, 1978).

Perhaps some participants, perceived recorded interviews as somewhat intimidating. However, I made several efforts to minimize this possible apprehension by contacting participants several times before the interviews and opening the interview process in a casual and friendly manner. I believe this approach made the participants more comfortable with me as they all opened up as we went along the interview process. Glaser (1998) cautioned that recording interviews may slow down the ability to conceptualize the data; however, recording interviews is a well-established practice in qualitative research. Although I acknowledge Glaser's (1998) warning about recording interviews, I still decided to do so. I believe taking notes alone would not have enabled me to produce the quality data I obtained, while maintaining rigor. I believe I would have missed important data generated by interacting with the participants at crucial moments during the interview process, as I would have been busy taking notes. I believe

that by relying only on notes, the data analysis would have been more subject to potential bias, and I may have begun conceptualizing the data too early. Having recordings enabled me to use direct quotes from participants to substantiate the data analysis, hence attain rigor.

Each interview began by using the guiding question *"Can you please tell me about your journey in becoming a parish nurse and providing spiritual care to your clients?"* Once participants were finished talking, I conducted probing questions such as: *"While functioning as a PN, could you describe one or more meaningful experiences when you offered spiritual care to your clients?" "How did you make the transition from the more secular type of nursing care to parish nursing with a focus on spiritual care and what helped you make the transition?"* These questions permitted a more comprehensive and systematic approach to gathering data from one participant to another, while allowing the participant flexibility to answer the questions (Melnyk & Fineout-Overholt, 2015).

During the interview process, I became the research instrument, by interacting with each participant and helping to reveal the required information to meet the purpose of the research question. As I listened to their stories, I tried to view and understand the participants' lived truth. By having a basic awareness and understanding of the subject of parish nursing while suspending opinions and preconceived ideas, I was better positioned to engage with the participants, thus creating what Killam (2012) described as an interactive epistemology that helped co-discover and co-create the data, as the participants perceived it. As one participant commented towards the end of the interview process, *"you're helping me to put all this into words anyway."*

In the beginning, participants' descriptions of their experiences in developing their spiritual nursing practice were complex, ill defined, and confusing, and required clarifying questions such as *"You mentioned you think it's being lost, what do you mean by that?" "You mentioned at one point that you were with your client and that you felt that you had benefited also from that encounter. Can you explain what you meant by that?" "You mentioned something about looking for opportunities. Can you explain to me what you mean by that?"* However, as participants described their experiences, the data became more repetitive, and I was able to ask more focused open questions such as, *"You say it's fulfilling; what makes it fulfilling?" "Did you have any spiritual care education in your nursing program?" "Going back a little bit, what brought you to be interested in spiritual care, what's your background?"*

Transcribing

Audio recordings were transcribed immediately following each interview. Each digital audio recording was downloaded into a password-protected file and assigned an alphanumerical code. The recordings were transcribed verbatim with all personal and identifying information removed. Each transcript was double-spaced and lines numbered. The process of transcription helped me begin to immerse myself in the data, as each audio-recorded interview took between eight and twelve hours to complete. Each interview was listened to several times, verified, and re-verified by playing back the recordings until all data were transcribed accurately and annotations made to reflect pauses and emotional responses.

All information was kept confidential, password-protected, and in locked storage when not being used. Signed consent forms were stored in a locked file separately from other data. Only the researcher had access to the transcripts during the entire study period. The research supervisor and one committee member were given access to the non-identifiable initial coded data. Costs of conducting the interviews remained within the allocated budget (Appendix F), as expenses incurred were mostly for long distant calls with limited travel.

Coding

Data analysis by coding the data is the second step in GT process (Morse & Richards, 2002). I used Glaser's substantive coding which includes two coding procedures: open and selective coding (Glaser & Strauss, 1967). Glaser defines coding as "conceptualizing data by constant comparison of incident with incident, and incident with concept" (Glaser 1992, p. 30). I constantly asked the following questions as I was coding the data, "What [are these] data a study of? What category does this incident [of data] indicate? What is actually happening in the data?" (Glaser, 1978, p. 57). The second step of substantive coding conceptualize the empirical data while the sixth step called "theoretical codes conceptualize how the substantive codes may relate to each other as hypotheses to be integrated into the theory" (Glaser 1978, p. 55).

Substantive-open coding.

Open coding began after transcribing the third interview and subsequent open coding was conducted immediately after each transcribed interview. Open coding of the data was done line-by-line on hard copies of transcripts by circling participants' words

and phrases in each line. All open codes used participants' own words or phrases as per the Glaserian method (1978). By using an Excel spreadsheet, I recorded each open code and tracked them by their corresponding transcript ID and line number. Therefore, each code "earn[ed] their way into the theory as workable and relevant" (Glaser, 1978. p. 64).

Each printed transcript took on average two hours to go through the line-by-line strategy and circle each identified open code. The sorting of the open codes into an Excel spreadsheet took on average an hour per double-spaced transcript page. However, at times open-coding took up to one and a half hours for only a few lines, in order to ensure the data remained grounded and the true meaning of participants' words or phrases were reflected in the codes. Particular attention was given to ensure similar open codes reflected similar meaning without forcing or ignoring any data. As the list of open codes began to increase, I continued to sort all the data using the Excel "search" function and by using the same word, synonyms, and other comparable words and phrases to best classify the data.

Before creating and adding new codes to the spreadsheet, data were constantly compared to all those previously identified thus far. By constantly questioning the context and meaning of a word or phrase, I was able to better compare and identify where the code belonged. To help distinguish each code's significant meaning, I began to produce as many labels as required to minimize error and ensure there was no forcing of the data into any particular category (Glaser & Strauss, 1967).

Glaser (1998) explains coding without forcing the data is when one "suspends what he [or she] knows, keeps studying the data, conceptualizes, and constantly compares" (p. 81). By being totally focused and interested in understanding what the

data were saying while comparing and verifying for accuracy at every moment, I was able to suspend whatever I knew. When I found myself thinking of something that related to my previous knowledge, I made a memo of it, let it go, and then continued to analyze the data. I constantly compared the data to the codes, and kept the labels fluid throughout the open coding process so as to better represent the data and ensure proper fit of the data. Some codes began as general concepts and as they grew in size, they were broken down and sorted into more specific open codes by constantly comparing the data to the codes, comparing the previous data that were categorized into those codes, and going back to the transcripts as needed to ensure accuracy of meaning. As a final step, nine open codes were further broken down. For example, the first open code *journey* was broken down into seven more codes including; *movement, accompanying, where you are at, invitation, reflection, become, cultivate.* I continued to do open coding without omitting any data until all the data were categorized without forcing any into particular codes. This resulted in a total of 343 open codes. According to Glaser (1978), open coding needs no further verification as it is a rigorous analytical process that "carries with it verification, correction and saturation…[and continues until] all data fit" (p. 60). A basic social psychological process began to emerge after the first 3 interviews which was *Love to serve, and partnership with God to serve others.*

Substantive-selective coding.

Once I completed the open coding, I began selective coding by grouping the many open codes into similar descriptive clusters or categories and labeling them using the participants own words. I used an Excel sheet and by adding all the open codes, I began

creating clusters by inserting new category labels for each open code in the adjacent column. Once I assigned new category labels to each open code, I then sorted this new column in alphabetic order so to identify the repeating label names. As I went through the data and new labels names, I ensured the original open codes were in the properly labeled category and adjusted accordingly. This first sorting produced 125 new category labels. By going through this exercise five more times, I ensured the codes remained pertinent to all the data by comparing each open code with all the codes and descriptive category labels. As codes clustered into categories of similar content, I continued to compare data with data and the number of categories reduced each time ending with a total of 21 selected codes. The final selective codes' labels included: acknowledge, attunement, beliefs and values, connection, context, critical moment, decision, environment, God, life events, openness, outcomes, personal/professional development, prayer, presence, reciprocity, reflectivity, relationship, timing, trust/faith, and will/action.

Core Variable

By looking at the many beginning selective codes, I then identified the larger story the data were trying to tell me. The process of substantive coding helped me identify an emerging core variable without compromising or forcing any of the original data (Glaser, 1978). The core variable is the "basic social psychological process" (BSPP) the participants are experiencing (Glaser & Strauss, 1967). This BSPP was identified as "Cultivating the soul to becoming a channel of God one moment in time" as it was a reoccurring theme that accounted for most of the variation in the data and theory, and related to all other categories (Glaser & Holton, 2004). This core variable became "a

guide to further data collection and theoretical sampling" (Glaser, 1978, p. 61). As the core variable began to emerge, I continued using guiding and probing questions during subsequent interviews and began theoretical sampling by using more specific questions to round out concepts, categories, and dimensions, and gain a deeper understanding of the emerging core variable.

Theoretical Sampling

Theoretical sampling is the process of data gathering and analyzing that is purposefully done to help generate a theory. "The analyst jointly collects, codes, and analyzes his [or her] data and decides what data to collect next, and where to find them, in order to develop his [or her] theory as it emerges" (Glaser, 1978, p. 36). As I began to see the core variable of "Becoming a channel of God" emerge, I continued to conduct interviews and began to select particular open-ended questions based on the information required to clarify concepts and themes and to fill out any thin areas in this new theory (Glaser, 1978). The simultaneous data analysis and collection helped establish rigor (Morse & Richard, 2002), and bring focus to my research early on during subsequent interviews, and allowed me to follow emergent leads, which were pertinent to the study area (Charmaz, 2015).

A few theoretic sampling questions used include, *"What are the challenges you've faced in order to be able to offer spiritual care?" "Can you explain to me the difference between providing spiritual care in the secular nursing role and in your parish nursing role?" "Can you give me more information with regard to your journey with the church?" " So you talk about connection and a bond. What's the difference between*

therapeutic relationship and this different relationship that you have with clients as a spiritual nurse, can you try to explain this?" " Previous interviewees talked about presence, and about being a channel of God. Does that resonate with you?" "What does presence mean to you?" "Offering spiritual care, what does it do?" "Did you feel you had some kind of mentoring or support or anything like that in your role or during your training as a parish nurse?" "Can you be effective without having long term relationship and if not, then what does it take to have that connection?"

Saturation

According to Glaser (1978), theoretical sampling provides just enough data until saturation is achieved, which occurs when no new information is forthcoming in the data (Glaser, 1978). I watched for the indicators of saturation, which include "the replication of data or verification of incidents/features/facts by several participants" (Morse & Richards, 2002 p. 100). According to Charmaz (2015), grounded theory seeks saturation of concepts rather than story outlines. Theoretical sampling also required me to gather and use data from literature, to help saturate the core and related categories (Glaser, 1978). This process enabled me to gather rich data with many examples, thus achieving saturation as no new concept were forthcoming from the participants and literature completed the thin aspects of the theory such as leap of faith, and emptying and humbling self. Even though this was a small sample size, participants who were interviewed had many years of experience as PNs providing spiritual nursing care, which made them subject matter experts. According to Guetterman (2015), the number of participants in a qualitative study is not as important as knowing how to gather the sample and why the

particular sample is adequate. PNs are part of a recognized nursing interest group (CNA, 2018, CAPNM 2015b) with specialization in spiritual nursing care. Since the study was designed to know how one develops a spiritual nursing practice over time, members of this interest group were appropriate to be interviewed. All participants in this study shared their experiences, which brought rich and diverse data with many examples. By asking the appropriate questions through theoretical sampling, the data included negative cases. These negative data seem to contradict other participants' experiences, however they are instead variations of the emerging theory. These cases helped clarify the emerging model by strengthening the understanding of the core variable and related concepts of the emerging theory (Glaser & Strauss 1967; Morse, 2015). In a study done by Guest, Bunce and Johnson (2006) on qualitative sampling, saturation was achieved by interviewing twelve of the 60 participants, which created 92% of the codes. The remaining 48 interviews produced only five new themes, four of which were variations of the previous existing themes (Guest et al., 2006). Morse (2015) states we can recognize saturated research when the data are rich in scope and comprehensiveness and when several participants have essential characteristics in common which can be described by many examples.

All concepts were identified through many examples from all participants with the exception of *humbling and emptying self* and *taking a leap of faith*, which have been mentioned by two and three participants respectively. Therefore, literature was used to help saturate these concepts. An academic research committee member, who taught many PNs over several years, stated many PNs have shared very similar experiences, which helped confirm the emerging theory.

Theoretical Coding

Once substantive open and selective coding were completed, I began theoretical coding which helped find relationships among the codes and brought the data to a higher level of conceptualization, which in turn helped generate the theory (Glaser, 1978). The empirical data were constantly compared with the goal of discovering various patterns of interactions and consequences over time. This helped to create stages of a theory that explained the phenomenon of how PNs develop their spiritual nursing practice over time.

I began by defining clusters of selective code and naming these categories at a more conceptual level. In order to understand the relationships among these, I used three types of family codes as described by Glaser (1978): (a) the 6 Cs: causes, context, contingencies, consequences, co-variances, and conditions; (b) self-identity: self-image, self-concept, self-worth, self-evaluation, identity, social worth, self-realization, transformation of self, conversion of identity; and (c) modeling (Glaser, 1978; Morse & Richards, 2002).

By using a matrix with selective codes and family of six Cs, I began finding relationships among them by asking questions such as "What seems to be the cause of this particular incident?" "What is the context of this story?" "What is accidentally happening which is affecting a secondary variable?" "What seems to be the consequence or outcomes of this action?" "What other connecting variables exist which are concurrently favoring or disadvantaging the situation or action?" "What are the conditions which help or hinder this action or situation?"

This was followed by a second and separate theoretical coding exercise using the family code of self-identity. While going through the codes and the transcripts, I asked

the following questions: “How do you portray yourself?”; “How do you define yourself?”; “What are your qualities?”; “How do you value yourself?”; “How do you question your beliefs, values and actions?”; “Do you reflect on yourself?”; “Who and what are you?”; “What is your place in society?”; “How did you achieve the full potential of your abilities and talents?”; “What process did you go through to change identities from PN to channel of God?”; and “ How is your identity now changed?”

Once these questions were answered, more conceptual theoretical codes were determined. Following these family coding exercises, I compared the theoretical codes to the selective codes and transcripts to ensure they remained grounded in the data. I continued to work and rework the theoretical codes until all the data fit and the codes worked to produce a final model recommended by Glaser (1978) to remain as simple as possible despite its complexities. The final ten theoretical codes included; *finding favourable environments, trusting in God, deciding to act, taking a leap of faith, foundation of God-related beliefs and values, presence with self, presence with God, presence with others, presence with God and others, and channel of God.*

Memoing

Memoing is the activity of taking notes while conducting coding (Morse & Richards, 2002). Clear descriptive memos were most helpful when going over them at a later date (Glaser, 1978; Morse & Richards, 2002). These notes were used to keep track of ideas that emerged while coding, and following discussions with participants and my academic supervisor. Memoing was useful in making notes of hunches, questions related to codes, theories, and various relationships that may show links and gaps. Other memos

included clarifying questions that I sought answers to while conducting theoretical sampling.

Memoing was a necessary exercise that helped me continue to code without being preoccupied with other emerging thoughts at that moment. Some memos included leads that could be investigated further at a later time such as books on spirituality, articles that may shed light on the process of conducting grounded theory, and decisions about codes and categories, potential links, gaps, practical implications, and theory being made (Glaser & Stauss 1967). Memoing helped bring clarity as I reworked the codes and the model in various ways over and over again to make the data work. This activity also helped me record descriptions of events that I observed, impressions during interviews, and questions needing clarification during future interviews. Memos were also used and reflected upon on while reading transcripts over again and listening to the news that may have triggered a thought during theoretical sorting, and when formulating a theory. Two notebooks were used for memoing during the study; one during the coding exercise and the other while developing the theory.

