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Job Termination Survey: Faith Community Nursing

Deborah Ziebarth
Herzing University

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Herzing University, Brookfield, Wisconsin and the Westberg Institute, Church Health, Memphis, Tennessee

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Nurses provide an important service in acute and community settings. Since there is a shortage of nurses in many geographic areas in the United States, voluntary termination is a concern to employers. Voluntary termination is when a nurse decides to leave a job of their own accord because there is a change in personal circumstances, dissatisfaction with working conditions, or the search for a better job. A national survey of 141 hospitals reported the average nurse's voluntary termination rate is 16.4%, which is a 2.2% increase from 2013 (Colosi, 2015, p.4). The bedside nurse voluntary termination rate has increased from 11.2% in 2011 to 16.4% in 2015 (Colosi, 2015).

Closi, (2015) states that the top ten reasons why bedside nurses voluntarily terminate, are: relocation, personal reasons (caring for a child/parent, marriage, disability, etc.), career advancement, retirement, education, salary, location, scheduling, workload and unknown. In response to the nurse increased voluntary termination rates, hospitals are "…building retention capacity, managing vacancy rates, bolstering recruitment initiatives and controlling labor expenses" (p.12). The average cost of bedside nurse replacement for hospitals ranges from $36,900 to $57,300 (Colosi, 2015, p.8). The economic impact of nurse voluntary termination is significant and hospitals are looking for ways to retain nurses.

Just as nurses are in demand in hospitals to facilitate care of patients, nurses are needed to provide primary, secondary, and tertiary prevention services in the community. Research regarding community-based nurse voluntary and involuntary termination rates are limited and outdated. This exploration project aims to explore faith community nursing termination through a national survey. Questions pertaining to why termination occurred, resources used during termination, and post termination behaviors will be addressed. With increased knowledge of the specialty of faith community nursing, one may fully understand the context in which termination occurs.

Literature Review
Faith Community Nursing

There are 34 nursing specialties that are considered to be community-based and faith community nursing is one of them (Ziebarth, 2015a) All nursing specialties practice under the legal authority of each state's nurse practice acts and policies. In addition, all specialties are guided by the *Nursing: Scope and Standards of Practice* (American Nurses Association, 2010). They are also guided by individualized specialty scope and standards of practice. Faith community nursing is guided by the *Faith Community Nursing Scope and Standards of Practice* (American Nurses Association and Health Ministries Association, 2012). This document states that faith community nursing is a "…specialized practice of professional nursing that focuses on the intentional care of the spirit as part of the process of promoting wholistic health and preventing or minimizing illness in a faith community" (ANA & HMA, 2012, p.1).

Two theoretical definitions of faith community nursing are:
> "… care that supports and facilitates: physical functioning; psychological functioning and lifestyle change, with particular emphasis on coping assistance and spiritual care; protection against harm; the family unit; effective use of the health system; and health of the congregation and community."
> (Twadell & Hackbarth, 2010, p.74).

"… a method of health care delivery that is centered in a relationship between the nurse and client (client as person, family, group, or community). The relationship occurs in an iterative motion over time when the client seeks or is targeted for wholistic health care with the goal of optimal wholistic health functioning. Faith integrating is a continuous occurring attribute. Health promoting, disease managing, coordinating, empowering and accessing health care are other essential attributes. All essential attributes occur with intentionality in a faith community, home, health institution and other community settings with fluidity as part of a community, national, or global health initiative."

(Ziebarth, 2014a, p 1829).

Ziebarth's (2014) definition of faith community nursing, was later tested in an evolutionary conceptual analysis of wholistic health (Ziebarth, 2016a). It was found that wholistic care providers have the same essential attributes (e.g. faith integrating, health promoting, disease managing, coordinating, empowering and accessing health care) as faith community nursing. Faith community nurses (FCNs) are wholistic care providers.

