Using Prayer to Decrease Nurses' Stress Levels and Improve Patient Outcomes

Submitted By

Monica LaShawn Bowie

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by

Monica LaShawn Bowie

has been approved

Date

APPROVED:

Jessica L. Johnson, DNP, RN, CNE, PIQI Project Chair

Committee Member

Content Expert

ACCEPTED AND SIGNED

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Jessica L. Johnson, DNP, RN, CNE
Dean, School of Nursing

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Date

Abstract

Spiritual practices and religious beliefs influence overall health and well-being (Eckerd, 2019; Bowie, 2021). Nursing itself is a stressful profession. The political, social, and healthcare effects of the COVID-19 Pandemic, a merger between two healthcare organizations, racial tensions in the United States, and the RaDonda Vaught verdict have impacted nurses' stress levels. This DNP project aims to determine if thrice weekly prayer would help decrease nurses' stress levels, resulting in a decrease in nurse call-ins and turnover rate and reducing the number of patient falls. There has been numerous research to determine the impact of prayer on patients, but limited research on how prayer impacts nurses. This project utilized prayer as an intervention to determine how prayer affects nurses' stress levels and patient outcomes. The investigator measured the nurses' stress levels before and after the prayer intervention using the Nursing Stress Scale instrument with a 4-point Likert scale.

Acknowledgment

First and foremost, I would like to thank God. “Give thanks to the Lord, for he is good; his love endures forever” (NIV, 1769/2023, Psa. 106:1). I also want to thank my family, my daughters, Martena and Mikaia, my mother, my sister NeKesha, and my Aunt Stella, for all their love, support, and prayers. I would also like to thank all my co-workers, colleagues, and classmates for their encouragement and nursing expertise.

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Chapter 1: Introduction to Project

The last few years have been difficult for those working in healthcare. It began in 2020 when the World Health Organization (WHO) identified the acute respiratory syndrome coronavirus 2 (SARC-CoV-2), which became known as COVID-19 (NIH, 2021; Bowie, 2021). COVID-19 morphed into a global pandemic, killing millions worldwide and leaving some survivors with long-term post-COVID-19 syndrome (Mayo, 2022). During this time, healthcare professionals (nurses, in particular) were stretched to their limits. The increased number of deaths, lack of personal protective equipment (PPE), and the fear of the unknown weighed heavily on nurses emotional, mental, and spiritual well-being.

Spiritual practices and religious beliefs influence overall health and well-being (Eckerd, 2019; Bowie, 2021). Nurses must be holistically sound in their mind, body, and spirit. A deficiency in one area (mind, body, spirit) could potentially cause the nurse to not be at their full potential, which can affect patient outcomes. Spiritual beliefs provide guidance and coping for some individuals (Tuck et al., 2006). Spiritual practices effectively manage stress and contribute to overall well-being (M & Fatima, 2021).

Background of the Project

A small community acute care hospital located in the Midwest licensed for 238 beds, which offered healthcare services such as but not limited to emergency, inpatient and outpatient surgery, women's services (including labor and delivery), cardiovascular, intensive care, pulmonology, and oncology. In 2018, the community hospital merged with a larger healthcare organization. The hospital name will be referred to as the healthcare organization to maintain anonymity. The healthcare organization is in a metropolitan, suburban area in the Midwest. The healthcare organization is licensed for 511 beds and offers numerous services

for all ages, including organ transplant, cardiovascular, oncology, women's, pediatrics, and specialized wound care services. The two hospitals, the community hospital and the large healthcare organization, are two campuses but are considered one healthcare entity.

After the merger, the inpatient healthcare services were halted at the community hospital. Services available at the community hospital were limited to the emergency department and outpatient services, such as radiology and outpatient infusion. The Labor and Delivery unit at the community hospital was closed; this contradicted the healthcare organization's stance that the labor and delivery unit would not be closed, this caused the staff to lose trust in the healthcare organization. The community hospital nurses were reassigned to various locations throughout the larger healthcare organization. Nurses at the community hospital were grieving during the merger transition between the two hospitals. The nurses were grieving the loss of the community hospital (some of the nurses on the Labor and Delivery unit began their nursing career there in the 1960s) and their colleagues, and they struggled to care for patients in an unfamiliar hospital, the healthcare organization.

As a result of the COVID-19 pandemic, inpatient services at community hospital were re-opened to care for COVID-19 patients. Nurses who were employed at the community hospital were given the option to remain at the healthcare organization or return to the community hospital to care for COVID-19 patients. Some nurses chose to return to the community hospital to care for COVID-19 patients. Those nurses were willing to jeopardize not only their lives and safety, but the lives and safety of their loved ones to return "home" to the community hospital. One nurse leader stated before the merger, there were approximately 80 nurses to staff two inpatient medical units at the community hospital. The nurse leader said that when those same units re-opened at the community hospital, around 40 nurses returned to

the community hospital, 8-10 remained at the healthcare organization, and the remaining nurses left the healthcare organization completely.

Patient care was affected by the well-being of the nurses. One study reviewing the number of cardiopulmonary arrests at community hospital demonstrated seven out of 90 total cardiopulmonary arrests occurred in non-critical care areas between January 2018 and September 2018, before the merger (Bowie, 2018). However, between October 2018 and November 2019, there were 73 cardiopulmonary arrests at the community hospital, of which 19 occurred in non-critical care areas (Bowie, 2018). This was after and during the merger between the two hospitals and the closing and re-opening of the community hospital to care for COVID-19 patients. This is one example of how nurses' stress levels and well-being can impact patient care.

Nurses deficient in their mind, body, and spirit cannot provide effective nursing care to patients (Bowie, 2021). The saying "hurt people hurt people" is relevant in healthcare. Nurses must be at their optimal well-being level to provide safe, competent, and effective patient care (NIH, 2021). The American Nurses Association (ANA) states that nurses owe the same duties to self as to others, including promoting health and safety (2021). The Bible also makes mention of self-care. "Come with me (Jesus) by yourselves to a quiet place and get some rest" (New International Version Bible, 2023, Mark 6:31).

The idea of using prayer to help nurses cope with the COVID-19 pandemic was born due to the investigator's personal experience while working at a metropolitan acute care hospital at the height of the COVID-19 pandemic. During the COVID-19 pandemic, healthcare caregivers and healthcare organizations were singled out and targeted by anti-COVID-19 groups. For safety reasons, nurses were informed by their employers not to wear

their work scrubs in public. A protest at a local hospital over the medical treatment of a COVID-19 patient in the intensive care unit led to the intensive care unit being locked down and a physician's home address being leaked on social media (Branham, 2022). The investigator observed nurses struggling to maintain their spiritual and emotional well-being while caring for patients with this new, strange, highly contagious, and deadly illness. Unfortunately, there was limited PPE available for nurses. The policies and procedures for caring for COVID-19 patients were constantly changed by the Centers for Disease Control and Prevention (CDC). Nurses feared that not having adequate PPE could increase the chance of nurses themselves contracting or spreading COVID-19 to their loved ones. To prevent spreading COVID-19 to their families, some nurses self-isolated themselves from their families, leaving the nurses without their emotional support systems (Thomas, 2020). As a result, nurses' stress levels increased, resulting in mental health issues such as anxiety, depression, compassion fatigue, and burnout (Thomas, 2020).

Another event that heavily impacted nurses was the RaDonda Vaught case in December 2017. Vaught was a Registered Nurse (RN) employed at Vanderbilt University Medical Center in Tennessee. She was sentenced to three years of supervised probation for reckless homicide and abuse of an impaired adult after Vaught made a medication error (Brusie, 2022). Vaught administered vecuronium bromide, Norcuron, instead of midazolam, to a patient, resulting in a patient's death (Brusie, 2022). The Vaught verdict goes against the Just Culture of safety, which is encouraged in healthcare organizations. A Just Culture encourages nurses to report errors, such as medication errors, without the fear of punishment and creates a trusting environment between the nurses and healthcare leadership (BWH, 2023).