Theoretical Sorting

Theoretical sorting is the sorting of ideas not data, and is an essential step in the development of a grounded theory (Glaser, 1978). This helps in developing the first and subsequent drafts of the manuscript (Glaser, 1978). Creativity and theoretical sorting of memos previously collected helped me generate more ideas at a higher conceptual level.

I followed Glaser's (1978) six basic rules to theoretical sorting, which helped guide me in what I needed to do next and what to keep track of while constructing and

writing the theory as it emerged. According to Glaser (1978), all these rules have a specific beginning and an end in generating a theory. The first being, *one must start to sort memos by beginning anywhere* (Glaser, 1978). This rule encouraged me as I began looking through the many pages of memos and not knowing what was still relevant. I decided to start with the most recent memos then working back to the beginning of the notebook.

In order to provide focus, the second rule to *only keep memos that are still pertinent to the core category* was observed. As I worked through all the memos, from back to front, only the memos that were still relevant to the core category were kept for further review and all the other "concepts [were] left out of the theory" (Glaser, 1978, p.121). Therefore, as I came across a memo, I reviewed it further only if it was pertinent to the core concept of "Cultivating the soul to become a channel of God one moment in time." The third rule includes *integrative fit*, whereby it is the researcher's responsibility to make sure all ideas fit somewhere in the outline or the integration must be modified accordingly (Glaser, 1978). This rule of sorting memos helped give a sense of order and readability to the categories, which were then included as headings in the findings chapter (Glaser, 1978).

The fourth rule is *theoretical completeness*, which includes using the least possible concepts to create the greatest possible scope and variation of the problem under study (Glaser, 1978). This rule was kept by collapsing several initial stages into six stages and by creating a four-step process of moving through these stages instead of having several key words that seemed unrelated.

The fifth rule includes the *mechanics of sorting*, whereby the researcher organizes piles of individual memos initially categorized, while spreading them out on a workable space (Glaser, 1978). I was able to sort them using an Excel sheet rather than sticky notes. The last essential rule is *theoretical pacing*, whereby the researcher schedules flexible uninterrupted time on a regular basis to sort the memos while taking unstructured breaks whenever needed as this maintains a better flow of ideas (Glaser, 1978). This was done by taking between 4-10 hours at time to go through the memos to ensue all hunches were looked at, and appropriately added to the theory.

While Glaser identified up to eleven rules for sorting memos, all the other rules complement these six basic ones (Glaser, 1978). According to Glaser (1978), it is through proper sorting that the theory becomes dense. According to Glaser (1978),

> Density puts a premium on the detailed, line by line grounding of categories. This is opposed to the overall grounding of a core variable, and then making it into a main theme, with only few conceptual details and lots of description, thus generating a very thin theory (p. 120).

I believe the many concepts identified and integrated have made the theory dense.

Glaser (1978) also identified the concept of *traction,* which is a means of going over the data to ensure all the data and ideas generated to date have been looked at, and that none have been lost. I believe using Glaser's analytic rules and traction to control the sorting of piles of memos, based on similarities, connections, and conceptual ordering, helped me begin to see patterns and an emerging theory. I looked at all annotations in the two memo notebooks.

Theoretical Sensitivity

Theoretical sensitivity is a quality ascribed to the researcher who is sensitive to what the data are saying and has enough insight to determine what data are important in the development of a theory (Glaser, 1978). Theoretical sensitivity also means the researcher does not have preconceived ideas or hypotheses about the data. Rather, the researcher immerses into the data for long periods at a time, and does line-by-line coding while constantly comparing data until all data fit (Glaser, 1978, 1998, 2002; Glaser & Strauss, 1967).

According to Glaser (1978), "the first step in gaining theoretical sensitivity is to enter the research setting with as few predetermined ideas as possible-especially logically deducted, a priori hypotheses…His [sic] mandate is to remain open to what is actually happening" (p. 3). Glaser (1998) suggests not doing a literature review in the substantive area of research, as this may colour one's perceptions, which may later influence the emerging concepts from the data, interpretation, and emerging theory. Rather, Glaser (1998) suggests doing a literature review during the sorting and writing phases, so as to weave the information into the theory and continue the constant comparison of data.

Although I understand Glaser's reasoning of entering the research area with a blank slate, I cannot agree with this assumption. As researchers, we must gain some level of information before deciding to conduct research and determining the proper research question to study. Also as professional nurses, we have been trained to set aside our own thoughts, feelings, and judgments as they relate to our work without compromising our integrity (CNA, 2008). As stated earlier, I had already conducted a review on policy, standards of practice in parish nursing, and the spiritual nursing practice of parish nurses

in order to ensure the research question was still unanswered. I also had some personal experience and exposure to parish nursing. Therefore, it was not possible for me to enter the field of parish nursing without any preconceived ideas. However, I certainly had no priori hypothesis on how parish nurses develop their spiritual nursing practice over time; I had only a heightened curiosity on the subject.

In order to address the issue, I took the time, before I began the interviews, to write down everything I knew about parish nursing, including any assumptions that may be perceived as related to the research question. As I looked at these after analysis of study data, I realized none of my notes had similarities with the study. For instance, I had the impression that most PNs, being of an older age group, went to religious schools of nursing, which may have offered spiritual nursing training. Also, I did not realize most PN certificate courses in the past 20 years had spiritual training and mentoring involved. Rather, I thought PNs took on other PN roles, such as coordinator and educator and offered more religious and spiritual interventions as they gained more experience as PNs while working with their pastors. Most surprising to me was that most PNs experienced fear in providing spiritual nursing care in their secular working environments prior to beginning as PNs in a faith community. These were all new knowledge for me as I began to analyze the data. The most revealing of all was the level of spirituality that PNs achieve and their ability to become a channel of God while offering their clients spiritual care.

I believe I attained theoretical sensitivity by immersing myself in the data for long periods of time (10-18 hours at a time) over several months, first by listening to the audio-recorded interviews several times, then transcribing and reading each transcript

several times to ensure accuracy. I continued to immerse myself in the data by doing line-by-line coding of each transcript while taking the time to compare codes to codes, codes to categories while going back to the transcripts to ensure proper understanding. The comparison was done constantly and reworked until the core variable emerged and all the data fit well within each category. Once the core variable began to emerge, I found it to be quite surprising, as it was something that I could not have imagined on my own. Therefore, I believe any prior knowledge in the field of study did not interfere with my ability to analyze data and develop data-driven theory that explained all of the data. I also incorporated a robust method of rigor that was used throughout the research strategy. I believe I maintained theoretical sensitivity during the course of conducting my research with GT because, as Glaser (1978) recommended, I did constant comparison of data, kept an open mind, maintained an acute continuous awareness of potential bias, and utilized proper methods of rigor.

Ensuring Rigor

Glaser's (Glaser, 1978; Glaser & Strauss, 1967) six criteria of rigor and Lincoln and Guba's (1985, 1989) four criteria of trustworthiness, as described below, were used throughout my research to ensure scientific rigor. "The goal of qualitative research is to accurately represent study participants' experiences" (Williamson, 2009, p. 205). Therefore, I believe it was my responsibility as a researcher to ensure the study findings represent the data well. It is noteworthy that Glaser (2004) critiqued the use of Lincoln and Guba's paradigm of Naturalistic Inquiry (NI, 1985) and method of trustworthiness with grounded theory saying, "NI can remodel GT into a search for causality and

severely restrict its generation of theory" (p.13). Glaser (2004) continues by saying "GT becomes subject to all the criteria for achieving accuracy of description, which do not apply" since GT is not designed to describe data but to conceptualize data into a theory. Despite these arguments, Lincoln and Guba's (1985, 1989) criteria for Trustworthiness in qualitative research studies are well established. In order to address these concerns, I was vigilant during the theoretical coding exercise so not to let it become simply a descriptive exercise but to bring the data to a higher level of conceptualization and generate a theory.

Glaser's criteria

Glaser and Strauss (1967) suggest these properties of GT to ensure rigor of the research: fit, grab, work, modifiability, generality and traction. The following gives a brief description of each property and how it was incorporated in the study.

Fit

Fit means data categories are "readily (not forcibly) applicable to and indicated by the data under study" (Glaser & Strauss, 1967, p. 3). All data were used, and fit into an open and substantive category without being forced, ignored, removed, or distorted. Subsequently, all data and substantive categories fit well into theoretical categories that generated the theory. According to Glaser and Strauss (1967), a theory that is grounded in data will automatically relate to what is really happening on a daily basis with the population.

Grab

Glaser (1978) describes theories with grab as those that people find interesting and tend to remember and use. In order to achieve grab, a theory must be relevant and useful to the people it is intended for (Glaser, 1978). By using participants' own words in developing the codes and theory, I believe it has achieved grab for those it is intended to represent. The findings were shared with the participants. The four participants that responded all agreed that theory represented their experience well.

Work

Work refers to categories being "meaningfully relevant to, and … able to explain the behaviour under study" (Glaser & Strauss, 1967, p. 3). It also means being simple enough for any laymen, who are involved in the area of study, to easily understand it (Glaser & Strauss, 1967). When presented with the theory, participants easily understood it as it clearly explained what happened to these PNs over time. I believe it can also help predict what will happen to PNs who continue on this path, and interpret what is happening when developing a spiritual nursing practice.

Modifiability

While generating the theory, I was constantly changing any and all codes and categories to accommodate the data, and did not guard any one favourite code. This enabled the theory to remain open to corrections at all times as new evidence emerged (Nathaniel & Andrews, 2010). After sharing the preliminary findings with participants, all comments received showed that the theory had grab, fit the data, and worked in the real world (Melnyk & Fineout-Overholt, 2015; Walker & Myrick, 2006). The theory was

strengthened as new data received were incorporated into the theory. Two participants suggested changing the term used for stage two *spiritual awakening* to *presence with self.* This term had a broader meaning that was more reflective of their experiences of being aware of themselves, what they liked, disliked, believed, and did not believe in, their feelings, and frustrations which better reflected the data as a whole. This showed that the theory remained relevant when confronted with new data, and was able to adapt to the new data. As Glaser (1978) suggested "The theory can never be more correct than its ability to work the data - thus, as the latter reveals itself in research, the former must constantly be modified…theoretical coding- allows for ready, quick modification to help explain surprising or new variations" (p. 5).

Generality

Generality ensures the theory, which is inductively generated, will be generalizable to the greater populations experiencing the issue researched (Glaser & Strauss, 1967). I created categories that were abstract enough to make the theory a general guide for those who wish to understand the process of developing a spiritual nursing practice. This guide became general enough to accommodate various conditions and situations encountered by PN participants. This step is not intended to be generalizable to a larger population, rather the theory should remain at a high enough conceptual level to make sense to those who experience the phenomenon of developing a spiritual nursing practice (Glaser & Strauss, 1967).

Traction:

Glaser (1978) describes traction as a means of going over the data. By ensuring that all the data and ideas generated to date have been looked at, and that none have been lost helps to generate a theory that remains grounded in the data (Glaser, 1978).

Lincoln and Guba's Criteria of Trustworthiness

Lincoln and Guba (1985, 1989) described the process of trustworthiness as a way of ensuring rigor in qualitative studies. Trustworthiness includes four subgroups: credibility, transferability, dependability, and confirmability. These four subgroups were used to strengthen the rigor of my GT study while keeping in mind not to compromise the conceptualization of the theory for description as Glaser (2004) argued.

Credibility

Credibility or plausibility was achieved as I was in contact with the participants on several occasions prior to the data collection. By communicating with the participants early on, it ensured that they understood the process and subject matter. I was also able to offer them their choice of venue that helped build the required trust and comfort level with the participants. Establishing a sense of trust from the beginning meant that participants felt safe and by remaining sensitive to what they were saying, I believe I helped them open up and share their experiences authentically with me. This helped ensure the information collected during the interviews was a true reflection of their authentic experience (Lincoln & Guba, 1985, 1989). During the interview several clarifying questions were used to ensure accuracy of words and meaning. In order to better inform data, I specifically added to the transcripts all pauses, facial expressions

(one face to face interview), or emotions that the participants showed through their voices, which was not always easily identifiable in the audio-recordings. Guiding and probing questions ensured depth of the data by identifying characteristics most relevant to the problem, and by focusing on them in detail (Lincoln & Guba, 1985, 1989; Robert Wood Johnson Foundation [RWJF], 2008). I ensured the generated theory accounted for all the cases, and tested the data, interpretations, categories, and conclusions with participants. This was done to ensure adequate representation of their authentic experience (Lincoln & Guba, 1985, 1989; RWJF, 2008).

Transferability

Transferability is the equivalent to external validity or generalizability in quantitative research whereby there sometimes is a randomized sample of the population (Lincoln & Guba, 1985, 1989). In order to obtain transferability, I selected a purposeful sample of parish nurses who fit the authentic experience under study and began the research data developing. A thick theory with many concepts was generated. As Lincoln & Guba, (1985, 1989) suggest, this will enable others to decide whether the conclusions can be transferred to other settings, times, situations, and people.

Dependability

To ensure reliability of the findings based on the data, I kept an audit trail of the research process from the gathering of data to the reporting of findings as suggested by (Lincoln & Guba, 1985; 1989). This included keeping an audit trail, or notebook of all data, analyses, synthesis, theoretical notes, relationships, methods, processes, and products used during the study.

Confirmability

To ascertain the findings are grounded in data, I kept a reflective diary, as suggested by Lincoln and Guba (1985, 1989). I used this second notebook as a self-journal to record all methodological decisions and reasons for them, and documented what was happening with regard to my own values, interests and judgments and emerging theory all of which helped generate the theory.

I used all of the rigor methods described above throughout the entire process of conducting my study. I believe by remaining cognizant of this fact, I ensured the criteria of trustworthiness did not limit GT to a descriptive exercise but generated the more conceptual theory called for by Glaser (2004).

Chapter 4 Research Findings

Parish nurses (PNs) develop a holistic nursing practice over time by caring for their clients' bodies, minds, and spirits while focusing specifically on spiritual nursing care. While PNs have many roles within their practice, this study and its findings focus on the spiritual aspect of their nursing practice. PNs develop their spiritual nursing practice by first cultivating their own souls. As they embark on a "spiritual journey," PNs go through an iterative four-step basic social psychological process (BSPP) called *Cultivating the soul to become a channel of God one moment in time.* The four-steps include *finding favourable environments, trusting in God, deciding to act,* and *taking a leap of faith at the right moment* (see Table 2). As they move through this process, PNs reach six stages of presence which include *foundation of God-related beliefs and values, presence with self, presence with God, presence with others, presence with God and others, and channel of God* (see Figure 1).

By cultivating their own souls, PNs can relate to their clients' spirituality by "listening to their stories." As one participant explains, "It would be very difficult to talk to others about their spirituality… if you haven't done your own work about your own spirituality." As PNs develop trusting relationships with their clients, they perceive their clients to be open to receiving spiritual care from them. PNs gain their clients' trust by (a) being (visible, accessible, attuned, interested, present, kind, competent, and professional); (b) knowing (helping clients reflect on their personal beliefs, values, strengths, and resources); and (c) doing (taking the time to assess, listen, pray, provide scripture reading, bring communion, and sing hymns). By assessing and meeting their clients' needs "where they are at," PNs "accompany" their clients on their spiritual

journeys. PNs help clients "move past" issues with the "ultimate goal" of making them "feel heard" and "feel less spiritually unsettled" which "gives them hope and peace." One participant explained "all that took time and relationship building and including a trust in who I was and what my skills were."

Iterative Four-Step Process

PNs describe going through a process over time, which helps them cultivate their souls, as they "evolve" from one stage of presence to another. As they grow spiritually, PNs become more aware of themselves, God, and others. They begin to see where they are in their current stage of presence, which enables them to better understand where others are coming from. PNs cultivate their souls at different rates, and only five of the six PN participants describe attaining all stages of presence. By desiring to move rather than remain in their "comfort zone," PNs climb the four-step iterative process of finding favourable environments by *desiring and seeking*; trusting in God by *being receptive, centering self, and praying;* deciding to act by *being attuned and seizing opportunities*; and taking a leap of faith at the right moment by *finding courage and strength through God* (see Table 2).