A FCN is a registered nurse that has additional training to work in or with a faith community. The FCN is considered to be a "nurse generalist". Based on a literature review of 124 faith community nursing articles, Ziebarth, (2014a) found that FCNs perform additional nursing interventions that are routine. These interventions occur over time when the client seeks or is targeted for wholistic health care and include: (a intentional spiritual care, spiritual leadership/practices, and the integration of health and faith; (b coordination, implementation, and sustentation of ongoing activities; (c utilization and application of survey results; (d training and utilization of volunteers; (e both multidisciplinary and interdisciplinary in resourcing and referring; and (f have the goal of wholistic health functioning.

The delineation of essential faith community nursing interventions is important because the Joint Commission (2010) states that patients have specific characteristics and nonclinical needs that can affect the way they view, receive, and participate in health care. In addition, supporting patient's spiritual needs may help them to cope with their illness. Patients that have services rendered by a FCN may experience a range of assessments and interventions that promote an adaptive process of attaining or maintaining wholistic health functioning (Cavan Frisch, 2000, 2001; Wolf, Lehman, Quinlin et al, 2008; Solari-Twadell & Hackbarth, 2010; Ziebarth 2015b). To further define Wholistic health [functioning], Ziebarth (2016a) states:

"The human experience of optimal harmony, balance and function of the interconnected and interdependent unity of the spiritual, physical, mental, and social dimensions. The quality of wholistic health is influenced by human development at a given age and an individual's genetic endowments, which operate in and through one's environments, experiences, and relationships." (p.32).

An FCN performs essential nursing interventions to promote wholistic health functioning.

Economic Impact of Faith Community Nursing

The economic impact of prevention services rendered by FCNs is difficult to actualize. Net Benefits analysis (McGuigan, Hozack, Moriarty et al., 1995; Buxton, Drummond, Van Hout et al., 1997; Dranove, 2003, Ziebarth, 2016b) provides a monetary case for prevention services. Using the equation: $NB(x) = B(x) – C(x)$ (NB = net benefits, x = FCN program, B = expected

benefits associated with the program, and C = expected cost of program), the expected benefit and cost associated with a FCN are realized. One might also consider: (a) medical cost averted because of an illness prevented or costs that would have incurred had the medical treatment not been implemented, (b) monetary value of the loss in production diverted because good health is restored, death is postponed or projecting the loss of income due to illness or death, and (c) monetary value of the loss in satisfaction or utility (usefulness) averted due to a continuation of life or better health or both (Santerre & Neun, 2012, pp 88-92). There are other economic considerations such as fixed and variable cost percentage (Santerre, et al., 2012; Ziebarth, 2016b) and patient re-admission avoidance (Ziebarth & Campbell, 2016b; Ziebarth, 2015c).

Hospitals are paying more to care for the Medicare population with decreasing payment reimbursements for re-admissions within 30-60 days (Smith, Gage, Deutsh et al., 2012). Hospitals have used FCNs to keep Medicare patients safe in their homes and communities (Schumacher, Jones & Meleis, 1999; Rydholm & Thornquist, 2005; Rydholm, Moone, Thornquist, 2008). The FCN addresses whole health care and may improve the patient's discharge experience, ensure post-discharge support and reduce hospital re-admission of patients (Carson, 2002; Hennessey et al., 2010; Marek et al., 2010; Nelson, 2000; Rydholm, 2006; Rydholm & Thornquist, 2005; Rydholm et al., 2008; Schumacher, Jones, & Meleis, 1999; Ziebarth & Campbell 2016b). Faith community nurses effectively assist older persons to obtain needed health care often preventing crisis care or readmissions. They also help older persons link to community long-term care services such as chore service and meals-on-wheels, and to access information resources such as free prescription medications for low-income individuals. Faith community nurses provide emotional and spiritual support for anxious and isolated elders (Rydholm et al., 2008). The FCN provides important work in the community by keeping patients well. Therefore, the issue of voluntary and involuntary termination of FCNs is of interest to hospitals, faith communities, and to the discipline of nursing.