At the same time, the healthcare industry is reeling from the political, social, and healthcare effects of COVID-19; Black, Indigenous, and people of color nurses were dealing with the added stress of racial tensions in the United States. In the original study by Gray-Toft and Anderson (1981), Black nurses were less satisfied with their work, supervision, and co-workers. Unfortunately, race relationships in the United States have only minimally improved since the 1980s. The stress faced by Black, Indigenous, and people of color nurses was further exacerbated by the murder of George Floyd in May 2020 by Minnesota police officer Derek Chauvin. Other social issues impacting minority nurse groups include, but are not limited to, legislation agendas related to what historical information is acceptable to be taught in public education and the exclusion of the lesbian, gay, bisexual, and transgender community. For example, referring to slavery as "involuntary relocation" and teaching that Black people benefited from slavery because it taught useful skills (Lopez, 2022 & Planas, 2023). As healthcare professionals, these minority groups care for patients and work alongside colleagues who agree with that legislative agenda. Regarding racism and discrimination, 79% of nurses report experiencing or seeing racism from patients and 59% reported racism or discrimination from colleagues (RWJ, 2023).

Interventions to foster nurses' well-being can be beneficial to healthcare organizations. Nursing care in healthcare organizations can either positively or negatively impact patient outcomes; negative impacts on patient care may include, but are not limited to, nurse retention and call-ins, patient falls, medication errors, and late identification of changes in patient status leading to patient deterioration (Sonemanghkara et al., 2019). The investigator proposes prayer to help decrease nurses' stress levels, improving, maintaining, and growing nurses' well-being. Prayer is a way for nurses to connect with a higher power (Cannon et al., 2019).

The investigator has benefitted personally from prayer. During the COVID-19 pandemic, the investigator's family members prayed for the investigator's safety, peace of mind, and angels of protection (Bowie, 2021). Offering daily prayer as a positive coping mechanism can help decrease stress among nurses, improve their well-being, and improve patient outcomes.

Organizational Needs Assessment

An organizational needs assessment is a systematic process of gathering information about the performance and factors that impact the performance of an organization (Moran et al., 2020). Organizational needs assessment helps to identify areas and opportunities for improvement. Part of an organizational needs assessment includes a strength, weakness, opportunities, and threats (SWOT) analysis. The initial organizational needs assessment was conducted around the summer/fall of 2021.

The merger between the two hospitals led to some of the nursing staff employed at the community hospital not being eligible for hire by the healthcare organization. The healthcare organization maintained a list of "do not rehire" employees. Nurses on this list are there permanently and are not eligible for rehire at the healthcare organization. During the merger, some nurses employed at the community hospital were on the healthcare organization's do not rehire list; they were not allowed to continue their employment. When the nursing staff on the do not rehire list were informed of the merger, those nurses resigned. The investigator was aware of four nurses in specialized areas of the community hospital whose employment status was affected by the merger. Two were nurses in the intensive care unit (ICU), one was a labor and delivery nurse, and the fourth nurse worked in the intermediate care unit (IMC). This loss of these nurses further exacerbated the nursing shortage at the community hospital. Staff morale was low and anxiety levels were high.

To add insult to injury, the healthcare organization began to cease healthcare services at the community hospital except for outpatient and emergency services. The nursing staff at the community hospital were reassigned to various units at the larger healthcare organization. Then the COVID-19 pandemic happened.

SWOT Analysis

A SWOT analysis objective analyzes internal and external attributes and threats to a phenomenon of interest (Moran et al., 2020). The phenomena of interest to be examined is whether daily prayer will improve nurses' well-being, thus decreasing nurses' stress levels. The patient outcome to be measured is patient falls. The investigator also measured nurse call-in and retention rates. The project's main goal is to use prayer as an intervention to decrease the stress levels of nurses, thus decreasing call-ins, increasing retention rates, and reducing patient falls. Prayer can offer numerous benefits to nurses in coping with stress and improves nurses' overall health and well-being (Cannon et al., 2019; Eckerd, 2019). Prayer offers words of comfort, hope, and peace and contributes to positive feelings, comradery, support, strength, and motivation (Cannon et al., 2019)

Strengths

The project site is a large healthcare organization (for the duration hospital will refer to both the community hospital and the healthcare organization) with resources to assist nurses with their well-being. Chaplains are available to the nursing staff at both campuses in person during normal business hours, Monday through Friday, 8:00 a.m. until 4:00 p.m. There are also chapels on-site at both campuses, accessible by the nursing staff 24/7. Chaplain services are only available after hours for patient care needs. They may be available after hours for the nursing staff during extenuating circumstances. Extenuating circumstances include but are not

limited to multiple deaths and patient events during a shift on one unit. For example, having three cardiac arrests in the intensive care unit, of which two were unsuccessful during one shift. Other extenuating circumstances could be the unexpected death of a co-worker. If the project is successful, the hospital has the resources to offer prayer to the nursing staff. The prayer may be implemented via a quick response (QR) code, intranet, or over the hospital's public address (PA) system.

Weaknesses

A challenge the project may face is the objection to prayer. This could come from employees and patients/visitors. Some may feel the hospital is attempting to convert or indoctrinate them into Christianity. Currently, the hospital does not offer daily prayer via the PA system. The Manager of Pastoral Services periodically emails words of encouragement to all the hospital staff. The investigator is unsure how the nursing staff responds to the emails, if they are read or deleted. No verbal prayer is played over the PA system, nor is the staff offered a QR code or link to daily prayers.

Opportunities

If the project shows favorable results and interest in prayers, signage could be posted throughout the hospital and in patient information pamphlets with QR codes or links to daily prayers. The nurses and patients may access the prayers at their convenience. This would also be an inexpensive intervention the hospital can provide to help decrease nurses stress levels and improve their spiritual well-being while improving patient outcomes. The QR code would remain the same; someone, possibly chaplain services, would be responsible for updating the prayer on the link attached to the QR code. For this project, the investigator will change the prayer thrice weekly at 7:00 a.m., Monday, Wednesday, and Friday.

Threats

The main threat to the project is that, at this moment, prayer is not allowed over the PA system. A QR code was created for participants to access the prayers to mitigate this issue. The investigator will manage and maintain the website during the project implementation.

Using the SWOT analysis, the hospital's strengths include the nursing staff's resilience to persevere despite their situation and circumstances. In addition, the nursing staff at the hospital were coping with internal and external factors that contributed to the nurses' well-being—leading to the potential for poor patient outcomes and a further increase in the nurse's stress levels.

Problem Statement

The problem to be affected during this project is the nurses' stress levels. The last few years have been exhausting for nurses. According to a survey by the ANA, 75% of nurses said they have felt stressed (2021). The investigator proposes that prayer will help to decrease nurses' stress levels. The hospital's mission is "Partnering with people to live healthier lives." Offering the nurses prayer can improve their stress levels and improve and maintain their spiritual health, thus reducing nurses' stress levels. Primary question: In nurses at a metropolitan acute care hospital, **(P)** how does thrice weekly prayer provided to nurses **(I)** compared to no daily prayer **(C)** affect nurses' stress levels **(O)** within five weeks **(T)** (Bowie, 2021)? Secondary question: In nurses at a metropolitan acute care hospital, **(P)** how does thrice weekly prayer provided to nurses **(I)** compared to no daily prayer **(C)** affect patient outcomes (patient falls) **(O)** within five weeks **(T)?** The original Nursing Stress Scale (NSS) instrument created by Pamela Gray-Toft and Dr. James Anderson (1981) was used to measure the nurses' stress levels.

Definition of Terms

- **stress:** experiences of an individual when the demands exceed their personal and social resources (M & Fatima, 2021); examples of stress experienced by nurses are understaffing and call-ins.
- **compassion fatigue**: linked to people in caregiver professions; characterized by stress and ineffectiveness (Joinson, 1992). The symptoms of compassion fatigue are similar to stress: forgetfulness, exhaustion, headaches, stomach aches, and anger (Joinson, 1992).
- **Just Culture** is a system of shared accountability and responding to employee behaviors in a fair and just manner, non-punitive (BWH, 2023)
- **burnout**: unmanaged, chronic workplace stress (ANA, 2023). Feeling constantly overworked and too tired to go to work, not looking forward to their job, and feeling underappreciated are characteristics of a nurse experiencing burnout (ANA, 2023).

Summary and Organization of the Remainder of the Project

The focus of chapter one is to provide the reader with the foundation for the project. Reasons such as the hospital merger, the COVID-19 pandemic, social issues, and their relationship to the nurses' stress levels were discussed. Key points discussed in this chapter include nurse stress, compassion fatigue, Just Culture, burnout, and their impact on nurses' well-being and patient outcomes. An explanation of using prayer as a positive coping intervention to help decrease the nurses' stress levels is also discussed in chapter one. The remaining chapters will describe the literature reviewed, implementation, and evaluation of

prayer to reduce nurses' stress levels. Nursing theorists and theories with religious underpinnings were reviewed.