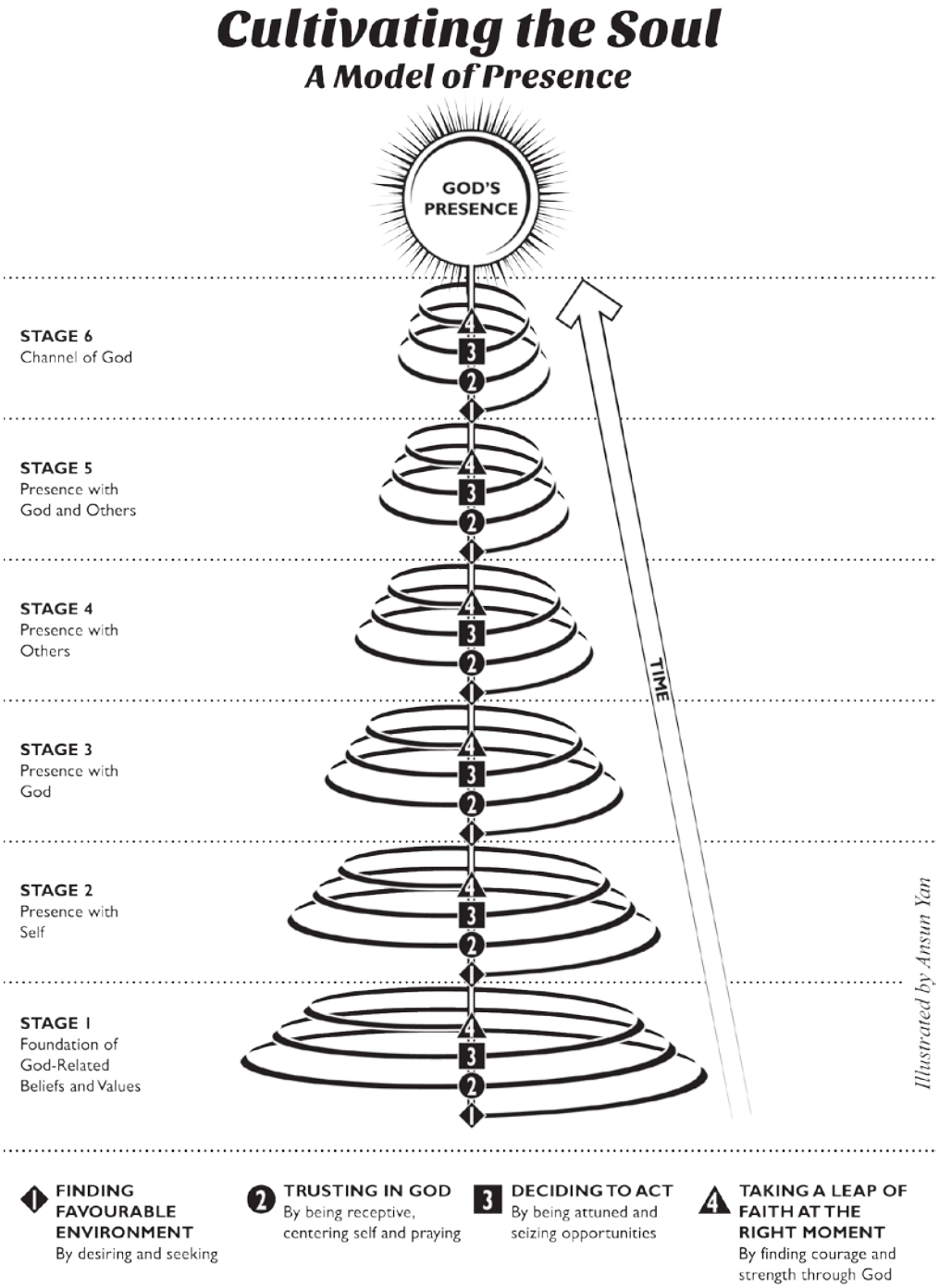
Table 2.

Four-step iterative process of cultivating the soul by stages of presence

Stages	Types of Presence	Step 1 Finding Favourable Environments By desiring and seeking	Step 2 Trusting in God By being receptive, centering self, and praying	Step 3 Deciding to Act By being attuned and seizing opportunities	Step 4
		Conditions	Causes	Consequences	
6	Channel of God	Communion with God and Others	Letting Go Through God	Humbling and Emptying Self	Taking a Leap of Faith at the Right Moment By finding courage and strength through God Time
5	Presence with God & Others	Prayerful Environment	Engaging in Service in Partnership with God	Praying with Others	
4	Presence with Others	Caring Environment	Loving God	Caring for Others	
3	Presence with God	Faith Community	Having Faith in God	Committing to God	
2	Presence with Self	Nurturing Community	Questioning and Hoping in God	Reflecting and Developing Self	
1	Foundation of God-Related Beliefs & Values	Faith-Inspired Environment	Learning about God and Related Beliefs and Values	Adopting God-Related Beliefs and Values	

Note: Each stage of presence has their specific conditions, causes, and consequences over time that enable movement.

Figure 1. **Cultivating the Soul: A Model of Presence:**



Note: PNs'soul is represented by six stages with God's presence (yellow) going through the center. The four-step process helps PNs move from one stage to another over time.

Step 1- Finding Favourable Environments by Desiring and Seeking

Each stage of presence has its own favourable environment or context that PNs desire and seek. Favourable environments include faith-inspired environment, nurturing community, faith community, caring environment, prayerful environment, and communion with God and others (see Table 2, column 2). Some environments PNs find themselves in may be hostile to developing a spiritual nursing practice. One participant explained a hostile environment as "you can be a believer, but you keep your mouth shut, was sort of the philosophy in my secular employment." The environments will either allow ample or limited opportunities for PNs to provide spiritual care and continue to cultivate their souls.

According to the English Oxford Living dictionary (2018) a desire is "a strong feeling of wanting to have something or wishing for something to happen." Sometimes, PNs are no longer comfortable where they are at and desire to move. One participant described her experience this way: "Unfortunately I've been through an awful lot to get to that point… [to decide to change jobs] I just knew this time was different [I had no other choice but to find a new job this time]." Another participant said " something prevented me from going into nursing after High School. So I took a secretarial course. So I did that for a year and thought, no, I need to be with people. So then I went back and took my LPN [Licenced Practical Nurse]." At other times, PNs move because they desire to live new opportunities in different environments as they "needed to connect with people."

Finding favourable environments may not be sufficient for PNs to move through stages that are "out of my comfort zone" because "there was no opportunity" or "I was completely burnt out." Once PNs find a favourable environment for their spiritual growth, they move to the second step- Trusting in God.

Step 2- Trusting in God by Being Receptive, Centering Self, and Praying

Trusting in God by being *receptive, centering self, and praying* changes over time as PNs move through levels which include *learning about God and related beliefs and values; questioning and hoping in God; having faith in God; loving God; engaging in service in partnership with God; and letting go through God* (see Table 1, column 3). PNs' level of trust in God depends on their level of receptivity to God, their ability to centre themselves by quieting their minds, and propensity to focus on God through prayer, all of which, according to Goldsmith (1964), will bring them closer to God's presence within their souls. One participant explained, "When I'm in prayer, I want to enter into the presence of the Lord and that takes time…where you are, really are connecting, it's not just a quick prayer."

Van der Riet, Levett-Jones and Aquino-Russell, (2018) conducted a literature review on Mindfulness Meditation with nurses and nursing students and found that there is a "positive impact on their level of stress, anxiety, depression, burnout, sense of well-being and empathy" (p.1). Mindfulness Meditation has its origins in the eastern cultures over 5000 years ago and in recent years has gained much attention including in healthcare (Van der Riet, et al., 2018). "Meditation is a tool to develop mindfulness [while] mindfulness refers to engagement in or curiosity about the present moment, which

encourages an attitude of non-judgemental openness and acceptance, so as to cultivate equanimity and stillness" (Van der Riet et al., p.1).

By training one's heart to listen and one's mind to be still, God will be near waiting for one's call (Goldsmith, 1964). As one begins to trust God and ask for help, one draws near to God who will come and take away all troubles in one's state of mind and heal one's soul (Goldsmith, 1961). One PN participant described her trust in God this way:

> I don't know how people do it if they don't have the hope and even the availability of linking with a higher power, higher than themselves. Life is rough, and I often think 'well okay God, what are you doing here?' But on the other hand, where do I turn? I have to turn to Him, because He's the only one that knows what's really going on, and He knows how to guide my spirit.

By trusting in God, PNs reconcile themselves with God and others after "a faith crisis" when they feel themselves questioning their faith following a life event. By "hav[ing] this little bit of respite," they "work[ed] through that [crisis]" until "we were ok." As PNs draw closer to God, it takes time for their fear of not being forgiven to dissipate, but as one participant summarizes, God is always faithful to us.

> When people are in crisis with their faith, I get it, I completely get it…I can say with great assurance…it's ok, no matter what way you're feeling…thank God, and I mean those words, that He's faithful. He's faithful because, just because, I took a break from him, He didn't take a break from me.

As PNs center themselves and come closer to God's presence, they draw on God's strength − "the strength that doesn't come from me but from elsewhere" and become aware of new opportunities as "perfect timing, God's timing." This brings PNs to the third step of deciding to act.

Step 3- Deciding to Act by Being Attuned and Seizing Opportunities

PNs attain the third step, *deciding to act*, by *being attuned and seizing opportunities* during various life events. Each stage of presence opens new opportunities for action and includes *adopting God-related beliefs and values, reflecting and developing self, committing to God, caring for others, praying with others, and humbling and emptying self* (see Table 1, column 4).

One participant acted despite the attitude of other nurses around a particular client who was homeless and in desperate need of a bath and clean clothes. "I said 'I'll go clean this man,' so I did…I just think that you need to have someone step up. He was a person, you know." At times, PNs may not be able to seize opportunities because of limited understanding, awareness, attunement, and receptivity to God, as they may be "just so rushed." At other times, PNs choose not to move for reasons of complacency, fear, doubt, anger, disinterest, and disagreement. When opportunities are missed in these ways, PNs remain where they are, and continue to live life events, whether comfortable or not, in the same stage of presence. One participant described her situation as "I was *mad***,** I was mad at God…I took a break for about ten years." Once they decide to act, PNs leave their comfort zone and go to the next step − taking a leap of faith at the right moment.

Step 4- Taking a Leap of Faith at the Right Moment by Finding Courage and Strength through God.

The act of transitioning from one stage to another at the right moment is called *taking a leap of faith* (see Table 1, column 5). This step is dependent on timing, *courage*,

and strength through God to leave their comfort zone and leap into an unknown stage of presence during critical moments in their lives while "pray[ing to] the Good Lord to help." As PNs continue to experience life events in the same stage of presence, they come to a point where they feel they have exhausted all opportunities and they begin to desire and seek new environments in a higher stage of presence, where they hope to have more opportunities available to them.

When PNs are not receptive to God during critical moments, God's strength may come to them through others, as one participant explained, "I was done, ready to stop nursing [but] she [clergy friend] said 'maybe you just need to do a different kind of nursing…would you ever consider parish nursing?' I had never thought of that…I just went and took the course." Thus, the door to new favourable environments is open to PNs who desire and seek it.

Goldsmith (1961, 1964) explains that trusting God begins by being receptive to the possibility of the existence of a God who is a loving Supreme Being, and by quieting the mind. According to Goldsmith (1961, 1964), as one prays, and learns more about God, one begins to incorporate God's will into their life and becomes more devout to God. Kempis (1418-1427/1993) states, "In silence and stillness the devout soul advances and learns the hidden truths…" (p. 46). Goldsmith (1947/1999) echoes this by saying that one becomes spiritual by being receptive, silencing the senses and listening for the "still small voice" p.185. Tolle (2008) explains that when we suspend our judgements, inner thoughts, and self-talks, we can better appreciate and live in each moment. Kempis (1412-1427/1993) encourages us to lean on God for help: "be silent and endure for a

while and you will experience the help of God in your need. No doubt about it, for God knows when and how to deliver you. So put yourself in His care" (p. 71).

These data help explain PNs experiences of taking a leap of faith at the right moment by finding courage and strength through God. This is also congruent with PNs explanation in the stage of channel of God as it relates to their communion with God and others by humbling and emptying self. Killingsworth and Gilbert (2010) report on a large US study whereby it was determined that a wandering mind is an unhappy mind, and they suggest that by stilling the mind, people may become happier. This may help explain PNs' feelings of satisfaction and peace when they center themselves while becoming a channel of God.

When PNs desire and seek new favourable environments; trust God by being receptive, centering self and praying; decide to act by being attuned and seizing opportunities; and find courage and strength through God, they take a leap of faith at the right moment and move to new stages of presence. One participant summarized the four-step process of moving through stages this way: "After talking… researching...I decided that, and praying about it for sure...I thought ok I'll give this a try. What else can you do, but to trust the Lord?"

Stages of Presence

By going through the four iterative steps of the BSPP, PNs move through six stages of presence, which are *foundation of God-related beliefs and values, presence with self, presence with God, presence with others, presence with God and others, and*

channel of God. The six stages of presence are joined together in the center by God's Presence, which together form PNs' souls (see Figure 1).

Stage One: Foundation of God-Related Beliefs and Values

Most PNs describe receiving an upbringing in the Christian faith. As believers in God, PNs' parents and grandparents laid the *foundation of God-related beliefs and values* (see Table 1, column 1, row 1). These *faith-inspired environments* provide opportunities for *learning about God and related beliefs and values.* By being open, PNs learn to pray and trust in God. Most participants regarded the church as foundational to their upbringing as their families had "very strong church affiliation." Adopting these God-related beliefs and values continued throughout PNs lives and became "a foundation of my life." However, one PN described having a different family upbringing as a child. "My home, being raised was not what we call a religious home, but there was a little church in our neighbourhood that I got involved [with]… that started my faith journey." Although all PNs expressed having received a foundation of God-related beliefs and values as children, they believe that all people are inherently spiritual beings. Therefore, according to PNs, everyone can choose to adopt these God-related beliefs and values and grow spiritually later on in adulthood:

> It would be very challenging, I guess, for people who really never had a spiritual background to do spiritual care…I guess they would have to bring it to the forefront…people can be spiritual without going to church and not really recognize that…because sometimes they don't want it to be seen as spiritual. We all have a spiritual side but lots of times people don't recognize it.

Stage Two: Presence with Self

As children and youth, PNs describe being part of *nurturing communities* where parents, grandmother[s], neighbours, friends, and youth groups continue to support them as they begin *questioning and hoping in God* and *reflecting and developing* their own set of beliefs and values (see Table 1, column 1, row 2). This support enables them "to look at [their] own personal spirituality" and is the beginning of their spiritual awakening. PNs continue their faith education by being "brought to church every Sunday"and "going to Sunday School" which includes learning about God, reading scripture, and learning prayers, hymns, and various other religious practices.

However, one PN described "not having a lot of support from my family" and expressed that this family environment created some difficulty as "I would have probably had a more consistent journey… It was kind of an off and on thing for a lot of years until I went into nursing. She continued to explain that she received spiritual support through "The Nurses Christian Fellowship [which] helped tie all these ends as well." As they develop their spirituality, PNs become more attuned to themselves, and their surroundings. PNs come to find out what corresponds best to them, what makes them feel alive, and move to the next stage, where they seek to be with faith communities.