Faith Community Nurse Termination

What is known about FCN termination in literature is very limited. Ziebarth and Miller (2010), found that certain FCN role-transition interventions had an impact on successfully assuming the role. Some negative perceptions from FCNs of role-transition deterrents were insufficient time to practice, inadequate knowledge, lack of support, and a lack of program value perceived by the faith community. A new FCN may voluntarily terminate due to unsuccessful role-transition. Some positive perceptions from FCNs of role-transition support were stated as peer support groups, orientation, mentors or role models, and continuing education (p.279).

Hospital-funded faith community nursing programs operate in a missional environment because they are a nonrevenue producing department and are "most at-risk for elimination when margin is threatened" (Ziebarth, 2015b, p.89). Revenue-producing activities are considered to be the core business of hospitals. Margin means having excess money to do mission activities. Unless additional altruistic reasons exist, most hospitals support FCNs through "Community Benefit" funding. Hospitals with a tax-exemption nonprofit status are expected by the federal government to give back to the community (Raden & Cohn, 2014). An FCN income can be reported as a community benefit expenditure because FCNs address "community needs and priorities primarily through disease prevention and improvement of health status" (Ziebarth, 2015b, p.92). A FCN may experience involuntary termination due to program elimination. Whether from voluntary or involuntary termination, there is a loss of benefit to the community.

Community Nurse Termination

Jansen, Kerkstra, Abu-Saad et al (1996) surveyed three hundred and ten (310) community nurses. The results revealed a relationship between lower scores on job satisfaction and the higher feelings of burnout. Several job characteristics were shown to be related to job satisfaction and burnout. Job satisfaction was positively affected by role clarity, skill variety, possibilities for growth and feedback at work. Community nurses, which were less satisfied with their job, attributed this to supervisor conflict, lack of role clarity, and lack of advancement opportunities. The greater complaints of burnout among community nurses seem to be the consequence of the fact that they felt themselves isolated and less supported by their supervisor. Although community nurses do have more autonomy in their work, this characteristic was less important for job satisfaction. The social support received at work was important in increasing job satisfaction and decreasing burnout.

Faith Community Leadership Termination

Since the FCN literature is lacking information regarding termination, a related concept, faith community leadership was explored. FCNs work in or with faith communities and are often hired by faith community leadership. Three studies (Blackmon, 2011; Krejcir, 2007; Fuller, Campbell, Celio, et al, 2003) were examined for similarity of results. Blackmon (2011) surveyed one thousand pastors from four major denominations in California. Over 75% of ministers were found to be extremely or highly stressed and 35% of them ultimately voluntarily terminate. The significance of the stress reported was in the areas of personal finances, church finances, and role issues, such as recruitment of volunteers, counseling, and visitation (Blackmon, 2011).

The second survey was done at two pastoral conferences held in Pasadena, California (N=1050). A total of 825, or 78% (326 in 2005 and 499 in 2006) of respondents said they were forced to terminate at least once (Krejcir, 2007). When asked why, structured responses included poor leadership, conflict with key staff or lay leadership, gossip, lack of funding, doctrinal divide, hardship on family, lack of connection with members, resistance to their teaching, resistance to their leadership style or vision, failure to teach biblically, poor people skills, failure to follow job description, inappropriate relationship, or other "sin" issues. The survey results include:

- Respondents (412 or 52%) stated that the number one reason for termination was organizational and control issues. A conflict arose that forced them out based on who was going to lead and manage the church—pastor, elder, key lay person, etc.
- Respondents (190 or 24%) stated that the number one reason for termination was conflict. There was already a significant degree of conflict and it could not be resolved (over 80% of pastors stated this as number two if not already stated as number one, and for the remaining surveyed, it was number three).
- Respondents (119 or 14%) stated the number one reason for termination was resistance to their leadership, vision, teaching, or to change, or that their leadership was too strong or too fast.
- Respondents (64 or 8%) stated the number one reason for termination was lack of connection on a personal level or the members over-admired the previous pastor and would not accept them.
- Respondents (40 or 5%) stated that the number one reason for termination

was a lack of skills.