Chapter 2: Review of Literature

Healthcare can be stressful for nurses. Unresolved stress has the potential to lead to nurse burnout, thus leading to adverse patient outcomes such as falls and medication errors (Dall'Ora et al., 2020). Copious amounts of nursing research data demonstrate the relationship between nurses' stress and the effects on patient care. In addition, research shows how prayer can be an effective intervention in helping to lower stress levels. This chapter examines the current and past knowledge about nurses' stress levels, prayer, and patient outcomes.

Literature Search Strategy

Literature research using an internet search using the following databases: Google Scholar, EBSCOhost, Health Source: Nursing/Academic Edition, and Cumulated Index to Nursing and Allied Health Literature (CINAHL). Scholarly, peer-reviewed primary and secondary articles for nursing related to stress in nurses, prayer, spirituality, and the effects of nursing care on patient outcomes. In addition, other nursing issues such as compassion fatigue, burnout, resiliency, and faith- and Christian-based nursing theories were reviewed. Valid and reliable survey instruments were also examined to assess nurses' stress levels. Of the numerous peer-reviewed research articles reviewed and referenced, ten were older than five years. Most of those ten articles included seminal research on burnout, compassion fatigue, and the Nursing Stress Scale survey.

Review of Literature

The investigator reviewed peer-reviewed primary and secondary research articles from 1974 to the present using the following keywords: stress, compassion fatigue, Just Culture, burnout, prayer, religion, spirituality, and the Nursing Stress Scale. The investigator reviewed seminal research on the Nursing Stress Scale, compassion fatigue, and burnout. Literature was

also examined from other disciplines, including psychology, sociology, anthropology, and yogic (yoga) science.

Spiritual beliefs and religious practices influence overall health and well-being (Bowie, 2021; Eckerd, 2019; Bowie, 2022). In addition, nursing research has provided evidence to support nursing care directly impacts patient outcomes (Sonemanghkara et al., 2019). Therefore, nurses deficient in their holistic well-being (mind, body, spirit) may negatively affect the nurses, healthcare organizations, and patients (NIH, 2021). Conversely, improving the holistic balance in the nurse can positively affect the nurse (Bowie, 2022).

Hospital nurses experience high-stress levels, leading to burnout, compassion fatigue, increased turnover, and patient safety issues (Gray-Toft & Anderson, 1981). Unfortunately, the past few years have added more stress on nurses. The investigator has observed nurses dealing with the backlash from the COVID-19 pandemic, staffing issues, and the RaDonda Vaught verdict. As a minority nurse, the investigator has seen how social issues such as race and non-Christian religions (Muslim and Jewish) can be added stressors. As a result of the aforementioned issues, nursing is suffering from a nursing shortage. The nursing shortage can be attributed to a lack of nurse educators, high turnover rates, nurse burnout, and violence in the healthcare setting (Haddad et al., 2023).

This project will focus on using prayer as an intervention to help decrease nurses' stress levels. The themes researched for this project include nurses' stress levels, burnout, spirituality, religion, prayer, the Nursing Stress Scale, and nursing models.

Stress

Gray-Toft and Anderson defined stress as an external cue threatening an individual's equilibrium (1981). Nurses experience elevated levels of stress due to intense working hours,

critical care patients, complex technological equipment, and high expectations (Mert et al., 2020). Hans Seyle defines stress as "the non-specific response of the body to any demand for change," leading to an imbalance between the mental, physical, and biological states (M & Fatima, 2021). When activated repeatedly, the "flight or fight" response leads to wear and tear of the body, resulting in fatigue (M & Fatima, 2021). Prolonged stress in nurses can lead to psychological issues such as anxiety and depression (Brown et al., 2018). In addition, job satisfaction, patient care quality, and concentration decrease, and the rate of making errors increases when nurses experience unresolved stress (Mert et al., 2020).

Stress is the most significant cause and precursor to compassion fatigue and burnout (Richemond et al., 2022). Developing stress relief interventions can decrease stress, decrease burnout, and improve patient outcomes. Stress is the most significant cause of burnout; sex, age, work environment, and work experience are four demographic factors contributing to work-related stress (Richemond et al., 2022). Mindfulness-based stress reduction training, emotional distancing, and conflict training are resources nurses can implement during a stressful situation (Brown et al., 2018). Other interventions healthcare organizations can use to decrease nurses' stress include but are not limited to ensuring manageable workloads, sustaining a supportive healthcare organization, and recognizing the needs of nursing staff with elevated levels of work-related stress (While & Clark, 2021). Spiritual and religious approaches can also manage stress (Husain & Khatoon, 2021). The American Nurses Association (ANA) Code of Ethics for Nurses, Provision 5, states, "The nurse owes the same duties to self as to others" (2015). Nurses should provide the same level of care for themselves as they do for their patients.

Burnout

Burnout was first described by Dr. Herbert J. Freudenberger in 1974 based on his observation of healthcare staff working in a free clinic during the 1970s'. He described burnout as exhaustion caused by excessive demands on energy, strength, or resources and stated the dedicated and committed are prone to burnout (Freudenberger, 1974). Burnout continues to be an issue in healthcare. Freudenberger said burnout could not be prevented, but it could be avoided (1974). To avoid burnout, healthcare organizations should encourage nurses to practice self-care. Dr. Christine Maslach, a psychologist who researched burnout, recommends to preserve physical and psychological well-being, nurses should engage in activities that are not work-related (1975). Positive activities could include but are not limited to spending time with family and friends, taking up a hobby, such as knitting, gardening, traveling, or exercising (Maslach, 1975). Freudenberger suggested ten preventative measures to prevent burnout, which are still applicable today. Some of the measures include, avoiding sending the same staff member into a given job situation over and over again, limiting the number of hours a person works, it is important for a group working together to feel together as a group, physical exercise, and sharing their experiences (Freudenberger, 1974).

Untreated burnout can lead to deterioration in physical and physiological well-being. Burnout risk factors among nurses include the work environment, time constraints, and shift work (Richemond et al., 2022). Both Freudenberger (1974) and Maslach (1975) list exhaustion, fatigue, gastrointestinal disturbances, insomnia, and shortness of breath as physical signs of burnout. Maslach states that to cope with the physical problems of burnout, nurses may turn to drugs and alcohol (1975). Psychological symptoms of burnout include anger, irritation, and frustration (Freudenberger, 1974). Patient care is negatively impacted by

nurse burnout. Nurse burnout contributes to poor patient satisfaction scores, increased infection rates, nurse turnover, and poor patient outcomes (Brown et al., 2018).

Nurses working in high-stress situations are at risk for developing burnout (Brown et al., 2018). Therefore, healthcare organizations should proactively identify and treat nurse burnout; this could be done by utilizing the Maslach Burnout Inventory. Once a nurse has reached burnout, it is more challenging to treat. Burnout in nurses can drain a person of the energy needed to perform tasks effectively, thus putting patient care at risk (Richemond et al., 2022). In addition, burnout impacts healthcare organizations' workforce through absenteeism (Richemond et al., 2022). Absenteeism leads to understaffing of nursing units, thus increasing nurses' stress levels. Understaffing due to nurse call-ins contributes to nurse burnout (Richemond et al., 2022). The investigator has observed nurse-to-patient ratios increasing while nurses care for patients with more complex health issues. For example, patients once cared for in the intensive care unit are now being cared for in the intermediate care units. Patients once cared for in the intermediate care units are now being cared for in the medical-surgical units.

There has been an increase in interventions for nurses at the organizational level to address burnout (Richemond et al., 2022). Some interventions mentioned by Richemond et al. to address nurse burnout include (a) improving the working conditions through a decentralized organizational structure (with nurses represented in all healthcare departments); (b) because female nurses are usually the caregivers at home, providing adequate time to attend to family issues; (c) limiting nurses' workload through hiring more nurses; and (d) reduced the length of shifts (2022).

Stress Scales

There are numerous scales available to assess burnout in healthcare workers. The investigator utilized the Nursing Stress Scale for this project. The Nursing Stress Scale is described later in the manuscript. Dr. Christina Maslach developed the Maslach Burnout Inventory. The Maslach Burnout Inventory measures burnout in three dimensions: feelings of energy depletion or exhaustion, increased mental distance from one's job, or feelings of negativism or cynicism related to one's job, and reduced professional efficacy (Maslach & Leiter, 2021). Kathryn M. Conner and Jonathan R.T. Davidson developed the Connor-Davidson Resilience Scale through their work with post-traumatic stress disorder patients. (Riopel, 2019). The Connor-Davidson Resilience Scale measures how well a person can bounce back after stressful events, tragedy, or trauma (Riopel, 2019). Hylton-Rushton et al. utilized both the Connor-Davidson Resilience Scale and the Maslach Burnout Inventory instruments to study burnout and resilience in nurses working in high-stress units (pediatric, neonatal, oncology, and adult critical care) at an acute care hospital (2015). The results indicated moral distress was a predictor for burnout.