Stage Three: Presence with God

As youth and young adults, potential PNs become more familiar with God and seek to be regular members of *faith communities* as they "just need[ed] a community, a church community," that allows them to be supported. By *having faith in God* and *committing to God*, PNs dedicate their lives to God (see Table 1, column 1, row 3).

These faith communities may not necessarily be of the same denomination as the PN. Yet, they are friendly, spiritual spaces where PNs feel "at home." One PN describes how she "didn't get the support from the church" and because she "wasn't getting what she needed," she left that church but "maintained my faith in God." As they become part of safe and supportive faith communities, PNs learn to be present with God by having faith in God through prayer, studies, and mentors which bring them to commit themselves to God. As one participant described, "by the time I was 12, I had come to faith myself and engaged myself in church youth group."

According to Dyess (2011), faith is "an evolving pattern of believing, that grounds and guides authentic living and gives meaning in the present moment of inter-relating" (p. 2723). Dyess (2011) identified four key attributes of faith which include focusing on beliefs, foundational meaning for life, living authentically in accordance with beliefs, and interrelating with self, others and/or Divine. De Rouville (1768/1985) states that "exhortations to virtue can make people value it. But when example is joined to word, it persuades them to practice that virtue. The example of the saints makes saints" (p. 117).

De Rouville (1768/1985) continues,

> if you want a deeper understanding of the mysteries of faith you must take them seriously and meditate attentively on them. By meditating often on the perfections of God and the nothingness of things human the saints achieved detachment from creatures and were able to concentrate their affections on the Creator" (p. 111).

Van Dover and Pfeiffer (2005) found trust in God is foundational to providing spiritual nursing care. In this study, PNs' faith in God is solidified not only through church attendance, but by being with others who believe in God. One participant said, "I

was so devastated [by my husband's sudden death, that] I stopped going to church, [and] I began to see a life coach…who was a pastor." One PN, who described struggling with her faith as a youth because of her family's different beliefs and values, was able to continue her faith journey as she "took religious studies that helped solidify my faith."

As they begin to live their faith, PNs get involved in their church community, take on "leadership roles in the church," and participate in various church activities by going "to youth group, junior choir ...[and getting] right into the church." Their faith is "hugely important" to them; as PNs grow spiritually, they continue building on their foundation of faith and strengthen their relationship with God by seeking spiritual and religious formation such as "a Clinical Pastoral Education (CPE) course." One participant explains, "I was kind of back and forth [to church until] when I decided to go to the Bible program to clarify things in my mind… and that did help solidify my faith." PNs believe "spiritual can be not just religious" as they seek various ways to cultivate their personal spiritual selves over time as "a work in progress."

Their "strong faith" helps PNs go through difficult life events by helping them understand things differently and soothing their souls. One participant said, "my faith at that point just became my rock… my faith never waivered." Another considered "spirituality is a plus…it just interprets things in a different way…[it] helps ease the burden that people seem to want to carry all by themselves."

As they become more attuned to coincidences and circumstances, PNs "catch things," "learn lots from people," and acknowledge God's work in people's lives. Becoming more aware of God's presence enables becoming more open to various opportunities. Examples include volunteering to "help a person when others would not

help" and seizing opportunities such as going to "Sunday School with neighbours," a "National parish nursing group meeting," and "mission work in Japan."

Therefore, as PNs grow spiritually, they become faithful and loyal to God. PNs' faithfulness to God brings them closer to God as they seek God in all circumstances. Their loyalty to God helps PNs willfully obey God and do what is required of them. As they grow and learn, they come to know there is a larger network of opportunities in caring environments where they can live out their faithfulness and loyalty to God. PNs decide to take a leap of faith at the right moment to live out new experiences in caring for others.

Stage Four: Presence with Others

PNs describe wanting to live their commitment to God by *loving God* and by seeking *caring environments* congruent with helping and *caring for others* (see Table 1, column 1, row 4). PNs build trusting relationships with others because they "really want to connect with people" and help to care for all their needs. One participant explained "that's where my journey began…being with people…feeling that spiritual nature…just wanted to help [and]... connect with people." PNs share their way of life with others by being kind at an early age, and loving others by providing them service, such as helping "older women in the neighbourhood do their chores" and "working as a nurses' aid…all through high school."

As they become older, PNs seek caring environments (e.g., church, community, other benevolent volunteer organizations, and secular health care settings) where they

have opportunities to help and care for people. One participant described her progress in seeking a caring environment this way:

> If you did the hours of volunteer work and everything went well, you could start as a nurse's aid at the hospital as a paid position… I needed to be with people so I went back and took my Licenced Practical Nurse (LPN)…and my Registered Nurse (RN)…I would connect with people, and I guess I always valued people.

As PNs become RNs and work in the healthcare setting, they seek quiet and prayerful environments to care for their clients' spiritual needs. However, such an environment can be difficult to find in secular settings "because you have to be political…dance around the hospital setting; it's *very* difficult to find" and they need to "look for opportunities" such as "when it was quiet on nights" and "go[ing] to visit before my shift started."

While PNs work as RNs in secular environments, they are keenly aware of their clients' needs and come across many opportunities to care for those needs. However, PNs describe feeling inhibited to care for their clients' spiritual needs while working in a secular environment where they feel "rushed" and "cannot pray and invite God into the conversation." This is similar to what Narayanasamy (2015) states, that "serving others takes on a deeper dimension of loving and caring as one promotes wellness. This involves the process by which the spiritual resources of the nurse are shared with others" (p. 241).

Caring involves being aware and open to the person in front of you, having no other preoccupation at that moment (Watson, 2008), and concentrating your whole being on what the person says, feels, reacts to, and senses in their environment (Rogers, 1970). One participant identified "if we're looking at the whole person…we have to be

conscientious of the spiritual needs of the people." PNs feel they "need to accept everyone regardless of their appearance and their lifestyle because that is what we're called to be." By being kind and accepting of others, they have "this ability to just sit and listen to people and not judge." People come close to the caring nurse who they see as fully immersed in the relationship, "connect[ed] with them and … connect[ed] to the church." According to a PN, "coming across as a caring, concerned person in your interactions, that's sort of showing that caring is a spiritual thing." Caring is also considered automatic for PNs. "It just comes out of you (spiritual care)…you don't even know you are doing it a lot of times; you don't think about it." The caring connection can be temporary for a few moments or longer, but their full attention is on the client "on what they are saying and where they are at." This caring attitude happens when nurses put their "own agenda aside" and focus on the person at their side, as one PN explained in the following way:

> Nurses are supposed to be caring but you have to be a little more than just caring. Some people do a good job but at the end of the day they go home and that's it…you have to *want* to help and that's what the spiritual part is…you want to help people…get to a better place. Because you can't cure things. But we can help people continue living and feeling good about that…and where they are at.

When PNs realise their clients are in need of their attention and spiritual care, they know that "a lot is just listen[ing], you know and being there for the person." They find opportunities at their disposal to bring about change that is required while taking into account their own capacity and competence in helping at that moment. This is important because as one participant explained:

> If your own personal…faith journey is unsettled…I think there needs to be some work done ahead of time…on where you're at yourself. After all, if you don't

> have the basic understanding of what their philosophy of life is, you can't really be effective in providing some spiritual care.

As they learn to care for the physical and emotional needs of their clients, parish nurses describe receiving little training on how to care for their clients' spiritual needs. With the exception of how in an emergency to administer the last rights and baptize a baby, PNs experienced "the nuns and priest provid[ing] all the spiritual care." Although the ultimate goal is connecting with others, PNs also "help them walk the journey [by] walk[ing] beside them." PNs realize there is limited time for spiritual interactions in their secular working environments since "presence takes time and sometimes we're rushed." One participant described it this way, "Nurses are now becoming task-oriented people…so that piece of [spiritual care] what can be done, is being lost because it takes time." Therefore, PNs seek opportunities to take the time and be at peace with clients without the distraction or noise of other responsibilities.

As parish nurses attune to their clients' needs and cues for spiritual care, they become distressed when they see their clients' spiritual needs being neglected. One participant said, "I always thought that the spiritual side of nursing was woefully neglected." Parish nurses are aware that other (secular) nurses often do not know how to offer spiritual care to their clients, and so may avoid and ignore these needs altogether. One participant explained,

> They can't give it if they don't have it in them to give. They just shut them [clients] down… it's easier that way when you are busy… they just don't know how to do it, how to connect with people on a spiritual level.

PNs understand for "clients, their spirituality is about religion and how they were raised." Yet "it's kind of gotten where, it's just kind of negative, anything religious is

negative." By encouraging their clients to lean on their own strengths and resources to work through difficult situations, parish nurses respect their clients' dignity and choices. For instance, "people often know what makes them heal, what makes their spirit soft or comfortable or whole. They often know but they just need some help to find it." PNs help their clients by " reconnecting them back to whatever it was…then they were empowered to go back wherever they came from." When clients acknowledge and appreciate their efforts in providing spiritual care, PNs feel a sense of satisfaction and joy. One participant said, "She called to thank [me]…because [I] took the time to help her focus …[on] what spiritual care she needed…and then she felt confident to go forward, [and that is what] keeps you going."

As PNs become proficient at centering themselves, they find ways to relate and connect with others quickly by being kind and "trying to understand that piece where people are at." This state of being does not take any more time for PNs to do their work, as this connection feeds and energizes them as well as their clients because "we are all sharing in this, so in some way, by sharing together, we're building each other up, it's not draining."

PNs describe how clients "feel you out" by sensing which nurse is open to spiritual conversations. PNs believe "the best gift you can give [to clients] is to not be scared of spiritual conversation," because sometimes "clients don't feel they can talk to that nurse about spirituality [if] they just don't feel [the nurse] would be open to that." Since PNs are open-minded and faithful to God, they believe their clients feel safe to request spiritual care and prayers from them. One participant described an experience she had with a client this way:

> They just started to say 'well I was really looking for someone that I can talk…talk to about my faith'…some [nurses would] just ignore and shut them down. I remember a guy grabbing me and saying in the middle of the night 'Nurse I'm afraid I'm going to die.'

As clients begin to trust PNs, they begin to seek spiritual care from them also, as one PN describes:

> A client said 'my faith comes from the strength of other people around me.' I said 'I will pray for you if you wish' and she said 'Well why don't you do that now?' So I was open, so I prayed with her, and I was in my nursing uniform.

PNs feel compelled to provide spiritual care when clients seek it as it "gives people hope," and PNs feel they have the competencies and "resource … to share with them [clients]." Sometimes PNs offer spiritual care by "being a presence just even if you just sit quietly with someone just giving up your time and not hurrying them, just being."

While working "as a secular nurse…you can still nourish people's spirituality and religiosity." However, PNs realize the limitations to opportunities the secular healthcare environment creates while attempting to provide spiritual care to their clients.

For one PN:

> I would say that in a secular role it's [spiritual care] a bit more generic…basically turning them back to reflect on what their spiritual needs are or experiences they have in the past…getting the client to reflect on what is spiritual for them; in a hospital setting…you would have to do a little bit more *digging* and you might in fact find common ground but it's not going to be as readily obvious [than]… in a congregation [where] we we're like-minded.

Therefore, they offer it in silence unbeknown to other staff members or colleagues, "because that wasn't really a practice." One participant explained: "In the hospital setting it has actually been… frowned upon and considered somehow proselytizing or an invasion of privacy…it feels so...clunky somehow." PNs believe they "weren't allowed" to provide spiritual care in their secular work setting as "it depends on the supervisor,

some say we don't have the time for that [spiritual care] and should leave it to nuns and the chaplains to take care of that." Despite this situation, PNs "did it [spiritual care], but never talked about it" when clients introduced and requested it, or their nurse manager asked them to pray. The hope PNs have to meet their clients' spiritual needs is now a state of mind that cannot be removed, and they seek to take advantage of more opportunities in this area of practice by coming "in early" and seeking opportunities on "nights" which "were quiet" and when they have "a little bit more time."

Once PNs become more proficient in spiritual care, they desire to care for their clients' spiritual needs in partnership with God. One participant said, "Being able to help people look at their wounded spirituality or helping them grow that's just really important to me *and I like it***,** it's very fulfilling." This desire propels them to the next stage where they seek prayerful environments and more opportunities to offer spiritual care and prayers that resonate with them.

Stage Five: Presence with God and Others

As PNs' level of trust in God increases, they begin to seek *prayerful environments* and opportunities to *engage in service in partnership with God* by *praying with others* (see Table 1, column 1, row 5). They do this because "when you're an ordinary nurse [not a PN], you're just looking for opportunities [to pray]." As PNs cultivate their souls, they believe they "bring hope and strength" to others who may not be receptive to God at that time.

However, opportunities are limited in their secular working environment. Therefore, PNs begin to desire and seek new environments where they can be less

inhibited and feel "freer" to ask their clients' permission to pray and invite God to help them care for their spiritual needs. One participant explained this desire as wishing for "an avenue where you could feel a little more freely able to address the [spiritual] side of…whole individual needs."

They realize clients come to them more often than to other nurses for their spiritual well-being. This motivates PNs "to investigate further" and meet all the requirements of the nursing profession and spiritual care ministries through education and parish nursing certification. As PNs become "more open," they "see opportunities" and find more favourable environments to pray with others. Putting their trust in God and deciding to seize these new opportunities to learn more about parish nursing, they take a leap of faith at the right moment and begin to practice as parish nurses in faith community settings. One participant said, "When I heard about parish nursing, I thought this is what…exactly what I wanted." For another participant, "All I knew is that it just made sense to me that it resounded… somewhere that there is this nursing background, and there's this faith piece." Sometimes, parish nursing is what they have longed for many years, and it resonates with them as if it is a calling. One participant decried "10 years later…this goal, this desire to do parish nursing was still on my mind" while another found "it was for me a distinct calling… it had moved from general information to a calling."

When caring for their clients' spiritual needs, a prayerful environment within a parish nursing setting enhances the PNs' spiritual care activities and prayers with clients. One PN participant described:

> When I'm in my nursing role at the hospital, I don't feel like I can freely attend to people, the spiritual side of people's well-being…You could never really say to them [in the hospital] 'where are you at right now with this situation?' or 'do you like praying?'… In my parish nursing role, I can freely bring that [praying to God] into those conversations… pray with people and talk about their faith, that's a widened door when you're a parish nurse.

In beginning their new practice, PNs seek "mentors" and "friendships" to support them and "get set up" in their new parish nursing roles. The mentors and friends include their own pastors, other more senior PNs, clergy, and peers support groups and they find "clinical mentoring" to be "invaluable" to their new role. PNs come to realize being a PN is a good fit for them personally. One participant described it this way: "I would say it was more like this would fit with more of my character. Spiritual care, I've always had a knack for that or an interest in that. I was convinced it was where I needed to be."

Providing spiritual care in faith community settings

As they become PNs, they find supportive parishes to begin their parish nursing practice. Although they realize their previous nursing background is very helpful "I worked in community care and then came into parish nursing…that was an excellent marriage" PNs describe needing the support of the clergy to be successful in their new practice, as "it makes your job and the position a lot easier if you've got the endorsement of the clergy right from the beginning." They really "don't think you can carry on a parish nursing ministry if you don't have the ministers backing you." Clergy support PNs by being available to "debrief after a particularly difficult encounter" and support them in their "personal spiritual journey." Clergy also respect and work collaboratively with PNs as one PN describes: "He got it…he understood the benefits of having a nurse complement his work…the relationship was extremely cordial." One PN, who did not

have her pastor's support, explains: "That was a very, very awkward place to be [not having the minister's support] and I…eventually that's what brought my practice to a close, working under that environment."

Although they are seasoned RNs who can transfer many nursing skills, PNs begin their new career in a parish community as advanced beginners (Benner, 1984). They gain knowledge and experience in this area of practice by "doing spiritual assessments" which were "never included" in their "hospital role" by taking "a course" that they "went looking for." PNs acknowledge spirituality "as a big learning curve" outside of their "comfort level."