The third study explored the top ten reasons for faith community leadership job termination (Fuller, Campbell, Celio, et al, 2003). The authors reported that the ten reasons in descending order were: lack of a shared vision between them and members, lack of denomination support, feeling alone, stress on the family and on health, can't be real-have to be the most spiritual, not appreciated, stress and burnout, lack of motivation, low income and low self-esteem, and lack of vision. The author reported that 75% of faith community leadership live close to the poverty level. Factors that contributed to financial hardship included: decreasing attendance, increased cost of living, lack of giving, mega churches drawing members away, lack of skilled training for a second job and guilt that prevents seeking a second job (Fuller et al., 2003).

All three studies identified stress, low income, low self-esteem, isolation, conflict, and lack of skills as contributing to faith community leadership termination. The studies also revealed that environmental stressors that are unique to faith communities exist. Since FCNs work in or with faith communities and are perceived as leaders, understanding FCN termination is important. A survey may reveal behaviors and resources related to FCN termination.

Methodology

A survey was developed for FCNs experiencing termination. A Delphi methodology was used to test confirmability, construct and face validity (Young & Jamieson, 2001). Five experts in the specialty of faith community nursing received the ten question survey and were asked to comment on the questions. Questions were revised based on feedback received. The experts were then excluded from the sample. Questions on the survey addressed were:

- Were you ever voluntarily or involuntarily terminated from your position as a faith community nurse or faith community nurse coordinator?
- What was the reason(s) for the termination?
- Was counseling sought?
- If resources were utilized, what were they?
- What resources would you recommend at the time of the termination or would be helpful after termination?
- Did you return to the FCN practice after termination?
- Did you return to the FCN practice as FCN (paid), FCN (non-paid), FCN Coordinator/Manager, FCN Scholar (Student- returning for additional education), FCN Educator, FCN Researcher, FCN Consultant, FCN Administration (Job in FCN but not direct care provider), or Other?

Since faith community nursing termination has never been studied before, a survey was thought to be the best method to reach a large sample. With a representative sample, one can describe the behaviors and attitudes of the larger population. Survey Monkey LLC (2012) was used to reach as many FCNs as possible. A link was available through *The International Parish Nurse Resource Center* e-newsletter.

Results

A total of 264 FCNs responded to the survey's first question and 87 respondents, who were identified to have experienced termination continued to answer the remaining questions. Out of 264 FCNs who responded to the survey, 23.69% (59) of them lost a position as a FCN and 12.73% (28) lost a position as a faith community nurse coordinator (FCNC). A total of 46.58% of respondents who had been terminated (voluntarily or involuntarily) were in paid positions and 53.42% were in unpaid positions.

Table 1: Results

Reasons for FCN Termination	Did you seek counseling? Yes- 32.61% 30 No- 67.39% 62	What resources would be helpful at the time of the termination?	Did you return to the FCN practice? Yes 79.01% No 20.99%
Change in leadership 29.11%	Family and Friends 59.38%	A tool specific for FCN experiencing termination and transition. 64.52%	Returned as FCN (non-paid) 48.44%
Not a strategic priority to leadership 26.58%	Spiritual in Nature 59.38%	A list of resources for job transition and "Grief and Loss". 46.77%	Returned as FCN (paid) 32.81%
Organization restructuring 25.32%	Peers 46.88%	A preconference, panel, or workshop session. 40.32%	Returned as FCN Educator 20.31%
Not a financial priority to hospital or health care organization 24.05%	Professional Therapist 28.13%	A retreat focused on FCN termination and transition. 32.26%	Returned as FCN Coordinator/Manager 17.19%
Not a financial priority to the faith community 21.52%	Books and Literature 28.13%	A support group. 29.03%	Returned as FCN Consultant 15.63%
Personal reasons 20.25%		Other: webinars, on-line support groups, blogs, and a virtual network to get resources and prayer.	Returned as FCN Scholar (Student- returning for additional education) 7.81%
Startup was grant driven and funds ran out 11.39%			Returned as FCN Administration (Job in FCN but not direct care provider) 4.69%
Retirement 11.39%			Returned as FCN Researcher 3.13%
Health Related 8.86%			Returned as Other: • Doing grief support groups and grief