Moral Distress

Moral distress, as defined by Andrew Jameton, is "a phenomenon in which one knows the right action to take but is constrained from taking it" (Epstein, 2010, para 2). Moral distress in nursing occurs when a nurse knows what is best for the patient, but the course of action conflicts with what is best for the organization (Epstein and Delgado, 2010). An example of moral distress in nursing is staffing. The investigator has observed nurses caring for patients beyond the recommended patient-to-nurse ratio in all areas of the healthcare organization. For example, the accepted standard of practice patient-to-nurse ratio in intensive care is 2:1. During

the COVID-19 pandemic, the investigator observed a 3:1 patient-to-nurse ratio in the intensive care units; this is a situation where nurses did more with less. Thus creating moral distress for the nurses through the unsafe patient-to-nurse ratio, but a financial benefit to the healthcare organization due to the increased patient numbers and decreased number of nurses.

However, nurses with spiritual well-being, who identified factors of spirituality and optimism as resources to cope with stress, were protected against burnout (Hylton-Rushton et al., 2015). Based on the study's results, strategies to address spirituality may help nurses cope with stressful situations (Hylton-Rushton et al., 2015).

Spirituality

Spirituality is intangible; it can boost inner peace and help deal with problems (Polat et al., 2020; Bowie, 2022). Spirituality is a feeling or belief there is a presence of something greater than oneself (M & Fatima, 2021). Studies have demonstrated how spirituality helps manage stress. People express spirituality in many ways; it crosses caste systems and cultural groups (Husain & Khatoon, 2021). Spirituality's benefits are helping people face challenging situations positively and being a resource for support in the face of struggles (Husain & Khatoon, 2021). Some ways to express spirituality include, but are not limited to, prayer, meditation, deep breathing exercises, and relaxation techniques (M & Fatima, 2021). Strategies to address spirituality may be helpful to nurses who are experiencing stressful situations (Hylton-Rushton et al., 2015).

A mixed-methods survey conducted on 119 deployed military nurses who transferred casualties from the point of injury to facilities capable of providing higher levels of care using interviews and the Posttraumatic Growth Inventory yielded, spirituality could be valuable as a coping mechanism (Simmons et al., 2018; Bowie, 2022). The Posttraumatic Growth Inventory is

a 28-item Likert survey that includes a subscale related to spiritual change (Simmons et al., 2018). Simmons et al. defined spirituality as the belief in someone or something greater than oneself that provides purpose and meaning (2018). Nurses rely on their spirituality to stay mentally fit; in deployed military nurses, spirituality helps protect their mental health (Simmons et al., 2018). Simmons et al. also state that spirituality helps military nurses cope with their deployment experiences. A separate study conducted by Shinbara and Olson (2010) explored spirituality as support for nurses grieving the loss of patients. This study utilized the "Faith, Religion, and Spirituality" portion of the Needs Assessment Questionnaire on a sample of 62 nurses (Shinbara & Olson, 2010). The results concluded 75% of nurses reported spirituality is important in their daily lives and helps them to cope with grief (Shinbara & Olson, 2010).

Inez et al. conducted a longitudinal study to determine the relationship between spirituality and stress. Stress was defined as one's response to an event considered dangerous or threatening to one's well-being (Inez et al., 2006). Twenty-seven participants consented to participate in the 12-month study. The study intervention consisted of the participants attending 90-minute sessions once a week for six weeks. The 90-minute sessions were facilitated by a leader and focused on various aspects of spirituality (Inez et al., 2006). Participants also completed three surveys: the Perceived Stress Scale, the Spiritual Perspectives Scale, and the Spiritual Well-Being Scale (Inez et al., 2006). The study's results documented the intervention effectively reduced stress in the study participants (Inez et al., 2006).

Religion

Religion involves beliefs, practices, and rituals related to the sacred (Koenig, 2009). General studies from subjects in different settings, ethnic backgrounds, and locations (United States, Canada, Europe) find that religion is related to better coping with stress (Koenig, 2009).

Bakibinga et al. (2015) conducted a qualitative study of 15 nurses via interview; each interview audio recorded and transcribed by the first author. The interview questions were predefined and divided into four themes: calling (choice of profession), work-life experiences, dealing with stressful conditions at work, and adaptive coping strategies (Bakibinga, 2013). The study addressed the role religion has in the work lives, self-care, and coping strategies of Ugandan nurses (Bakibinga et al., 2013). Bakibinga et al. summarized faith in God helped nurses stay on the job during challenging times (2013).

Prayer

Prayer is a spiritual communion with God or an object of worship (Tambagahan, 2016; Bowie, 2022). People from various spiritual backgrounds perform prayers. Between 44% and 55% of Americans pray daily and approximately 50% of people worldwide pray a few times a week (Newman et al., 2023). Prayer has gained attention in the United States after school shootings, presidential debates, and political discussions (Newman et al., 2023). Eckerd lists prayer as one of the relevant tenet categories and describes prayer as a request for spiritual, emotional, and physical needs of self (2019). There are several types of prayer. Types of prayers include, but are not limited to, supplication (to ask), thanksgiving, adoration (give homage), confession, and intercessory (on behalf of someone) (Tambagahan, 2016; Bowie, 2022).

Research was conducted at a mid-western United States hospital where healthcare members gathered on the oncology unit at the beginning of the day shift for prayer' led by a chaplain. This research examined the influence prayer has on healthcare workers' perceptions regarding the work environment (Cannon et al., 2019). Using convenience sampling, 28 healthcare team members agreed to participate in the study (Cannon et al., 2019). Although

the study was conducted over one month, at the end of the month, study participants were voluntarily asked to complete a questionnaire developed by the faculty and hospital administrators (Cannon et al., 2019). The results showed prayer helped participants feel calm and reduce stress (Cannon et al., 2019; Bowie, 2022).

Achour et al. conducted a study to examine the effects of prayer and age on the relationship between job stress and nurses' well-being (2019). The study consisted of 300 randomly selected nurses completing a questionnaire developed by the researchers (Achour et al., 2019). The results highlighted the importance of prayer on job stress and nurses' well-being (Achour et al., 2019). The studies conducted by both Achour et al. (2019) and Cannon et al. (2019) exhibit that regardless of religion, prayer can decrease stress among nurses in healthcare organizations and improve nurses' well-being (Bowie, 2022). In addition, numerous studies conclude that those who pray frequently have higher levels of well-being when compared to those who do not pray frequently (Newman et al., 2023).

Prayer is an economical intervention the hospital may use as a positive coping mechanism for nurses (Bowie, 2022). The benefits of prayer are it helps in relieving stress and enhancing well-being (Achour et al., 2019). Therefore, prayer is the intervention the investigator will use to decrease the nurses' stress levels.

Nursing Stress Scale

The Nursing Stress Scale is the instrument used by the investigator to assess the nurses' stress levels. The Nursing Stress Scale instrument was developed in 1981 by Pamela Gray-Toft and James G. Anderson to measure the frequency and sources of stress experienced by nurses (Gray-Toft & Anderson, 1981). Although the Nursing Stress Scale (NSS) was created in 1981, the 34 items remain applicable to assess nurses' stress levels at the hospital.

Some of the items listed in the Nursing Stress Scale include the death of a patient, floating to other units that are short-staffed, difficulty in working with a particular nurse (or nurses) outside and on the unit, breakdown of the computer, not enough staff to adequately cover the unit, and not enough time to complete all of my nursing tasks (Gray-Toft & Anderson, 1981). The Nursing Stress Scale instrument consists of 34 items describing situations identified as causing stress for nurses (Gary-Toft & Anderson, 1981). The 34 items are categorized into the following seven subscales, also labeled as factors: death and dying, conflict with physicians, inadequate preparation, lack of support, conflict with other nurses, workload, and uncertainty concerning treatment (Gray-Toft & Anderson, 1981). The 34 items on the Nursing Stress Scale are scored using the following Likert scale: never (0), occasionally (1), frequently (2), and very frequently (3), with higher scores indicating higher levels of stress (Gray-Toft & Anderson, 1981). The investigator reviewed numerous research documenting the validity and reliability of the Nursing Stress Scale in its original form and modified versions. The literature does not support or describe the original or modified Nursing Stress Scale as superior to the other.