PNs are content knowing now they have the freedom to provide, not only spiritual care, but also physical, emotional, and community care, as they feel called to do and are well placed to do. For instance, they offer "health promotion" and "health education" to their clients "that opens the door towards getting to know the person more, and talking about spiritual things." PNs wish to remain professional nurses, rather than become ordained clergy, explaining they are "professional nurses, still interested in being nurses" who "worked hard to get it (RN license), and … don't want to lose it." PNs consider their nursing practice holistic. For example:

> We talked a lot about the role of exercise, prayer, antidepressants… whole person, and that being healthy mentally, physically, and spiritually meant we had to deal with his cardiac situation, his depression, his relationship with his wife, his relationship with God, and all that was going to make him a healthy person.

Although PNs come to practice parish nursing as advanced beginners, they quickly move to become what Benner (1984) terms as competent, proficient, and then expert PNs by gaining the required competencies in their new specialty (see Table 3). Their previous

backgrounds enable PNs to transition quickly, as they seek and seize opportunities for additional courses, mentors, and churches where they can practice their new specialty. They described taking "the year of Clinical Pastoral Education (CPE)[1] *that* was *really really* valuable" and telling clients 'I'm just learning this' but everybody was very appreciative." As they begin to practice parish nursing, PNs realize they need continual mentorship such as "meet[ing] with the pastor regularly" to help gain competencies caring for their clients' spiritual needs.

PNs come to realize how important prayer is for their clients, "that [prayer] is what they're looking forward to because that's what has been important for them." PNs also appreciate when other people pray for them when providing spiritual nursing care to their clients. One participant said: "She prayed to God the whole time I went on a visit…that kind of spiritual care was being provided to me, and she *consistently* took that role on." Another said "He would pray for me if I was going into a particular difficult encounter…I knew that I had his prayer backing as I went to that visit."

[1]Clinical Pastoral Education (CPE) is a multi faith education program designed for clergy and other spiritual care providers to provide hospital and hospice pastoral care to clients. The program has an experienced-based approach to teaching, which includes "supervised encounter with persons in crisis." (UC Davis, 2018, p.1)

Table 3 Benner's stages of clinical competence

Benner (1984)

"**Stage 1 The Novice or beginner** has no experience in the situations in which they are expected to perform. The Novice lacks confidence to demonstrate safe practice and requires continual verbal and physical cues. Practice is within a prolonged time period and he/she is unable to use discretionary judgement.

Stage 2 Advanced Beginners demonstrate marginally acceptable performance because the nurse has had prior experience in actual situations. He/she is efficient and skilful in parts of the practice area, requiring occasional supportive cues. May/may not be within a delayed time period. Knowledge is developing.

Stage 3 Competence is demonstrated by the nurse who has been on the job in the same or similar situations for two or three years. The nurse is able to demonstrate efficiency, is coordinated and has confidence in his/her actions. For the Competent nurse, a plan establishes a perspective, and the plan is based on considerable conscious, abstract, analytic contemplation of the problem. The conscious, deliberate planning that is characteristic of this skill level helps achieve efficiency and organisation. Care is completed within a suitable time frame without supporting cues.

Stage 4 The Proficient nurse perceives situations as wholes rather than in terms of chopped up parts or aspects. Proficient nurses understand a situation as a whole because they perceive its meaning in terms of long-term goals. The Proficient nurse learns from experience what typical events to expect in a given situation and how plans need to be modified in response to these events. The Proficient nurse can now recognise when the expected normal picture does not materialise. This holistic understanding improves the Proficient nurse's decision making; it becomes less laboured because the nurse now has a perspective on which of the many existing attributes and aspects in the present situation are the important ones.

Stage 5 The Expert nurse has an intuitive grasp of each situation and zeroes in on the accurate region of the problem without wasteful consideration of a large range of unfruitful, alternative diagnoses and solutions. The Expert operates from a deep understanding of the total situation. His/her performance becomes fluid and flexible and highly proficient. Highly skilled analytic ability is necessary for those situations with which the nurse has had no previous experience." (p.13-34).

Note: In the acquisition and development of a skill, a nurse passes through five levels of proficiency: novice, advanced beginner, competent, proficient, and expert.

Learning to pray out loud with others

PNs work in collaboration with ministers and other clergy to learn to pray with their clients in all places and circumstances, as their clients expect them to be able to pray out loud with them and appreciate the prayers. This new skill does not come easily to most PNs, who initially feel uncomfortable and uneasy. As they desire to experience life in a new stage of presence, they seize opportunities to gain the skills required to lead others in prayer. One participant acknowledged her pastor who "has more experience and has directed me…she's helped me with learning to pray with other people."

As PNs begin to have close connections with their clients and with God, they realize their clients can also help them develop their skills of praying out loud. "It's people like that that really help, have helped me in my comfort level of praying with people…I think well they appreciate this so they're benefitting from it." By leaving their comfort zone to pray out loud with their clients, PNs begin to attune to their clients' openness to pray and wait until clients "open the door" to the conversation. Once open, PNs "always ask permission" to pray with clients. PNs believe inviting God to be with them through prayer gives their clients a sense of hope, comfort, and peace. One PN explained, "pray[ing] before we went in…that the Lord would be with us… it's an understanding and a peacefulness about it."

As their clients are seeking prayers, PNs feel they must perfect this new skill by seeking practice, mentorship, and "prayer courses" to help them "have some structure to [their] prayers" while learning how to pray out loud with others. PNs learn to "lead [in prayer] in my CPE course" and "lead the people's prayers on Sunday," and practise praying out loud with their pastor. All those situations "accumulate and help my comfort

level." Over time, as PNs begin to work in a safe environment that supports prayer, they learn and practice leading in prayer; with experience, they become more confident leading in prayer with their clients. As they practice this new skill, they are enthusiastic when their clients acknowledge their efforts and appreciate their prayers with them.

As PNs become proficient at praying out loud with others, they see their clients are calmer, "more peaceful," and satisfied once they complete prayers out loud with them as evidenced by "I just saw a change in her … It was just so beautiful." PNs think clients come to expect PNs to lead them in prayer, "call them on it" in all contexts and situations, and trust they will "always start by praying" when they visit them.

In this fifth stage of *Presence with God and Others*, PNs feel "a partnership in my parish nursing role where God is there." As PNs provide spiritual care to their clients, they are connected with God and seek to invite God with them more often, which propels them to seek communion with God and others. One PN described:

> In my nursing acute care setting…it's scolded somehow maybe attended to in an odd way, it's not a partnership…somehow it's excluded… in a parish nursing role it's an expectation…You can say 'can we open our conversation here with a prayer to invite the Lord to this gathering?'…and people are ok with that…expect that.

Stage Six: Channel of God

As PNs become proficient at praying with others, they seek to connect at a "higher level" through *communion with God and others* by *letting go through God* and by *humbling and emptying* themselves (see Table 1, column 1, row 6). When PNs step aside from being the caregiver and instead become an empty vessel for God, they help make room for God to work and care for the spiritual needs of their clients, which brings a

sense of joy and peace to both PNs and their clients. According to Goldsmith (1964), "prayer is the avenue leading to God, and it is through prayer that we make our contact with God. It is through prayer and communion that we have the God-experience" (p. 34). Kempis (1418-1427/1993) states: "…they [who] are firmly grounded in humility and filled with charity…they may really hope that they have advanced spiritually…" (p. 116). Kempis (1418-1427/1993) also states: "Humble people are always at peace, …So if you wish to reach the height of perfection, never think of yourself as being virtuous until you know sincerely in your heart that you are the least of all" (p. 71). Kempis (1418-1427/1993) continues to write about humility and self-denial and states:

> When you have wholeheartedly delivered yourself up to God, seeking neither this nor that, according to your own wish or will, but placing yourself entirely in His care, you will find yourself united to Him in peace; for nothing will so satisfy you or give you greater pleasure than the will of God being accomplished in you…Where the Lord finds vessels empty, He fills them with His blessings... The more perfectly persons abandon worldly things and the more they rid themselves of self-love through contempt of self, the sooner grace will come, the more abundantly it will enter in, and the higher it will lift their liberated hearts" p.275.

St Paul wrote to the Philippians about Jesus:

> Let nothing be done through strife or vainglory; but in lowliness of mind let each esteem other better than themselves. Look not every man on his own things, but every man also on the things of others. Let this mind be in you, which was also in Christ Jesus: Who, being in the form of God, thought it not robbery to be equal with God: But made himself of no reputation, and took upon him the form of a servant, and was made in the likeness of men: And being found in fashion as a man, he humbled himself, and became obedient unto death, even the death of the cross. Wherefore God also hath highly exalted him, and given him a name which is above every name (King James Version 2: 3-9)

As PNs move to the fifth and six stages, they describe being in two levels of presence as they connect with their clients while in partnership with God and in communion with God and others. These are further explained below.

Two levels of presence

PNs describe "two levels of presence," one being in the presence of the Lord, and the second being in the presence of others by connecting with them where they are at. PNs seek God's presence as they come to their clients with willing hearts to serve this holy presence. Participants discussed praying for God to be with them on "every visit" and "wanting to enter into the presence of the Lord [which] takes time." PNs describe being "not afraid to speak about spirituality" with others as they become "more experience[d] and older in my nursing career." As they begin to be proficient at connecting with God and their clients, PNs look to accompany their clients on their spiritual journey and help them move.

Connecting with God and clients

PNs believe clients connect with them because they relate with their clients by "starting at the same base," and "let[ting] them [their clients] come" close. PNs report their clients also feel accepted rather than judged by them, as explained by one participant, "people keep coming back here…they like it because they are not hurried, it's a safe environment, …they can talk to us pretty well about anything."

As PNs attune to their clients' needs, they assess clients' capacity and readiness to pray and "depending on their response, then I can get into a deeper conversation." As PNs become experts in spiritual care, they are capable of connecting quickly "depending on what they are saying and where they are at" as well as their clients' level of openness. One participant described this as being "at level one to start with, but you can take it

higher and you can reach people to a higher faith ehh…dependency on the Lord experience."

As conversations progress to more spiritual topics, PNs center themselves by connecting with God and seeking their clients' consent to pray and lead in prayer. As they begin to pray out loud, PNs are attuned to the conversations and prayers and recognize when they become deeper as if "rising above" to a different "higher" level because they begin to feel a "deeper bond" while in the presence of God and their clients. As parish nurses recognize this special moment while in this "different dimension," they find it to be "beyond you," "challenging," and "remarkable" and come to sense if their clients' are "open to that" and willing to move or not as they may be in "a spiritual [faith] crisis." As PNs see that God is greater in caring for their clients' spiritual needs in that moment in time, they humble themselves and "let God figure this part out, because He knew better." PNs realize "it's all about them [clients], not me" and they need to "show up and believe I'm doing my job really well, and then to let go …of the outcomes" because "it's in good hands, it's beyond you." By emptying themselves, PNs leave room for God to work with their clients. At that moment, PNs become empty vessels and witnesses of God rather than care providers. One participant described it as "letting your spirit go, I guess, so that the spirit of the Lord can work…do His work in the other individual."

PNs "feel[s] like a channel of God at that point working with the clients, so I wasn't doing it alone, God was in it as much as I was." PNs describe this experience of becoming channels of God in that, "it's all about the client and you're just there to be …a

channel to be used by the Lord." One participant summarizes her experience of being a channel of God in this way:

> When you are really connecting, it's just not a quick prayer. It's a time of fellowship and just sitting and listening and communicating with the heart more than with the mouth, and that is very necessary to have that presence…it's kind of being there like a channel [to] let the Lord do His work in the other.

PNs describe the experience of being a channel of God as "uplifting," "beautiful," and being at "another dimension" with their clients and God, and they see their clients resonate with hope, satisfaction, peace, and beauty throughout the experience despite any illness and disease. One participant described her experience as "it's not a burden to you, it's kind of a relief, everything is a relief and there is a hope, a positive connection even in the midst of tragedy or of dying."

When parish nurses experience being a channel of God, they acknowledge God's work in these moments. PNs describe being privileged, whereby they are part of a larger experience that benefits both their clients and themselves. One participant said: "Sometimes, I marvel at parish nursing…I think 'oh my goodness' it's something I never thought of, and it's enriching my own life. It just makes me a better person." This experience leaves them in awe and with a sense of contentment, peace, and desire to experience the amazing experience over again.

One participant explained:

> Their spirit and their faith experience and my spirit and my faith experience, it kind of helps things *well up* to be something even more than what you'd thought it would be…[it's] just uplifting to see how they are calm and peaceful, and he was dying! It was really beautiful.

As they gain more proficiency in attaining this level of presence, PNs feel energized, remain hopeful, and seek to share this hope with other clients. "That's very

uplifting for you as a nurse to believe them, to encourage them, to guide them in that dimension." One PN explained her experience with a new client, who was very spiritual, with whom she was able to move quickly to this final stage of presence in just one visit and felt blessed by it:

> I went to see this fellow…in the hospital and I didn't know him at all, and I thought 'well what will we talk about?' You know, anyways he was very easy to talk to and [I] got to know him ummm... in just one visit quite well…ummm, then I said 'would you like me to pray for you?' and he said 'yes'. So I, I prayed with him…and then he prayed for himself and for…for me and umm… that was really beautiful. I haven't had many…ummm…clients that will pray for me (light laugh), but he was just spontaneous…and after that…we kind of bonded at that time, we were on the same level…it just lead to a higher conversation about the Lord and the things the Lord does, and I mean this man was dying…but it was just a beautiful time. I think it was just that sharing, not conversation sharing but just prayer, you know both of us taking it up to the ehh…heavens I guess…that was beautiful beautiful time there, yeah. I think he was a channel for both of us to be in the presence of the Lord…He was just so spiritual, I learned from him. You come away feeling, I've been really richly blessed by that person, that I was supposed to go there and help bless.

Summary of Findings

PNs develop their spiritual nursing practice over time by moving through a BSPP called *Cultivating the soul to become a channel of God one moment in time* (see Figure 1). This iterative BSPP includes four-steps of *finding favourable environments by desiring and seeking; trusting in God by being receptive, centering self, and praying; deciding to act by being attuned and seizing opportunities; and taking a leap of faith at the right moment by finding courage and strength through God*. This process helps PNs move through six stages of presence: *Foundation of God-related beliefs and values, presence with self, presence with God, presence with others, presence with God and others, and channel of God.*

PNs begin their spiritual journey by receiving a foundation of God-related beliefs and values and through a faith-inspired environment, they begin learning and adopting these God-related beliefs and values (see Table 1). As PNs take a leap of faith at the right moment by finding courage and strength through God they pass to the next stage of presence. The second stage is presence with self, where PNs begin their spiritual awakening. Here PNs seek nurturing communities where they begin questioning and hoping in God, which helps them in reflecting and developing themselves including their spiritual selves. PNs then take a leap of faith at the right moment by finding courage and strength through God and move to the third stage of presence. As PNs enter the stage of presence with God, they find faith communities that help to support them in having faith in God, and committing to God. Then PNs move to the fourth stage by taking a leap of faith at the right moment by finding courage and strength through God. When PNs are in the fourth stage, Presence with others, they seek caring environments where they can live out their faith by loving God. By being faithful and loyal to God, they begin caring for others and meeting all their clients' needs. When PNs realize opportunities to care for their clients' spiritual needs through prayer are limited in their secular working environment, they begin to seek prayerful environments. By engaging in service in partnership with God, PNs begin praying with others. As they seek to increase their opportunities to pray with others, they take a leap of faith at the right moment by finding courage and strength in God and attain the fifth stage. Once they obtain their PN qualifications and become PNs, they begin working within faith communities, where prayerful environments are enabled. As they work in faith communities, PNs have more opportunities to engage in service in partnership with God by praying with others as part

of their holistic nursing practice. This enables PNs to gain experience to pray out loud with their clients and invite God into conversations and seek communion with God and others. This brings PNs to take a leap of faith at the right moment by finding courage and strength through God and move to the sixth stage of presence. As they reach new higher-level conversations with their clients, PNs begin letting go through God, and humbling and emptying themselves to make room for God's presence to work in their client's lives. Humbling entails recognizing that God is better at caring for their clients' spiritual needs than they are. PNs are capable of emptying themselves by leaving their own agenda and desired outcomes aside and letting go of doing tasks so that God can work. As PNs empty themselves, they take a leap of faith, witness God's work at that moment in time, and become a channel of God. This experience leaves both PNs and their clients uplifted, energized and with a sense of peace and satisfaction.