			counseling in the community. • Organize blood drives and keep a bulletin board in the faith community. • On the advisory board for our local FCN organization. On the board of our state led FCN organization. • Went from a hospital paid to church paid FCN.
Not the best fit 7.59%			

In response to the reasons for termination, FCNs were given the opportunity to also write in comments. Comments included:

- Not paid enough to cover child care expenses
- Pastors unwilling to let go of duties they were used to doing
- Declining membership and available funds
- The practice was not readily accepted by pastor.
- I quit the job because it had become too stressful to work with the church leadership.
- …was told that the reason for my position being terminated was not financially or performance based. The congregation wants to move in a different direction.
- I resigned. Pastor did not fully support what I was doing.
- The church wanted a younger nurse
- Closure of the ministry came in response to numerous changes including personnel changes.
- Some "mission drift" occurring
- My husband was ill and passed away.
- It was a non-revenue-generating department and keeping patients out of the system was counterproductive.
- Reported abuse and lost my job
- New pastor removed all leaders and office personnel
- Moved away
- Personality conflict with pastor
- The clergy appointment became detrimental to the faith community
- Church closed
- The hospital systems in the area are not interested in supporting this.

A total of 32.61% of respondents sought out counseling at the time of FCN termination. Sources of counseling were reported. Termination coping resources were also suggested. In response to the question, "Did you return to the FCN practice", 79.01% responded yes and

20.99% responded no. See Table 1. Survey respondents were given an opportunity to write in "Other" responses. Other responses included:

- I am in a paid position in a funeral home setting doing grief support groups and grief counseling in the community.
- I continue to organize blood drives and keep a bulletin board in the faith community.
- I remained on the advisory board for our local FCN organization.
- I remained on the board of our state led FCN organization.
- I went from a hospital paid to church paid FCN.

Discussion

Of the 87 FCN respondents who were terminated, more were unpaid (7%) than paid. One may surmise that a FCN non-paid position as a FCN in a faith community insulates one from termination. That may not be the case. The top three reasons for termination as reported were leadership change, not a strategic priority to hospital or faith community leadership, and organization restructuring or elimination of the program. The term involuntary termination, in many cases, was synonymous with faith community nursing program closure. Leadership change insinuates that site leadership had a positive impact on the program but when leadership changed, there was an adverse effect. Respondents reported: "New pastor removed all leaders and office personnel", "The [FCN] practice was not readily accepted by the new pastor", and "Closure of the [FCN] ministry came in response… to pastoral changes". Leadership changes and lack of a communication plan regarding the future of the program prior to the leadership change may be a precursor to FCN termination.

"Not a strategic priority" as a reason for termination was captured in the additional comments section of the survey. One respondent stated that the "Pastor did not fully support what I was doing" and another wrote, "…was told that the reason for my position being terminated was that… the congregation wants to move in a different direction". This may speak to a conflict between the faith community nursing program's mission/vision and that of the setting. Lack of shared visioning between program advocates and site leadership early on and regularly as needed, may be a precursor to FCN termination.

Many times when an organization restructures, it is to operate more efficiently. By reorganizing, downsizing, or eliminating departments, services are streamlined and budgets are decreased. A lack of flexibility and regular reporting program value (economic and altruistic) may be a precursor to FCN termination.