A study of oncology nurses at Sanford Health in Fargo, North Dakota, utilized the Nursing Stress Scale to identify stress levels and factors of nurses working in oncology (Ko et al., 2016). The Likert scale from the original Nursing Stress Scale was modified using a range of 1 (never) to 4 (very frequently) (Ko et al., 2016). The test-retest reliability was 0.81 and internal consistency coefficients ranged from 0.79-0.89 (Ko et al., 2016). As a result, Ko et al. (2016) state occupational stress should be managed to prevent nurses from becoming highly stressed.

Mert et al. conducted a study to test the reliability and validity of a Turkish version of the Nursing Stress Scale (2020). In this study, the English version of the Nursing Stress Scale

was translated into Turkish by three translators who spoke English. The study comprised 349 Turkish nurses with at least six months of nursing experience completing the translated Nursing Stress Scale. The results documented the test-retest reliability coefficient of r =.859, Cronbach α = .928, and total score correlations range between 0.418 and 0.662 (Mert et al., 2020).

Sanso et al. (2021) conducted a study using a modified version of the Nursing Stress Scale, the Brief Nursing Stress Scale, using a 4-point Likert scale with a reliability of .712. In this version, subscale Factor III, "inadequate preparation," is removed and each of the remaining six subscales is prefaced with the following: "stressful situation derived from" (Sanso et al., 2021). For example, the original Nursing Stress Scale subscale factor I states, "Death and Dying," in the Brief Nursing Stress Scale subscale factor I states, "stressful situations derived from the process of death and dying" (Sanso et al., 2020). Unfortunately, the study design was cross-sectional; therefore, test-retest reliability was not completed (Sanso et al., 2020).

Susan French and colleagues developed the French's Expanded Nursing Stress Scale; this scale expanded the original by increasing the number of subscales from seven to nine, increasing the number of items from 34 to 57, and using a 5-point Likert scale (Khanmohammadi et al., 2020). Khanmohammadi et al. utilized the French's Expanded Nursing Scale to investigate the relationship between resilience and occupational stress among nurses working in coronavirus wards (2020). The survey yielded reliability and validity with Cronbach α = 0.94 (Khanmohammadi et al., 2020).

A limitation of the original Nursing Stress Scale was the sample size. Gray-Toft and Anderson's sample consisted of 122 nurses on five units at a large private healthcare

organization (1981). Although, in the original research, only five hospital medical units were included in the study, not all the medical units at the hospital were represented (Gray-Toft & Anderson, 1981). In addition, a gap is the Nursing Stress Scale does not measure the intensity of the nurses' stress; it measures the frequency and source of nurses' stress (Gray-Toft & Anderson, 1981).

Nursing Models

The Agape Nursing Model developed by Nancy Eckerd is based on agape love and Christian characteristics (2019). Eckerd describes the Agape Nursing Model as a stand-alone model focusing on the nurse's character, whereas patient care is enhanced (2018). Agape is love that is charitable or caring for strangers (Eckerd, 2019). In this nursing model, Eckerd states nurses rely on prayer to strive for spiritual and professional growth (2019).

The Agape Model contains 13 relevant tenets (beliefs), which include shalom and prayer (Eckerd, 2018). Shalom is holistic healing: mind, body, and spirit (Eckerd, 2018). This model addresses nurses' well-being and the importance of prayer. Prayer is communication with God to request strength of spirit, guidance, wisdom, and knowledge (Eckerd, 2019). Another element of prayer is the request for spiritual, emotional, and physical needs of self (Eckerd, 2019). This model demonstrates the power of prayer. The American Nurses Association (ANA) Code of Ethics for Nurses, Provision 5, states, "The nurse owes the same duties to self as to others" (2015). The Agape Nursing Model addresses the nurse's and patient's well-being through prayer.

Limitations and Gaps

Measuring the intensity of nurses' stress has the potential to early identification and treatment of nurses at risk for burnout. There needs to be prevention versus correction of nurse

burnout. The response to burnout is to quit and get out (Maslach, 1976). The national average for nurse turnover rates is between 8.8% and 37.0% (Haddad et al., 2023). The average cost of turnover for a staff registered nurse is $52,350 (Plescia, 2021). Nurses leaving the workforce due to burnout can negatively affect healthcare. The investigator has seen the effects of burnout concerning nurse staffing. The hospital has closed and limited the number of patients to be cared for on medical units; as a result, the time patients wait in the emergency department for an available bed has increased.

Other gaps in the literature review include the lack of diversity among some samples. Some of the study participants were active military nurses, of the Muslim faith, and whose primary language was not English. For example, Simmons et al. (2018) study was conducted among military nurses, Bakibinga et al. (2013) was conducted in multiple languages, and Polat et al. (2020) research was conducted in a Muslim country. Another gap in the literature was the use of various survey instruments to assess the nurses' stress levels. There is no consensus in the healthcare industry on which survey instrument to use to evaluate nurses' stress. Some researchers created a specific survey, while others utilized established surveys, such as the Nursing Stress Scale and the Maslach Burnout Inventory.

A gap is the limited amount of research available on using prayer to decrease nurses' stress levels. However, there is numerous research on the effects of prayer on hospitalized patients. A gap exists between early identification, continuous monitoring, and intervention for nurse burnout.

Change Recommendations

A literature review has demonstrated a positive correlation between prayer, spirituality, religion, and stress. This project focuses on using prayer to decrease nurses' stress levels,

leading to improved patient outcomes. A strength observed is prayer is not specific to age, religion, spirituality, or gender, and it is celebrated worldwide.

Theoretical Foundations

The project will be based on the conceptual framework and the investigator's experience as a nurse. The foundation theory for the project is the Theory of Nursing for the Whole Person developed by Dr. I. Tomine Tjelta in the 1970s for the College of Nursing at Oral Roberts University, Tulsa, Oklahoma. Another theoretical model utilized is the Agape Model developed by Nancy Eckerd. In the Agape Model, nurses work to continue their spiritual and professional growth (Eckerd, 2019). Spiritual growth improves nurses' moods and enhances physical and mental healing, leading to positive patient outcomes (Eckerd, 2019).

The Theory of Nursing for the Whole Person is based on the spirit, mind, and body (Tjelta, 1982). The theory also includes five concepts. "Patient" will be substituted with "nurse" and "nurse" will be substituted for "hospital" for this theory. In this theory, the patient (nurse) is an intricate part of the family and community (Tjelta, 1982). How the patient (nurse) interacts with illness, family, and community determines the nursing interventions that should be instituted by the nurses (the hospital) for disease prevention and health promotion (Tjelta, 1982). The three categories of interventions are health promotion, maintenance, and restoration (Tjelta,1982). Interventions (prayer) for health promotion prevent illness (decrease stress levels and improve patient outcomes) and educate (Tjelta, 1982). Interventions to maintain health are to strive for the highest level of health. Finally, interventions for restoration assist in returning to health (Tjelta,1982).

Lewin's Change Theory consists of three stages: unfreezing, change, and refreezing (Petiprin, 2023). The first stage of implementing prayer at the hospital is unfreezing finding a way to let go of old patterns (Petiprin, 2023). In unfreezing, the hospital will implement a way to assess the nurses' stress levels routinely. The assessment will include an evaluation before and after the intervention. Change involves a change in thoughts, feelings, and behavior (Petiprin, 2023). During this phase, the hospital must be willing to assess, treat, and reassess nurses' stress levels. Lastly is refreezing, establishing a new change habit (Petiprin, 2023). This is where prayer and assessment become customary practice at the hospital.

Integration of Kingdom Nursing

This quality improvement project aims to decrease the stress levels of the nursing staff at the hospital. Reducing the nurses' stress levels and improving their overall well-being could tremendously affect the hospital. Some effects include but are not limited to a decrease in nurse call-ins, an increase in the nurse retention rate, and a reduction in patient falls.

Nurses have been ranked number one for 21 consecutive years in honesty and ethical standards in Gallup's annual Most Honest and Ethical Professions Poll (ANA, 2023). Nurses are educated to treat each patient with respect and dignity. The Bible states, "So in everything, do to others what you would have them do to you" (NIV, 1769/2023, Matt. 7:12). Access to healthcare in the United States is contentious. Some Americans think healthcare is a privilege, not a right. Kingdom nurses' campaign for every American to gain access to safe and competent healthcare. Some ways Kingdom nurses provide access to healthcare is through volunteering at local clinics with an emphasis on rural, underserved, uninsured, and underinsured populations.