PNs believe clients trust them to provide the spiritual care they seek because PNs are competent professionals who are kind, open, and non-judgemental. By connecting with God and others through prayer, PNs offer expert spiritual nursing care and become channels of God, witnessing God's work in their clients' lives. PNs become proficient and expert spiritual care providers as they advance in their nursing careers. It seems to take the better part of PNs lives to cultivate their souls to the point where they are spiritually mature to achieve the level of presence with God and others required to become a channel of God. As PNs work, they do not grow weary, for God's presence energizes them and they feel uplifted in bringing both peace and hope to their clients.

“But they that wait upon the Lord shall renew their strength; they shall mount up with wings as eagles; they shall run, and not be weary; and they shall walk, and not faint” (Isaiah 40:31 King James Version)

Chapter 5 Implications for Nursing

The implications of the findings of this research on nursing practice are organized based on Fawcett's (2006) six-step evaluation of pragmatic adequacy which is a reporting framework and includes: (a) identifying the social meaningfulness of the study findings, (b) determining if the study findings are ready for use in practice; (c) making certain the study findings are relevant for a specific practice situation; (d) analyzing the feasibility of using the findings in a particular practice setting; (e) analyzing the congruence of use of the study findings with clients' expectations; and (f) determining if the practitioner has legal control of use of the study findings. The limitations of the study and the applicability of rigor throughout the research study are also discussed.

First Step-Social Meaningfulness

The Glaserian grounded theory (GT) research method was appropriate for the research question: "How do parish nurses develop their spiritual nursing practice over time?" The method worked well in analyzing the data, as a Basic Social Psychological Process (BSPP) emerged called "Cultivating the soul to become a channel of God one moment in time."

By using the emerging theory and model of presence as a pathway, PNs as well as nurses and student nurses of different gender and faith backgrounds can begin to understand the importance of developing their spiritual selves. As nurses cultivate their souls, they are well positioned to gain spiritual nursing competencies that can help meet their clients' spiritual care needs in various practice settings.

Second Step- Ready for Use in Practice

The findings illustrate the conditions, causes, and consequences that may help and hinder the development of PNs' spiritual nursing practice over time. PNs may use this study's mid-range theory and model of presence to guide them as they seek to develop their spiritual nursing practice and competencies from beginning novice to expert (Benner, 1984). All nurses interested in providing holistic nursing care to their clients can also use these findings to better understand the impact favourable environments may have on their ability to cultivate themselves and provide spiritual care to their clients.

Third Step- Relevant for a Specific Practice Situation

A discussion follows on the implications of these findings for nursing practice, education, administration, policy, and further research. Nursing theories are used to help bring perspective to PNs' practice. However, rather than providing a full description of nursing theories, the focus here is on linkages of the mid-range theory of Cultivating the soul: A model of presence with selected nursing theories. The linkages may help put the findings into perspective as PNs develop their personal selves and their holistic nursing practice within a particular nursing theory.

Virginia Henderson's (1967/1997) need theory

The 14 basic components of Henderson's needs theory (Henderson, 1967/1997) are based on Maslow's Hierarchy of Needs (1943), which include spiritual needs. This theory lends itself well to PNs' practice since it defines nurses' role as assisting their clients in performing activities that contribute to their health, healing, or peaceful death when they do not have the necessary strength, will, or knowledge to do it alone

(Henderson, 1967/1997). Findings show PNs provide care, encouragement, knowledge, and resources as they meet their clients where they are at and assist them in meeting their spiritual and other needs. PNs' practice helps their clients become empowered to get the required resources, which bring them to a better place in their lives. PNs also accompany those who are dying and help bring comfort and peace to them.

Rogers' (1970; 1991) science of unitary and irreducible human beings

PNs' holistic approach to care in their daily professional practice is congruent with Rogers' holistic view of caring for clients. Rogers (1970; 1991) explains that humans are unitary and irreducible, that is they cannot be divided into parts because they are more and different then the sum of their parts. For example, the properties of H_2O must be studied as a whole rather than by studying the properties two elements separately (Rogers, 1970; 1991). Rogers' views of nursing include four postulates; *energy fields, openness*, *pattern*, and *pan-dimensionality*, and three homeodynamic principles*; resonance, helicy, and integrality. Energy fields* are the fundamental unit of the living and non-living our environment, and are in constant motion (Rogers, 1970; 1991). Rogers explains that everything is a form or manifestation of energy which varies in intensity, density, and extent. *Openness* describes the fact that energy has no boundaries and flows between human and environmental fields making all things one. Humans are therefore an integral part of their environment. Person and environment are two of the four basic concepts of the nursing metaparadigm which also includes health and nursing. Rogers view of humans and environment as irreducible whole in nursing is significantly different than other health care disciplines such as medicine and psychology. *Pattern*

provides characteristic or identity to the energy field as each single wave, or person, differ from others through their particular habits and patterns of being that are ever changing (Rogers, 1970; 1991). *Pan-dimensionality* is a non -linear domain without space and time. Since time and space are relative to human experience, pan-dimensionality helps explain paranormal experiences such as distance healing and the healing power of prayer (Rogers, 1970; 1991).

Rogers' (1970; 1991) view of change includes three homeodynamic principles; resonance, helicy, and integrality. Resonance relates to the continuous change in energy fields patterns from lower to higher frequency (Rogers, 1970, 1991). Integrality is the human and environmental fields that co-evolve together in a mutual process. Helicy is described by Rogers (1970; 1991) as the continuous unpredictable patterns that happen in the human environment energy field.

Rogers' concepts of nursing (environment, strength, action, and time) are congruent with the findings and the model of presence. PNs view their clients as more than the sum of their bodies, minds, and spirits, which is congruent with Rogers (1970; 1991) explanation that humans are unitary and irreducible. Although Rogers' concept of energy fields as an integral part of human beings and their environment does not mention God or a Supreme Being, it remains similar to PNs' concept of God's presence as a strength (energy) that can be tapped into and is an integral part of all human beings and their environment. PNs understand the importance of being open to opportunities, being attuned to their clients' openness to spiritual care, meeting others where they are at (resonance), and the patterns of behaviours of people (patterns). PNs understand their role as facilitators of change and accompany others as they move through difficult issues

(helicy). PNs understand the importance of favourable environments that are crucial to help provide spiritual care (integrality). PNs' capacity to act and move stages over time by taking a leap of faith is also congruent with Rogers' concept of pan-dimensionality.

Benner's (1984) model of practice from novice to expert

The findings can be used along with Benner's (1984) model to help PNs identify their personal level of spiritual nursing competencies as they move through Benner's five stages of being novice, advanced beginner, competent, proficient, to becoming expert (see Table 3). Novice PNs have limited ability to predict what will happen as they relate to their clients spiritual needs (Benner, 1984). This stage may represent some PNs before they obtain the required education and training in spiritual care, as they may feel the need to help but may not know exactly how to help. Advanced beginner can be represented by newly certified PNs who begin their parish nursing roles in a faith community. Advanced beginner PNs have the knowledge and know-how to offer spiritual care but lack the experience (Benner, 1984). Competent PNs begin to recognize patterns more quickly and accurately, yet still lack the speed and flexibility of the proficient PNs (Benner, 1984). Proficient PNs learn from their previous experience and see situations as a whole rather than in parts (Benner, 1984). As they experience different events, proficient PNs modify their plans and interventions more quickly than the competent PN. By identifying their clients' spiritual needs and required interventions more accurately, proficient PNs can meet the clients needs where they are at more quickly. Expert PNs have an intuitive grasp of the essential situation that needs their attention and can mobilize the appropriate resources to obtain the required outcomes (Benner, 1984).

Expert PNs can quickly assess where a new client is at, and become a channel of God within a short visit. As they move from being novices to experts, PNs can use the findings and model of presence to help them evaluate their capacity to move from one stage of presence to another while caring for their clients' spiritual needs.

Barker's (2001) tidal model

Barker (2001), in the tidal model, views health and illness as being fluid and life as a journey, which are undertaken on an ocean of experience, and clients can be in physical, emotional, and spiritual crisis. Barker (2001) explains nurses can use exploratory questioning and by being curious and interested in listening to their clients' stories, nurses can help their clients understand hidden meanings and identify what is required as well as their own resources to recover. The findings show that PNs are genuinely interested in other peoples' stories and have the ability to listen without judgment. PNs also help their clients use their own resources and inner strength to move past difficult issues and crisis. PNs believe their clients "know what makes their spirit whole; they just need help to find it" which is congruent with Barker's tidal model.

Watson's (2008) science of caring

In this theory, Watson (2008) speaks about caring as an integral part of holistic nursing practice and states, "without attending to and cultivating one's own spiritual growth, insight, mindfulness, and spiritual dimension of life, it is very difficult to be sensitive to self and other…[which is] a lifelong process and journey" (p. 67). Watson's theory (2008) includes ten caritas processes: (a) *Altruistic values, loving-kindness and equanimity; (b) faith, hope and authentic presence; (c) sensitivity, spiritual practices and*

self-awareness; (d) helping, trusting, and caring relationship; (e) positive and negative feelings of self and others; (f) knowing, being, doing, and problem-solving in the caring process; (g) transpersonal teaching-learning towards a coaching role; (h) being/becoming the healing environment and a caring moment; (i) human needs, and reverently and respectfully touching the embodied spirit; and (j) life-death-suffering and "allowing for a miracle." The mid-range theory of cultivating the soul: A model of presence shows PNs embark on a life long journey to demonstrate a deep understanding of caring while they build trusting relationships with their clients. The findings have many congruent aspects with Watson's theory (2008); for example, PNs develop their God-related beliefs and values by hoping and having faith, trusting in God, developing themselves, and caring for others. PNs also seek favourable environments where they can help clients meet their spiritual needs and accompany them on their journeys towards healing. When PNs become a channel of God while in communion with God and their clients, they let go and let God work in their clients' lives. This brings them healing, hope, and peace, which are similar to Watson's "allowing for a miracle."

Implications for education

Entry-level nursing educators may use the study findings to help develop curricula, course contents, and objectives for basic spiritual nursing care including spiritual needs assessment as these were not available in the participants basic education and work experience. Educators in PN certification and mentorship programs can use these findings to help develop more advanced spiritual nursing care competencies. According to PNs, they developed many of their spiritual nursing competencies through

demonstration and practice. Students may have better learning results in spiritual nursing practice by observing others offer spiritual care. Therefore, mentorship may be a crucial component of developing spiritual nursing competencies.

Peplau's (1991) theory of interpersonal relations in nursing was based on two assumptions: the kind of person the nurse becomes, and the function that nursing and nursing education have in fostering development of nurses' personal maturity. These assumptions can be developed by using the model of presence as a frame of reference and building blocks to know how to help nurses build therapeutic relationships with their clients by first developing themselves as mature persons.

Implications for administration

For over a decade, the health care industry has recognized person-centered care (PCC) as an essential foundation for quality care and client safety; however, employers have had difficulty implementing this concept (Santana et al., 2017). Based on a literature review, Santana et al. (2017) developed a conceptual framework for implementing PPC. This framework includes *structure, process, and outcome*. Seven core domains of *structure* were identified as foundational to promote PCC, one of which is "providing a supportive and accommodating PCC environment" (Santana et al, 2017, p 432). This includes environments that are "welcoming, comfortable, and respectful, spaces that provide privacy, spiritual and religious spaces" (Santana et al., 2017 p. 432). Importantly, all the participants shared their concerns and fears in providing spiritual care to clients who requested it in their secular work environments for fear of reprisal from their employers. These environments of fear were not conducive to meeting their clients'

spiritual needs, nor were they providing favourable environments to cultivate the nurses' souls. The second part of the framework called *process* includes four domains that relate to interactions between the person and the care providers, two of which are cultivating communication, and respectful and compassionate care. According to Santana et al. (2017), this includes building relationships with their clients' based on their unique psychosocial, spiritual, and cultural context and by "being responsive to client preferences, needs, and values while expressing empathy" (p. 434).

According to Lencioni (2010), functional healthy workplaces are built on trust. These findings can help us understand how to build trusting relationships that can create healthy working environments and enable nurses to provide person-centered care. PNs can become examples for others on how to seek, find, and help create safe environments wherever one may be, by first developing their spiritual selves and choosing to be kind while relating to others where they are at. Employers may use the findings to better understand the importance of creating favourable environments where nurses can develop themselves and provide person-centered care to their clients.

Implications for policy

Parish nursing associations may use these findings to assist their members to identify the different levels of spiritual competencies and the process required to improve their spiritual nursing care. Other implications include self regulation and regulation of the nursing profession.

Most governments have delegated the regulation of nursing to professional regulatory bodies for public protection (Nurses Association of New Brunswick, 2018).

These regulatory bodies rely in large part on the self-regulation of its members through legislated mandatory requirements, standards of practice, and Code of Ethics (CNA, 2017). Most regulatory bodies have mandatory self-reporting and require evidence of continuing competence and self-development through reflection, education, and practice. These processes are in place to help prevent unsafe practice, maintain safe practice, and intervene in any cases of unsafe practice. As regulated professionals, nurses are required to reflect on their practice and develop themselves to ensure public protection (CNA, 2017; NANB, 2018). Nurses have the responsibility to be "moral agents in providing care… and there is a pressing need for nurses to work with others to create the moral communities that enable the provision of safe, compassionate, competent and ethical care" (CNA, 2017. p. 5). The Code of Ethics (CNA, 2017) requires nurses to advocate for conditions that support ethical practice including quality practice environments and states, "Such environments have the necessary organizational structures and resources to promote safety, support and respect for all persons in the practice setting" (p. 5). The findings of this study identify the importance of favourable practice environments for offering and receiving spiritual care and patient-centered care.

As nurses reflect on their practice and themselves, they can choose to grow spiritually, which can help them meet their standards of practice. Standards are based on building trusting relationships, creating safe environments, providing safe, competent, compassionate and ethical care to others. Therefore, spiritually-mature nurses can lead to a better self-regulated nursing profession which meets the expectations of the public they serve.

Implications for further research

Further research is required to determine how the six stages of presence, can better integrate with Benner's (1984) stages from novice to expert in providing spiritual care to clients. Further research is required to assess the level of personal spiritual growth of PNs who provide spiritual care to clients as it relates to the stages of presence. Other topics may include identifying some of the prerequisite skills and abilities for self-regulation, as prospective students and others seek to enter the nursing profession. By developing their personal selves, nurses develop their therapeutic relationships with clients and ability to provide safe, compassionate, competent, and ethical care to the public. These skills and abilities may help ensure successful transition from education to practice.

Further qualitative research can also help develop the concept of channel of God, so to better describe the experiences PNs have when becoming a channel of God. According to Glaser and Strauss (1967), once concepts are well defined, tools can be created for use in quantitative research studies.

Further research may help us to understand how nurses who profess not having a connection with God provide or do not provide spiritual care. Perhaps this area may identify the conditions, causes, environmental factors, and consequences that may lead some nurses over time to develop and act in an opposite spectrum, which can negatively affect their clients' wellbeing. This type of research may help identify some predispositions, precursors, indicators, and warning signs where nurses may be inclined, consciously or not, to harm each other and their clients. Such research can help nursing regulators better understand, prevent, mitigate, and effectively intervene in protecting the

public from these potentially negative behaviours and help maintain the public's trust in the nursing profession.