The 4th, 5th, and 7th reasons for termination were financially based and consisted of:

- not a financial priority to hospital or health care organization
- not a financial priority to the faith community leadership
- startup was grant driven and funds ran out

Statements from participants regarding financial reasons for termination, from a hospital program, included, "It was a non-revenue-generating department and keeping patients out of the system was counterproductive" and "The hospital system was not interested in [financially] supporting this". Statements regarding financial reasons for termination, from a faith community, included "Declining membership and lack of available funds…", "The church closed", and "Facility and meeting space closed". Since faith community nursing programs in

hospitals operate in a missional environment, FCNs that do not respond or report on funder's priorities, both economic and altruistic, may be at-risk for termination.

The survey indicates that voluntary termination may occur due to personal reasons 20.25%, retirement 11.39%; or are health related 8.86% reasons. Personal reasons included: "Not paid enough to cover child care expenses", "Husband's job transfer", and "Personality conflict with pastor". Health related reasons include stressors. One respondents wrote, "I quit the job because it had become too stressful to work with the church leadership". Another one wrote, "My husband was ill and passed away". Both "financial" and "stressors" are ranked high as reasons given for church leadership and FCN voluntary termination. This may indicate that the faith community environment has determinates that can adversely impact job satisfaction.

At the time of the FCN position termination, respondents sought out professional therapy, peer support, books and literature, and holistic healing methods. Most reported (59.38%) that the counseling or the support sought was spiritual in nature. This aligns with what we know about FCNs. Spirituality is an essential attribute of faith community nursing (Ziebarth, 2014). Respondents recommended several resources. They stated that a resource specific for FCN experiencing voluntary and involuntary termination would be helpful. Electronic resources were mentioned as other resources suggested. This coincides with a recent study (Ziebarth & Hunter, 2016) exploring the development of a virtual knowledge platform for FCNs. The study revealed that FCNs are comfortable with using electronic resources to support their practice (Ziebarth & Hunter, 2016).

Most of the respondents (79.01%) returned to the specialty of faith community nursing. This indicates that these FCNs have a favorable viewpoint of faith community nursing even after termination. However, nearly half stated that they returned to the specialty as a non-paid FCN (48.44%). The nurses returned to the faith community nursing specialty as a FCN, educator, coordinator/manager, consultant, scholar, administrator, and researcher. Some FCNs remained active in local and state professional organizations. After termination, many FCNs remained engaged in faith community nursing indicating a special loyalty or connection to the specialty.

It was noted that after termination, some FCNs continued to provide a limited service: blood drive, bulletin board, or support group for the faith community where they had been employed. The nurse may have been a member of the faith community prior to accepting the FCN position and chose not to leave after termination. However, some FCNs expressed looking for a new job and a new faith community at the same time. They were members in the faith community before accepting the FCN position and now terminated, feel the need to leave. The feelings of loss may be complicated by the leaving the job and their family and friends at the faith community.

The survey results highlighted some issues that are unique to faith community nursing within the discipline of nursing. They are: (a) the high percentage of involuntary FCN termination due to program closure (both hospital and faith community based models); (b) the FCN search for both a new job and new faith community post involuntary termination; (c) the high percentage of FCNs returning to unpaid positions after termination; and (d) the lack of resources for FCNs experiencing termination. With awareness being the first step, there may be some urgency for the specialty to address these disparities through education.

Conclusion

A total of 87 FCNs, who experienced termination, completed a survey examining behaviors, feelings, and therapeutic resources. The top three reasons for termination were due to changes in leadership or priorities. Financial was also given as a reason for termination. A communication plan and routine economic and altruistic reports to stakeholders was suggested. Most FCNs reported (59.38%) that their post-termination counseling was spiritual in nature, which aligns with what we know about the practice. Spirituality is an essential attribute of faith community nursing. Most respondents (79.01%) returned to faith community nursing after termination, which indicates a favorable viewpoint of the practice. Finally, resources for FCNs experiencing termination were suggested. Some disparities regarding termination were: high percentage of involuntary termination, the search for both a new job and new faith community, and high percentage of unpaid positions post termination. It was suggested that these issues be addressed within the specialty.

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