The American climate is disheartening to diversity, equity, and inclusion. Countless laws, policies, and procedures are aimed at returning to Jim Crow Era legislature. These new laws impact every non-White and non-Male American. Kingdom nurses practice what the Bible teaches, “There is neither Jew nor Gentile, neither slave nor free, nor is there male and female, for you are all one in Christ Jesus” (NIV, 1769/2023, Gal.3:28). With all the division occurring in the United States, implementing prayer will not only be instrumental in decreasing nurses’ stress level, but also to help the nurses’ cope with societal stressors.

Summary

The key points discussed in this chapter, stress, burnout, prayer, spirituality, and religion, the Nursing Stress Scale, and nursing models, will be helpful to the implementation of the quality improvement project at the hospital. Early identification and treatment of nurses’ stress levels can positively affect the hospital. The ways the hospital can be affected include a decrease in call-ins, an increase in retention rates, and a reduction in patient falls.

The next chapter will focus on how data is collected, how the survey instruments will be disbursed, and how daily prayer will be implemented.

Chapter 3: Methodology

The focus of this project is to help decrease nurses' stress levels through prayer. Reducing the nurses' stress levels can potentially increase nurses' overall well-being, thus decreasing nurse call-ins, increasing nursing retention rates, and decreasing patient falls. Nursing is a high-stress occupation. In addition, the COVID-19 pandemic, the political and social environment in the United States, and the RaDonda Vaught verdict exacerbated the nurses' stress levels. For this project, prayer will be used as an intervention to lower nurses' stress levels.

Purpose of the Project

This quality improvement project aims to use prayer to improve the nurses' stress levels. This chapter discusses prayer as an intervention to help decrease the nurse's stress levels and the Nursing Stress Scale instrument to measure the frequency and sources of the stress experienced by nurses in an acute care hospital. In the original study, the Nursing Stress Scale was readministered to the nurses after two weeks (Gray-Toft & Anderson, 1981). However, the original authors of the Nursing Stress Scale did not recommend a time frame between pre- and post-intervention for the nurses to complete the Nursing Stress Scale.

The population affected is the nurses and patients at the acute care hospital. After consenting to participate in the project, the nursing staff at the acute care hospital completed the Nursing Stress Scale pre- and post-implementation of the prayer intervention. The Nursing Stress Scale was conducted two times during the project: before implementing prayer and at the end of the five weeks of reading the prayers. The nurses were encouraged to read the prayer thrice weekly via a QR code. The investigator updated the prayer three times a week on the following days at 7:00 a.m.: Monday, Wednesday, and Friday.

The primary problem addressed is the nurses' stress levels. The secondary issues addressed are nurse call-ins, retention rate, and patient falls. For example, during the COVID-19 pandemic, nurses were under an increased amount of stress. The investigator observed nurses calling in, changing employers, and sometimes leaving the nursing profession due to the increased stress during the COVID-19 pandemic. This led to inadequate staffing, nurses caring for more than a safe number of patients, and adverse patient events.

Clinical Questions

Primary question: In nurses at a metropolitan acute care hospital, **(P)** how does thrice weekly prayer provided to nurses **(I)** compared to no daily prayer **(C)** affect nurses' stress levels **(O)** within five weeks **(T)** (Bowie, 2021)? Secondary question: In nurses at a metropolitan acute care hospital, **(P)** how does thrice weekly prayer provided to nurses **(I)** compared to no daily prayer **(C)** affect patient outcomes (patient falls) **(O)** within five weeks **(T)?** The independent variable is prayer. The dependent variables are the nurses' stress levels and patient falls.

The investigator collected the data from the Nursing Stress Scale and Google Forms. A statistical consultant analyzed the results of the Nursing Stress Scale before and after prayer intervention. Aggregate data collected at the hospital include nurse call-ins, nurse retention rates, and patient falls. The statistical consultant compared the demographic information and aggregate data collected to the survey results.

Project Methodology and Design

The project design is quasi-experimental, consisting of a one-group pre/post-test design. In this design, the outcome (nurses' stress levels) is measured twice using the Nursing Stress Scale at the beginning and after exposure to the intervention (prayer). Nurses who

consented to participate in the study were required to create a six-digit numerical code. The nurses used their numerical code to access the thrice weekly prayers. Quasi-experimental is helpful in a practice setting because it does not require randomization or a control group (Moran et al., 2024). Nurses participating in the project voluntarily consented to participate. Participants were solicited through signage placed throughout the hospital. The Chief Nursing Officer emailed the nurse leaders information about the project in the July 28, 2023 Weekly Nursing Leadership Updates email. The email encouraged nurse leaders to inform the nursing staff about the project. The investigator collected quantitative data from the pre- and post-nurse Stress Scale results and the number of nurses participating in daily prayer. Although not required, demographic information such as age, gender, race, nursing educational level, years as a nurse, years at the hospital, patient falls, nurse call-ins and nurse retention rates were collected and analyzed. All project components, including consent, pre- and post-survey, and prayer, were accessed via a QR code with a link to the online survey using Google Docs, a secure, anonymous platform. Data was collected via Google Docs. Hospital human resource staff provided the nurse retention data to the investigator. A nurse leader provided the nurse call-in data to the investigator and the investigator was granted access to review the patient fall data. The biostatistician consultant then analyzed the data.

Qualitative data combines scientific and emotional concepts, such as pain, unhappiness, rage, irritation, and love, to improve the understanding of a phenomenon (Hall & Roussel, 2017). Participants accessed the pre- and post-survey and thrice weekly prayers via a QR code with a link to Google Docs. The Nursing Stress Scale survey included space for free text in the pre- and post-survey. In the free text, the nurses could make comments.

Although the comments were not required, the investigator reviewed, collected, and categorized them on a spreadsheet.

Setting

The setting for this quality improvement project is a large urban Midwest healthcare organization with two campuses. The main hospital is a 511-bed licensed acute-care hospital accredited by the Joint Commission. Healthcare services available at the hospital include, but is not limited to, cardiovascular, oncology, pediatric, obstetrics, and gynecology. During the COVID-19 pandemic, the smaller hospital campus began to care for only COVID-19 patients. With the conclusion of the COVID-19 pandemic, the smaller campus resumed care for non-COVID-19 patients. Therefore, the setting for the quality improvement project includes both campuses.

Population and Sample Selection

The hospital nursing staff comprises 53 licensed practical nurses (LPNs) and 1308 registered nurses (RNs.) The population will consist of all hospital nurses employed during the project dates. The nursing staff at the hospital functions in a variety of roles. The roles include bedside, clinic, outpatient, and leadership. Registered nurses include advanced practice registered nurses, including but not limited to nurse practitioners, clinical nurse specialists, and certified registered nurse anesthetists.

Signage with the QR code linked to the quality improvement project was displayed throughout both campuses. Voluntary response sampling was utilized to invite nurses to participate in the project. In addition, informed consent and participant requirements were obtained via a QR code and link using Google Docs. Demographic information collected included age, gender, educational level, years as a nurse, years at the hospital, and ethnicity.

Each participant was required to create a six-digit numerical code. The participants used the six-digit code to access and complete the consent, pre-and post-surveys, and the thrice-weekly prayer intervention. The investigator stored the data on the investigator's password-protected laptop. The investigator also tracked the weekly nursing compliance with the project via Google Docs.

Inclusion criteria to participate in the survey include (a) all licensed practical nurses and registered nurses with an unencumbered nursing license employed at the hospital and (b) 18 years of age and older. In addition, nurses working in clinical and non-clinical positions and those working occasional part-time, as needed, or full-time were allowed to participate in the project. Contracted nursing staff with contracts during the project were allowed to participate in the survey. Participants may be withdrawn or excluded from the project if they are no longer employed at the hospital during the project period.

Measures to ensure participants' confidentiality include limiting access to participants' responses on the survey to only the investigator and having each participant create a six-digit numerical code. The investigator scanned and saved project data in a password-protected folder on the personal laptop of the investigator. The statistical consultant performed a power analysis. The power analysis was performed with G*Power software. The investigator needed a minimum of 52 nurses to ensure a moderate difference between pre- and post-implementation with 99% reliability (A. Moore, personal communication, May 8, 2023). As a conservative approach, ten nurses were added to the minimum sample size estimation in cases of attrition for project participation (A. Moore, personal communication, May 8, 2023).