Step Four- Feasibility of Using the Findings

Grounded theory studies are mid-range theories designed to be more practical and easier to implement than grand theories, as they are easily understood even by laypersons. Therefore, mid-range theories help bridge the gap between nursing research and practice.

The model helps to provide an understanding of the upward climb process PNs go through to cultivate their souls. PNs who practice in favourable environments such as faith communities, can begin using these findings to help them provide spiritual care to their clients and reach all six stages of the BSPP. Nurses working in less favourable and secular environments can use these findings to help them develop their spiritual nursing practice by focusing on their spiritual selves and the first four stages of the BSPP. While the model helps to provide an understanding of the upward climb process parish nurses go through to cultivate their souls, the last two stages depend on their level of trust in God and their ability to pray with their clients in a supportive environment. Further research would be necessary to identify if the process is relevant to nurses who profess not having a connection with God, and if so to what extent.

Step Five- Congruence with Client Expectations

While research shows clients consider their spiritual well-being to be just as important as their physical or mental well-being, they feel their spiritual needs are not being fully attended to by those in the secular health care system (Mueller, Plevak &

Rummans, 2001). Nurses have great opportunities to help clients meet their spiritual needs because nurses are accessible with many at the bedside 24 hours a day, seven days a week. All nurses interested in developing their spiritual nursing practice can cultivate their souls by using the four-step iterative process to achieve the six stages of presence. As nurses become more aware of their own spirituality, they will become more attuned to their clients' spiritual needs. As PNs develop their level of competencies, they may be more inclined to help clients meet their spiritual needs and refer to the pastoral care team as required.

Step Six- Legal Control

The Code of Ethics for Nurses (CNA, 2017) describes the expectation of providing holistic nursing care to all clients by respecting their needs, beliefs, values, and cultural contexts, which include spiritual care. However, the medical model used in the current health care system is not designed to create favourable opportunities to provide spiritual care to clients (Mueller et al., 2001). Therefore, nurses often feel uncomfortable tending to the spiritual needs of their clients because of their own level of competence and unfavourable working environments. The fear of being perceived as proselytizing while working in secular environments may also inhibit some nurses from discussing and openly offering spiritual care to their clients.

Limitations of the Study

The limitations of this research project include the limited opportunities for face-to-face interviews with four participants living in a different province than the researcher. Recorded telephone interviews were used with five of the six participants. During two

interviews, the telephone connection was intermittent at times, which required asking the participant to repeat certain words and required clarifications, which may have cut off the flow of ideas of these participants. Also, using telephone interviews as a method of gathering the data, may have limited the ability to perceive body language and required making annotations when voice changed during pauses and emotional responses to better reflect the intent of the message.

The pool of potential participants was limited as this is a relatively new specialty, with limited opportunities for employment. Perhaps approaching the Canadian Association of Parish Nursing Ministry could have extended the pool of participants as they also have members in British Columbia, Saskatchewan, and Ontario. Another potential limitation is the intimate nature of the research subject, which could have made some potential participant uncomfortable discussing their experiences, as I personally knew many PNs from New Brunswick and Nova Scotia. As spiritual care can be offered by nurses of other faiths, such as in the Hindu, Islamic, and Jewish faiths, having only PNs of Christian faith was a limitation.

Rigor Achieved

GT criteria for rigor (Glaser, 1978) were practiced throughout this study. Rigor of fit was achieved by doing line-by-line coding, using all data without forcing and ignoring, and by doing simultaneous data analysis and collection. The model was based on data collected from interviewing six senior PNs with several years of spiritual nursing care and data collected from literature. By using participants' own words, the theory had grab since it is relevant and useful to the participants and others who may be affected by

it. Rigor of work was achieved as the theory is easily understood, has meaning to the participants, and explains their experience well. All six participants described progressing through the first five first stages of presence from receiving a foundation of God-related beliefs and values to presence with God and others. Five of the six participants described becoming a channel of God, which the model describes as the highest level that PNs achieve in offering spiritual care. Four of the six participants responded and said the findings had meaning to them and represented their experiences well thus validating the findings, BSPP, and the model of presence.

Rigor of modifiability was achieved as I constantly changed any and all codes and categories in order to accommodate the data. I adjusted aspects of the emerging theory according to participants' suggestions to change the name of stage two to better reflect their experience, which only helped strengthen it. Therefore the theory remained open to corrections. Rigor of generality was achieved as debriefing comments received from the academic committee confirmed the findings are generally applicable to many other PNs experiences. Rigor of traction was done as I went back on all memos and journals, transcripts, Excel files to make sure that all data was looked at and accounted for.

I explain earlier I decided to also use Lincoln and Guba's (1985, 1989) four criteria of trustworthiness to ensure rigor of my research project. I have assessed the provisions I made to meet each of four rigor criteria of trustworthiness as described by Shenton (2004).

Credibility was achieved by being in contact with participants early on and developing a trusting relationship so to ensure the information collected during the interviews were a true reflection of their authentic experience, which was later confirmed

by the participants themselves. Only the participants who met the selection criteria and genuinely wanted to participate were interviewed. I verified the meaning of some participants' comments during the interviews to ensure proper understanding and interpretation. I had several debriefing sessions with my supervisor to ensure the method was being properly used during interviews and subsequent data analysis. A few negative cases emerged which help to refine the theory. The findings are congruent with many nursing theories and GT research studies found in literature on PNs experiences and spirituality.

Transferability was achieved by selecting a purposeful sample of parish nurses who fit the authentic experience under study in different settings and provinces. Sample and boundaries of the study were well described and the findings generated a thick theory with many concepts, which were well defined, all of which will help others decide if the theory fits their experience.

Dependability was achieved as I described in detail the design and implementation of the method used throughout the study. I also kept an audit trail journaling the entire research process from developing of data to reporting the findings. Therefore, another researcher could easily replicate this research study.

Confirmability was also achieved in that before I began the interview process, I wrote down all my perceptions related to the research question. I also used a second notebook as a self-journal to record all methodological decisions and the reasons for them, and documented what was happening with regard to my own values, interests, judgments, and emerging theory. I was surprised with the emerging theory and basic social process, which were not similar to my previous list of perceptions.

Evaluation of the theory

Fawcett's (2005) identified six criteria for evaluating theory which include; *significance, internal consistency, parsimony, testability, empirical adequacy, and pragmatic adequacy.* The developed theory of presence has significance as the research is founded on the sound philosophical underpinnings that include interpretive paradigm, relativist ontology, interactive epistemology, and qualitative research methodology and grounded theory (GT) method. Nursing literature reviews were conducted and cited throughout and senior PNs were interviewed to uncover their experiences related to spiritual nursing care.

Internal consistency was achieved as the paradigm, ontology, epistemology and research methodology of qualitative GT are consistent to answer the research question "How do PN develop their spiritual nursing practice over time?" The context is congruent with the method as interviews were conducted to develop data from experienced PNs who were subject matter experts.

The theory has semantic clarity and consistency throughout, as participants own words were used as much as possible. One term was used to explain and describe one concept consistently throughout the theory. Consistency in structure has also been achieved as evidenced through the model by using consistent words to describe the types of presence, environments, levels of trust in God, and decisions to act in each stage.

Parsimony was achieved as the dense theory was stated clearly and concisely, enough for participants to easily understand it. Testability was achieved in part as GT is designed for developing mid-range theory. Also the concepts and theory are easily understood and usable in practice. However, further research is required to develop

specific instruments to measure the assertions of the mid-range theory, which will ensure testability.

Empirical adequacy can only be achieved once the theory has been tested and empirical evidence is developed from it. The evidence generated should give a degree of confidence that the theory does not need modification, refinement, or that concepts should not be discarded (Fawcett, 2005). However, at first glance, the theory seems to be congruent with many prior GT PN studies, and literature.

Pragmatic adequacy "requires that the theory actually is used in the real world of nursing practice" (Fawcett, 2005, p. 134). Although the theory represents the lived nursing experience of six senior PNs, there has not been any other application of this theory in real life. However, it is clear that the theory-based actions of providing spiritual care are compatible with nursing expectations, client outcomes, and legal authority. It is noteworthy to say that the theory would require special training before implementation in nursing practice.

Summary of Implications

Using Fawcett's six step reporting framework helped identify the implications of this study and has provided some structure to discuss how the research findings can be of use in nursing practice, education, administration, policy, and research. The findings were linked to several nursing theories as a means to understand congruence with them and how the findings may be used in practice. Educators and regulators may use these findings to help identify more competencies and establish standards in spiritual nursing care. Administrators may use the findings to help create favourable environments that

enable nurses to develop themselves and provide person-centered care. This framework also helped identify how the findings of this research had social meaning to PNs and all other nurses as well as their clients as spiritual care is something most clients want but rarely receive through our health care system. Findings are ready for use in practice as they are congruent with various nursing theories and as the mid-range theory, provides a link to practice. This mid-range theory can be relevant for PNs specific practice situations and easily implemented as they continue to develop their parish nursing practice in more favourable environments. The findings are congruent with clients' expectations of receiving spiritual care in various practice settings and nurses have the legal authority to use the findings based on their Code of Ethics and standards of practice.

The limitations of the study included small sample size and the fact that all participants were female and of Christian background, which may not represent others from different faith religions and gender. The applicability of GT rigor (Glaser, 1978) including fit, grab, work, modifiability, generality and traction as well as Lincoln and Guba's (1985, 1989) criteria of trustworthiness of credibility, transferability, dependability, and confirmability were also achieved throughout the study.

Fawcetts' (2005) evaluation of theory shows that it achieved significance, internal consistency, semantic consistency, parsimony, and testability. The theory of presence shows significance as the research was conducted with congruence in philosophical underpinnings and methodology. Literature reviews were conducted and cited throughout the study and experienced PNs were interviewed. The theory of presence shows internal consistency as the research methodology is consistent to answer the research question. Structure and semantics are consistent throughout the theory such as

the iterative process and titles of the stages. Context is congruent with the method of interviewing experienced PNs as subject matter experts to develop the data. Parsimony was achieved as the dense theory was stated clearly and concisely enough for participants to easily understand it. Testability was achieved in part as the mid-range theory is consistent with literature and produced concepts required to develop testing instruments. However no testing instruments have been developed. Empirical adequacy has not been met as the theory needs to be used in practice and research conducted to assess it's usefulness and integrity in the real world. Pragmatic adequacy has not been met as nurses have not gained a full understanding of the theory, may not have the necessary skills to apply it, and may not be in a setting that is conducive to its application. However, the theory is consistent with nursing scope of practice and client expectations.

Conclusion

This research study used an interpretive paradigm, relativist ontology, interactive epistemology, qualitative research methodology and a Glaserian grounded theory (GT) method to help answer the research question "How do parish nurses develop their spiritual nursing practice over time?" Once ethical research board review was obtained and consent received from participants, interviews were scheduled at a mutually agreed upon time. Six seasoned and experienced PNs were interviewed after meeting the selection criteria of receiving certification in parish nursing, having a minimum of two years of parish nursing experience in offering spiritual care, being willing to participate in an interview for approximately one hour, and living in New Brunswick, Nova Scotia, Prince Edward Island or Alberta.

All participants were female, aged between 55-71 years or more, and of a Christian faith. All were experienced in providing spiritual nursing care. Most participants practised as PNs for between 6-10 years. Data were developed by interviewing participants, mostly via telephone. Interviews were recorded, transcribed verbatim, and analyzed using line-by-line coding. A core variable was identified as *becoming a channel of God one moment in time*, which related to all other variables. Data were then categorized using participants' own words. Theoretical sampling was done by asking participants more questions related to the core variable and by using literature as data, all of which helped develop the BSPP, its concepts, and the model of presence. Memoing was done throughout the study to keep track of ideas, hunches, notes and decisions on categories and emerging theory. Theoretical coding was conducted by using three types of theoretical code families including 6Cs (context, condition, cause,

consequence, covariance, and contingency), self-identity (self-image, self-concept, self-worth, self-evaluation, identity, social worth, self-realization, transformation of self, conversion of identity), and modeling. These family codes helped develop relationships among the categories, which helped create conceptual level codes for the emerging theory. Theoretical sorting was done as ideas generated from memoing were reviewed and sorted as it related to the theory. Theoretical sensitivity was achieved by being immersing in the data, doing line-by-line coding for long periods of time, remaining open-minded, and being cognizant of potential biases. A mid-range theory was generated called "Cultivating the soul: A model of presence. Saturation was achieved as no new information was forthcoming from the data and literature was used to saturate the concepts of humbling and emptying self and taking a leap of faith. Rigor was achieved as the GT rigor criteria of fit, grab, work, modifiability, generality and traction as well as Lincoln and Guba's (1985, 1989) four criteria of trustworthiness were used throughout the research project.

The BSPP called "Cultivating the soul to become a channel of God one moment in time" is a four-step iterative climb that PNs use to progress through six stages of presence. The four steps include: (a) finding favourable environments by desiring and seeking; (b) trusting in God by being receptive, centering self, and praying; (c) deciding to act by being attuned and seizing opportunities; and (d) taking a leap of faith at the right moment by finding courage and strength through God. The six stages of presence include: (a) foundation of God-related beliefs and values; (b) presence with self; (c) presence with God; (d) presence with others; (e) presence with God and others; (f) channel of God.

Implications of the research findings were organized using Fawcett's (2006) six-step evaluation of pragmatic adequacy. Step 1- social meaningfulness of the study findings was achieved as the research method was appropriate to answer the research question and the findings uncovered the BSPP PNs go through to develop their spiritual nursing practice over time. This can help other PNs, nurses, and student nurses understand how to develop spiritual nursing care competencies and meet their clients' spiritual needs in various practice settings. Step 2- it's ready for use in practice as the model illustrates how to develop spiritual nursing competencies over time and helps us understand the impact favourable environments may have on nurses' abilities to cultivate themselves and provide spiritual care to their clients as part of holistic nursing care. Step 3- it's relevant to several practice situations including; (a)- clinical practice as the findings are congruent with several nursing theories including Virginia Henderson (1967/1997) needs theory, Rogers (1970, 1991) science of unitary and irreducible human beings, Benner's (1984) model of practice from novice to expert; Barker's (2001) tidal model; and Watson's (2008) science of caring. It's relevant to (b)- education as it can help with developing curricula and spiritual nursing competencies. It may also help develop therapeutic relationships since Peplau (1991) identified that the kind of person nurses become and the development of nurses' personal maturity are two assumptions in establishing therapeutic relationships. It's also relevant to (c)- administration as the findings may help understand the importance of creating supportive and accommodating environments that encourage relationship building through communication and respectful and compassionate care which are essential to implement patient-centered care. It's relevant to (d)- policy as findings can be used as building blocks to develop standards of

practice in spiritual nursing care and therapeutic relationships. It's relevant to (e) research as further studies are required to determine several unanswered questions such as (i) How can Benners' model from novice to expert be integrated with the six stages of presence? (ii) How does nurses' level of spiritual maturity relate to the model of presence and impact their ability to establish therapeutic relationships? (iii) Can we develop a concept analysis of channel of God? and (iv) Can nurses who profess not believing in God develop spiritual nursing competencies and what is the impact on their therapeutic relationships?

Step 4- the feasibility of using the findings is probable since the model of presence is a mid-range theory which is designed to bridge the gap between nursing research and practice. The model is easily understandable and PNs and other nurses interested in providing spiritual care can use the findings. However in order to fully implement the model, nurses will need access to supportive work environments. Step 5- the findings are congruent with clients' expectation as literature shows that clients see their spiritual needs to be just as important as their physical needs, yet they feel these are not being addressed properly in the health care system. This model has the potential to help nurses develop their spiritual care competencies and inform employers of the importance of creating favourable environments that are required to provide the spiritual care as expected by their clients. Step 6- nursing has the legal control to use the model of presence since spiritual care is part of the nursing scope of practice. However, nurses need to feel supported by an employment culture that encourages them to provide spiritual care to their clients without the fear of being reprimanded.

Limitations of the research included small sample size, long distance telephone interviews, limited pool of participants as this is a new specialty with very few employment opportunities which limits the consolidation of their knowledge into practice and their years of experience as PNs. The sensitive nature of the subject may have made some potential participants uncomfortable, as the researcher was personally familiar with them. Homogeneity of Christian faith and female gender of the participants may also have been a limitation, as many other potential participants from other faiths and gender were not represented in the study. It is well known, however, that at this time, such a group of participants is quite representative of the population of parish nurses worldwide.

The evaluation of the theory of presence was based on Fawcett's six criteria of evaluation. The theory of presence shows (a) significance as the research was conducted with congruence in philosophical underpinnings and methodology. Literature reviews were conducted and cited throughout the study and experienced PNs were interviewed. It shows (b) internal consistency, as the research methodology is consistent to answer the research question. Structure and semantics are consistent throughout the theory such as the iterative process and titles of the stages. Context is congruent with the method of interviewing experienced PNs as subject matter experts to develop the data. The theory achieved (c) parsimony as the dense theory was stated clearly and concisely enough for participants to easily understand it. The mid-range theory achieved partial (d) testability as it is consistent with literature and produced concepts required to develop testing instruments. However no testing instruments have been developed. The theory has not met (e) empirical adequacy as the theory needs to be used in practice and research conducted to assess it's usefulness and integrity in the real world. The theory did not

achieve (f) pragmatic adequacy as nurses have not gained a full understanding of the theory, may not have the necessary skills to apply it, and may not be in a setting that is conducive to its application. However, the theory is consistent with nursing scope of practice and client expectations.

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Appendix A Invitation Letter Participants of Listserve

UNB REB#2016-122

Date….

Dear NANB/ NBPNM member _____ (name)

You are receiving this letter via your Nurses Association of New Brunswick, College of Registered Nurses of Nova Scotia, Association of Registered Nurses of Prince Edward Island, or New Brunswick Parish Nursing Ministries membership listserv because you have experience as a parish nurse offering spiritual nursing care in New Brunswick, Nova Scotia or Prince Edward Island. Denise LeBlanc-Kwaw, is a graduate nursing student at the University of New Brunswick, who is conducting a research project entitled "The process of developing a spiritual nursing practice: Uncovering parish nurses' experiences." The project will explore the process parish nurses go through to develop their spiritual nursing practice skills and abilities over time and will require interviews of approximately 60 minutes in duration.

You are eligible to participate if you:

- Have undergone a formal parish nursing education program,
- Are or were a parish nurse offering spiritual nursing care
- Have at least 2 years of experience working in parish nursing,
- Reside in NB, NS, PEI or AB
- Are willing to participate in a confidential telephone, Skype, or face-to-face interview

The research project has been reviewed by the Research Ethics Board of the University of New Brunswick and is on file as REB 2016-122 If you wish to participate in this important research, please contact Denise LeBlanc-Kwaw, Graduate student Program of Graduate Studies in Nursing, University of New Brunswick, telephone: 506-451-0787 or email denise.leblanc-kwaw@unb.ca

If you have questions about this study and you wish to speak to someone not directly involved, please contact:

Dr. Kathy Wilson, Assistant Professor and Director of Graduate Studies, Nursing UNB Faculty of Nursing, (506) 458- 7640, e-mail: kewilson@unb.ca

or

Steven Turner, Chair UNBF Research Ethics Board (506) 458-7433, Email: turner@unb.ca

If you wish to speak to the research supervisor, please contact Dr. Kathryn Weaver, Associate Professor, Faculty of Nursing, University of New Brunswick, (506) 458 7648, email: kweaver@unb.ca

Sincerely,

Name of Representative of NANB/CRNNS/AAPNM/NBPNM.

Appendix B Participant Information Letter

UNB

REB#2016-122

Title of Project: The process of developing a spiritual nursing practice: Uncovering parish nurses' experiences.

Principal Investigator: Denise LeBlanc-Kwaw, Graduate student at UNB Fredericton Campus

Supervisor: Dr. Kathryn Weaver, Faculty Nursing UNB Fredericton Campus

Background:

You were made aware of this research study through an invitation letter you received from the Nurses Association of New Brunswick, College of Registered Nurses of Nova Scotia, Association of Registered Nurses of Prince Edward Island, the New Brunswick Parish Nursing Ministries, or the College and Association of Registered Nurses of Alberta from a parish nurse already participating in the study. You are invited to participate in an interview. I will ask you to describe your experience as a parish nurse and your journey in offering spiritual nursing care to your clients.

Purpose:

To learn more about the prerequisites and process parish nurses go through to be able to offer spiritual nursing care to their clients. Although spiritual care is promoted, it is often missing in education curricula and most nurses do not offer it as it is often confused with religion. The insight gained through this study will enable other nurses, educators, and regulators to know how to develop and maintain the spiritual nursing competencies.

Expectations:

Eligible nurses must have received specialized education in parish nursing, reside in NB, NS, or AB, have a minimum of 2 years of experience in providing spiritual nursing care, and be willing to participate in a confidential interview.

All participants will be asked to sign a consent form prior to being interviewed.

You will be interviewed for approximately one hour, either face-to-face, via Skype or by telephone, whichever you prefer. You may be contacted subsequent to the interview for some clarification.

You will be asked to talk about your experience as a parish nurse and the journey you went through to develop your spiritual nursing competencies. Information will be collected on the context, and history of the experience. We will also collect some non-personally identifying demographic information, such as age range and education.

All interviews will be audio recorded and transcribed by the Primary Investigator (PI) and all personal identifying information will be removed such as names and places. The PI is the only one who will listen to the recorded interviews. The information of the transcripts (with all personal identifying information removed) will only be accessible to the PI and her supervisor.

You will be offered a copy of a summary of the research, which includes information from all other parish nurse participants without any identifying information.

Benefits:

You may not have any direct benefit for participating. However, you may appreciate the opportunity of sharing your experience and knowledge about your spiritual nursing practice. This may help the nursing profession gain knowledge about what is required in

order to provide spiritual nursing care to clients.

Risks:

There are no expected risks in participating. Throughout the interview, should you feel unsettled and no longer comfortable in participating, the tape will be stopped and you will have the time to decide if you wish to continue. You may also stop the interview at any time without any negative consequences.

Confidentiality:

All recordings and information will be kept confidential, password protected, and in locked storage in a secure place accessible to the PI and supervisor alone. All identifying information will be removed from the interview data when the information is transcribed. Fictive names and places will be used in any reports about the study. No identifying information will be used in any publication. No names will be used in any discussions about the study.

Conflict of Interest:

None declared.

Any future use of information:

All collected information will be stored in a locked cabinet throughout the study. The transcripts from which all names and other identifying information have been removed are restricted to the PI and supervisor. After the analysis is complete, the memory sticks containing the interview data, demographic information, and consent will be transferred to a secured locked cabinet. These data will be retained for a period of seven years following completion of the study. Your data will be destroyed after a period of seven

years. One copy of the transcribed interviews with identifying information removed will be kept for future related studies.

Freedom to withdraw:

You are free to withdraw your consent to participate in the study at any time during and following the interview without any negative consequences. If you withdraw your consent, any data collected from you will be destroyed upon request.

Your Right to refuse to answer a question:

You are free to not answer any questions. You are free to decide which question to answer at all times.

Informed About Study Outcome:

If you choose to participate in the interview, you may choose to receive through e-mail or by Canada Post a summary of the research findings.

Additional Contact Information:

You may contact the following people who are not directly involved in the study should you have any questions or concerns about any aspect of this study please contact:

Dr. Kathy Wilson, Assistant Professor and Director of Graduate Studies, Nursing UNB Faculty of Nursing, (506) 458- 7640, e-mail: kewilson@unb.ca

or

Dr. Steven Turner, Chair UNBF Research Ethics Board (506) 458-7433, email: turner@unb.ca

PI Contact Information: please contact Denise LeBlanc-Kwaw, Graduate student Program of Graduate Studies in Nursing, University of New Brunswick, telephone: 506-451-0787 or email denise.leblanc-kwaw@unb.ca

Supervisor Contact Information: Dr. Kathryn Weaver, Associate Professor, Faculty of Nursing, University of New Brunswick, (506) 458 7648, email: kweaver@unb.ca

Funding Agency:

Canadian Nurses Foundation New Brunswick Centennial Fund

Appendix C Snowball Invitational Letter

UNB REB#2016-122

Dear parish nurse_____ (name),

Re: Research Study entitled "The process of developing a spiritual nursing practice: Uncovering parish nurses' experiences"

Are you, or were you, a parish nurse offering spiritual nursing care to your clients in New Brunswick, Nova Scotia or Prince Edward Island?

Are you interested in participating in a study about how nurses develop their spiritual nursing practice?

You can participate if you

- Have undergone a formal parish nursing education program,
- Are, or was, a parish nurse offering spiritual nursing care
- Have at least 2 years of experience working in parish nursing,
- Reside in NB, NS or AB, and
- Are willing to participate in a confidential telephone, Skype, or face-to-face interview of approximately 60 minute duration.

The research project has been reviewed by the Research Ethics Board of the University of New Brunswick and is on file as REB 2016-122 If you want to assist in this important research, please contact Denise LeBlanc-Kwaw, Graduate student Program of Graduate

Studies in Nursing, University of New Brunswick, telephone: 506-451-0787 or email denise.leblanc-kwaw@unb.ca.

If you have questions about this study and you wish to speak to someone not directly involved, please contact:

Dr. Kathy Wilson, Assistant Professor and Director of Graduate Studies, Nursing UNB Faculty of Nursing, (506) 458- 7640, e-mail: kewilson@unb.ca

or

Steven Turner, Chair UNBF Research Ethics Board (506) 458-7433, email: turner@unb.ca

If you wish to speak to the research supervisor, please contact Dr. Kathryn Weaver, Associate Professor, Faculty of Nursing, University of New Brunswick, (506) 458 7648, email: kweaver@unb.ca

Appendix D Informed Consent for Participants in Interview

UNB REB

#2016-122

Study Title: The process of developing a spiritual nursing practice:

Uncovering parish nurses' experiences

Researchers: Denise LeBlanc-Kwaw & Dr. Kathryn Weaver

Participant Statement

By signing below, I consent to my participation in this study designed to research how parish nurses develop their spiritual nursing practice and how they offer spiritual care to their clients. I have read the letter of information and understand the purpose of this study as well as the risks and benefits of participating. I have had the opportunity to ask questions and my questions have been answered to my satisfaction. I understand that I am free to ask questions at any time throughout the study. I have received a copy of the consent form and I give permission to use the information I provide in the interview for the purpose of this research.

I understand that while I am taking part in this study, I will be asked questions related to my spiritual nursing practice, which may include information related to my personal spiritual journey. I have also been told that I am free to not answer any questions that I do not wish to answer. I understand that should I experience any discomfort or uneasiness, I will report it to

the researcher without delay. I can choose to withdraw from the research study at any time during or after, without reason or negative consequences. If I withdraw after being interviewed, my interview data will be removed from the study and destroyed.

I understand that my identity and data will be kept anonymous and confidential and that I will be informed of the results of the research. I know that only the PI (Denise LeBlanc-Kwaw) will know my identity. The PI will protect my identity by storing my signed consent form separately from other study information and by transcribing my interview herself using a headset. My identity will also be protected by having all identifying information removed from my transcript and by storing data in a locked cabinet in her home or at the university when the data are not in use. I am aware that one copy of my transcribed interview data with all personal identifying information removed may be kept for future research.

I understand that I may take any complaints or concerns that I may have to the primary researcher, Denise LeBlanc-Kwaw (506-451-0787), the Supervisor Dr. Kathryn Weaver (506) 458-7648, email: kweaver@unb.ca, and/or Steven Turner, Chair UNBF Research Ethics Board (506) 458-7433, email: turner@unb.ca

I have read the above statement and freely consent to participate in this research.

Participant's Printed Name:_____

Participant's Signature:_____ Date: _____

Witness Printed Name:_____

Witness Signature:_____ Date: _____

Appendix E Demographic Information Form

Gender

___Female ___Male

Age range

___25-34 ___35-44 ___45-54 ___55-64 ___65-70 ___71+

Religion

___Roman Catholic ___Pentecostal ___Wesleyan/Methodist
___Anglican ___Baptist ___Islam
___United ___Jewish ___Hindu
___Other

Highest Level of Education

___RN Diploma
___Bachelor's degree Nursing ___Bachelor's degree other
___Master's degree Nursing ___Master's degree other
___PhD in Nursing ___PhD other

Education in Parish Nursing

___Certificate ___Certificate and mentorship
___Degree ___Clinical Pastoral Education

Parish Nursing Employment status

Employed:	*# hours worked/week:*	*Remuneration*
___Full-time	**___20+ hours**	**___Paid**
___Part-time	**___10-19 hours**	**___Unpaid**
___Retired	**___Less than 10 hours**	**___In-kind Donation**

Years of Parish Nursing Experience

___0-2 years ___3-5 years ___6-10 years ___10+ years

Appendix F Budget

Travel throughout NB to do initial and secondary interviews with 6-10 parish nurses.	**$1500.00**
Purchase tape recorder	**$ 150.00**
Microphone and head set	$ **60.00**
Batteries	**$ 30.00**
Paper and printer ink cartridges	**$ 150.00**
Miscellaneous stationary	**$ 20.00**
Memory sticks (2)/back up CDs (2)	**$ 40.00**
Fee to NANB to run data query for sample	**$ 75.00**
Total	**$2025.00**

Curriculum Vitae

Candidate's full name: Denise J. LeBlanc-Kwaw

Universities attended:

2015 Diploma of University Teaching

University of New Brunswick, Fredericton, NB

1984 Baccalauréat en Sciences Infirmières

Université de Moncton, Moncton, NB

Conference Presentations:

LeBlanc-Kwaw, D (July 21-27, 2019) Abstract accepted for presentation. A model of presence: A grounded theory study. *International Academy of Law and Mental Health,* Rome, Italy.

LeBlanc-Kwaw, D (June 20-22, 2016). Poster Presentation. Scoping literature review-parish nursing spiritual care. *Canadian Nurses Association Biennial Convention,* Saint John, NB.

LeBlanc-Kwaw, D (Sept 15, 2015 at 10:00-10:20 am). Student Presentation. Parish nursing ministry a community health nursing practice. *Course 3065: Community health nursing 3d year students, UNB Fredericton.* Assistant professor Tracey Rickards.

LeBlanc-Kwaw, D.; MacIntosh, J.; O'Donnell, S. (2015, Sept 10; 7-8pm). Public Presentation. How do workplace resources help bullied men*? Respectful Work-Week.* Fredericton Public Library, Fredericton, NB.

LeBlanc-Kwaw, D. (2015, June 11-13). Poster Presentation. Parish nursing: A literature review on policy and practice standards. *Atlantic Regional Canadian Association Schools of Nursing*, Saint John, NB.

LeBlanc-Kwaw, D. (2015, May 2 at 10:30-11:30 am). Public Presentation. Parish nursing: Proposed bylaws for New Brunswick Parish Nursing Ministry (NBPNM) based on literature review. *NBPNM Special Membership Meeting.* Fredericton, NB.

MacIntosh, J., LeBlanc-Kwaw, D. (2014). Poster Presentation. Effects of workplace bullying on men. *Poster program 6th annual conference on health research in New Brunswick.* New Brunswick Health Research Foundation, p.14.