Project Planning and Procedures

Project planning was implemented to assist the investigator in staying on track with the data collection and project implementation. In addition, project planning helps to move a quality improvement project through the phases of a project cycle (UNC, 2023). The general stages of a quality project include the definition of the problem, analysis, implementation, and sustainment (UNC, 2023). Some popular quality improvement methods include, but are not limited to, Plan-Do-Study-Act, Six Sigma, and Root Cause Analysis (RCA) (Moran et al., 2024). The investigator utilized Plan-Do-Study-Act. In Plan-Do-Study-Act, a change is planned (P), implemented (D), the results are analyzed (S), and action (A) is taken based on the results (Moran et al., 2024).

Interdisciplinary Collaboration

The investigator consulted with a statistical consultant to analyze data for this project. In addition to the clinical site preceptor, the investigator collaborated with other departments at the clinical site, including human resources, quality and compliance, and nurse leaders. In addition, the investigator administered surveys online using a QR code through Google Docs. The informed consent, Nursing Stress Scale instrument, and prayer were provided to participants via a QR code. The statistical consultant analyzed the quantitative project data collected from Google Docs and hospital staff. The investigator collected and reviewed qualitative data from the Nursing Stress Scale, free text in both the pre and post-survey.

The preceptor at the hospital is a Director of a Medical-Surgical Unit with over 20 years of experience as a nurse leader. She has seen and experienced the effects of nurses' stress levels. As a nurse leader, she understands the importance of lowering nurses' stress

levels. The preceptor can positively impact the project by informing the nursing staff about the project and its significance.

The statistical consultant has over 15 years of graduate-level experience teaching statistics (Moore, 2023). She has also trained nurses and physicians to implement statistical analysis (Moore, 2023). The statistical consultant analyzed the project data without any biases.

The investigator received positive support from the preceptor, nurse leaders, and the nursing staff at the hospital. The preceptor agrees that improving nurses' stress levels benefits the hospital. In addition, the preceptor discussed hospital data such as nurse retention and call-in rates, and patient falls with the investigator. The intervention of prayer can be sustained at the hospital. The prayers can be provided to nurses via email, QR codes, or signage on the medical units. Chaplains are at the hospital Monday through Friday from 8:00 a.m. to 4:00 p.m. They could also provide prayer for the nursing staff on a routine basis. Chaplains are available after hours for patient deaths or when needed by staff. The staff may need a chaplain to cope with numerous deaths in a shift or violent outbursts from staff, patients, and patient's families.

The internal stakeholders include the nurse leaders, patients and their families, and all hospital staff members. The external stakeholders are the community and the community leaders. All stakeholders can impact the sustainability of improving nurses' stress levels. Internal stakeholders can assess, identify, and treat nurses' stress levels before they become burned out. Internal stakeholders can work to decrease issues that negatively impact nurses' stress levels, such as violence in the workplace and nurse incivility. External stakeholders could support the nurses by praying for and with them, and local churches and their members

could be a resource for nurses. Community leaders could also advocate for the nurses. Community leaders can advocate for things such as safe workplaces. Being a resource could mean being there for the nurses, talking, praying, or listening to their concerns.

The investigator's roles and responsibilities in the project were to maintain confidentiality, implement the project per the design, and follow ethical guidelines and considerations.

Feasibility

The project ran over eight weeks. Week one consisted of the investigator educating participants on the survey and posting signage on the nursing units. During week one, participants were able to access the QR code to give consent and complete the pre-Nursing Stress Scale. The investigator created a second QR code to access the thrice weekly prayers. In weeks two through six, the nurses accessed the thrice weekly prayers via the second QR code. The investigator replaced the signage from week one with new signage containing the second QR code for the thrice-weekly prayers. Week seven consisted of the nurses completing the post-Nursing Stress Scale. The investigator removed the signage for the thrice-weekly prayers and replaced it with signage containing a third QR code to complete the post-Nursing Stress Scale survey on both campuses. In week eight, the investigator reviewed and prepared survey data to present to the biostatistical consultant and closed all the survey links. During week eight, the investigator removed all the signage from the nursing units at both campuses. There was no cost to the hospital. The investigator paid for the signage (printing, laminating, and hole-punching) and the statistical consultant.

For this project to be successful, a minimum of 52 nurses are needed to consent and participate in the project. The investigator educated the staff at the hospital on the project

while posting signage on the units. Education could occur during shift change, signage posted on unit huddle boards, and hospital leadership huddle meetings. A confidential, dependable electronic survey that can collect statistical data is needed. A statistical consultant with experience analyzing statistical data and doctoral projects for nurses is also needed. The investigator's laptop must be updated, safe, and contain products to protect its security and from viruses.

Project Intervention Procedures and Data Collection

Before beginning this project, the investigator received Institutional Review Board (IRB) approval from Oklahoma Wesleyan University and the acute care hospital. This quality improvement project assessed the nurses' stress levels at a local acute care hospital. After obtaining informed consent, the participants completed the Nursing Stress Scale pre-survey. Then, the nurses had to read the prayers thrice weekly for five weeks. After five weeks of prayer, the nurses completed the Nursing Stress Scale post-survey. Demographic information on age, gender, educational level, years as a nurse, years at the hospital, and race were collected in the pre- and post-surveys. The investigator reviewed and compared nurses' call-ins, retention rates, and patient falls before and after prayer intervention. The investigator collected the qualitative data from the Nursing Stress Scale pre- and post-survey.

The rationale for prayer is to help decrease nurses stress levels. Prayer helps contribute to positive feelings, camaraderie, support, strength, and motivation (Cannon et al., 2019). In addition, prayer is a way to communicate with God to request spiritual, emotional, and physical needs (Eckerd, 2019).

Participants were recruited for the project by signage on both campuses, word of mouth from the investigator, and an email from the Chief Nursing Officer to the nurse leaders.

The investigator requested to use the healthcare organization's intranet to inform the nurses of the project, but the hospital's marketing and communication specialist denied the request. The intranet is for organization-wide communications, not for communications to each entity within the organization. Participants were also notified during the unit huddles. The signage posted on the nursing units at both campuses contained a QR code where participants could access information about the project, give consent to participate, and participate in the project.

The project was scheduled for eight weeks. The first week allowed participants to learn about the project, obtain informed consent, create a six-digit code, and complete the pre-Nursing Stress Scale instrument. The six-digit code is needed to complete the pre- and post-surveys and access the thrice-weekly prayers. The investigator updated the prayers every Monday, Wednesday, and Friday at 7:00 a.m. Participants in the study were asked to read the prayers thrice weekly for five weeks, weeks two through five. During week seven of the project, the participants had to complete the Nursing Stress Scale again. The statistical consultant analyzed the pre- and post-survey data and the nurses' demographic information. The investigator reviewed the qualitative data collected.

Measures to ensure participants' confidentiality include limiting access to participants' responses on the survey to only the investigator and having each participant create a six-digit numerical code. The investigator scanned and saved hospital data in a password-protected folder on the personal laptop of the investigator.

Instrument or Data Source

The instrument utilized for this project was the Nursing Stress Scale (NSS). The NSS was developed in 1981 by Pamela Gray-Toft and James G. Anderson. The NSS consists of 34 items identified as causing stress for nurses (Gary-Toft & Anderson, 1981). Some items

include, but are not limited to, watching a patient suffer, criticism by a physician, lack of opportunity to share experiences and feelings with other personnel on the unit, and floating to short-staffed units (Gray-Toft & Anderson, 1981). The Nursing Stress Scale was administered and readministered to 122 nurses, demonstrating consistent scores after two weeks (Gray-Toft & Anderson, 1981). The test-retest coefficient for the total scale was 0.81 and an internal consistency exceeded 0.70 for all components except two subscales (Gray-Toft & Anderson, 1981). Empirical data testing validity was confirmed by correlating the higher Nursing Stress Scale scores to high nurse turnover (Gray-Toft & Anderson, 1981). Gray-Toft and Anderson observed medical units where nurses scored high on the Nursing Stress Scale also had a high nurse turnover rate (1981).

Permission was requested and received from Dr. James A. Anderson on November 17, 2021, to use the NSS for the investigator's quality improvement project.

Ethical Considerations

For all nurses participating in the project, anonymity was maintained. Each participant was required to create a six-digit numerical code to maintain the nurses' anonymity. The nurses' identities remained anonymous throughout the survey. The investigator did not share this information with any acute care hospital members. Aggregate data collected from the hospital and survey results were kept in a password-protected folder and saved on the investigator's password-protected laptop for seven years. The investigator has no other ethical concerns.

Summary

This chapter discussed the approval process for implementing the project at the hospital and the investigator's approval to use the Nursing Stress Scale. In addition, the

investigator addressed the project's implementation, storage, collection, and analysis of project data. Limitations and biases were also identified in chapter three. The next chapter focuses on the results with an in-depth analysis performed by the statistical consultant.

Chapter 4: Data Analysis and Results

The investigator examined whether prayer at the hospital was beneficial in decreasing nurses' stress levels. The nurses' stress levels were assessed using the Nursing Stress Scale with a 4-point Likert scale before and after the thrice weekly prayers. The investigator created QR codes for nurse participants to consent, access the pre- and post-Nursing Stress Scale, and the thrice-weekly prayers. In addition to the pre- and post-Nursing Stress Scale survey results, the investigator also reviewed nurse call-ins, retention rates, and patient falls data**.**

The project aims to determine if thrice weekly prayers help decrease nurses' stress levels and improve patient outcomes such as patient falls. Nursing stress levels were measured using the Nursing Stress Scale instrument in its original form. The project's design was quasi-experimental, consisting of a one-group pre/post-test design. In this design, the outcome (nurses' stress levels) was measured two times, once at the beginning and after exposure to the intervention (thrice weekly prayer).

Data collected during the survey included results from the pre- and post-Nursing Stress Scale survey, nurses' comments made on the surveys, the number of falls, nurse call-ins, and retention rates collected from July 2022 to September 10, 2023. Other data collected included demographic data such as the primary area/unit the nurse is assigned, age, gender, educational level, years as a nurse, years at the hospital, and ethnicity.

Data Analysis Procedures

A biostatician consultant conducted the analysis. The investigator needed approximately 52 nurse participants to ensure a moderate difference between pre- and post-implementation with a 99% reliability of the hypothesis testing. The investigator did not meet the minimum of 52 nurses; 20 nurses consented and completed the pre-Nursing Stress Scale survey, sadly, only

two completed the post-Nursing Stress Scale survey (see Table 1). One nurse accessed the QR code and created a six-digit numerical code but declined to consent and complete the pre-Nursing Stress Scale survey. This nurse's information was not collected or included in the data from the 20 nurses who consented to participate in the project. Another nurse participant accessed the thrice weekly prayers by creating an eight-digit numerical code. This nurse participant did not give consent or complete the pre- and post- Nursing Stress Scale survey. The investigator was short 32 nurses for the pre-Nursing Stress Scale survey and 50 for the post Nursing Stress Scale survey.

The Nursing Stress Scale survey was scored using a 4-point Likert scale from 0-4. Participants could score between 0 and 102 on the 34 items on the Nursing Stress Scale survey—the higher the score, the greater the stress experienced by the nurse. The original developers of the Nursing Stress Scale did not specify a numerical range. Gray-Toft and Anderson stated higher scores on the Nursing Stress Scale indicated more frequent stress (1981). Nurses who completed the Nursing Stress Scale survey scores ranged between 23 to 74.

The 20 respondents scored the highest on the pre-Nursing Stress Scale survey in the following items; the numerical score is in parenthesis:

- Factor I: Death and Dying
    - Feeling helpless in the case of a patient who fails to improve (33) and
    - Watching a patient suffer (35).
- Factor V: Conflict with the other nurses
    - Floating to other units that are short-staffed. (31)
- Factor VI: Workload

- Breakdown of computer (32),
- Unpredictable staffing and scheduling (35), and
- Not enough staff to adequately cover the unit (37).

This aligns with the 2021 Advisory Board hospital turnover and vacancy benchmarks, which documented insufficient staffing, workload intensity, the emotional toll of the job, and not feeling supported or listened to at work as the top factors nurses leave their jobs (Boston-Leary, 2023).

All phases of the surveys were conducted via Google Forms. The survey data were collected using an Excel spreadsheet created by Google Forms. The hospital's nurses' retention and call-in rates and patient falls from July 2022 to September 10, 2023, were provided to the investigator by staff at the healthcare organization. The investigator then provided the data to the biostatician consultant for analysis.

Due to only two nurses, identified as Nurse A and Nurse B, completing both the pre- and post-Nursing Stress Scale survey, the biostatician consultant could not perform a t-Test to analyze the Nursing Stress Scale scores. As a result of the low number of participants, the investigator was unable to determine any statistical significance between prayer, nurses' stress levels, nurses' call-in and retention rates, and patient falls. The independent variable in the quasi-experimental study design is the thrice weekly prayers and the dependent variable is the nurses' stress levels and patient falls.

Nurse A and B's pre–Nursing Stress Scale survey scores were 34 and 23, respectively. Nurse A's post Nursing Stress Scale results were 19 and Nurse B's were 26. Nurse A's stress scale decreased while Nurse B's stress scale increased. Nurse A read seven of the 15 prayers, while Nurse B only read one of the 15 prayers.

There were 598 falls at the healthcare organization between August 1, 2022, and September 12, 2023. The healthcare organization had 108 falls between May 28, 2023, and July 29, 2023. During the project and after July 30, 2023, through September 30, 2023, there were 66 falls at the healthcare organization (see Figure 1). Although there were 42 fewer falls after the implementation of the project, there is no clear evidence to support that the thrice-weekly prayers helped lower the number of patient falls.

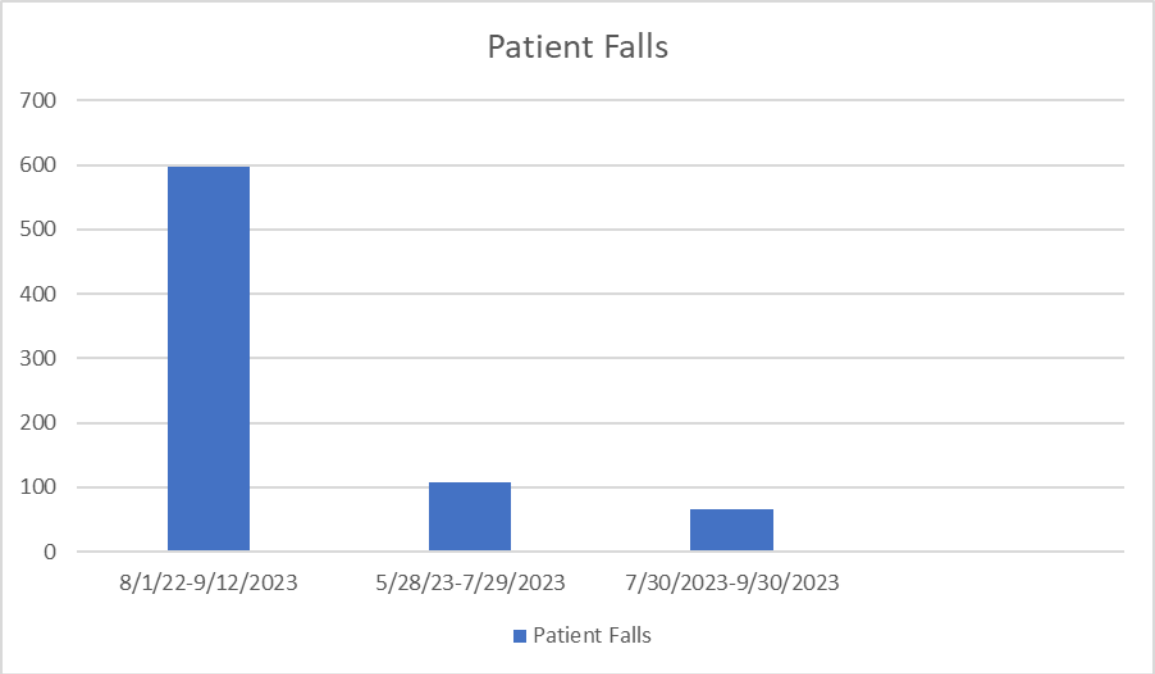

Figure 1. Comparison of Falls pre/post prayer

Although not included in the project question, the investigator reviewed the healthcare organization's nurse call-ins and retention rates. At the healthcare organization, 1728-day shift nurses (7a-7p) called in between July 2022 and August 2023. During the same time frame, 1763 night shift nurses (7p-7a) called in. The night shift nurses had more call-ins compared to the day shift nurses for the following months in 2022: July, August, October, November, and January 2023. One hundred- and one-day shift nurses called in during July 2023 compared to

100-night shift nurses who called in. For August 2023, 129-day shift nurses called in versus 116-night shift nurse call-ins. These results do not support the investigator's PICOT question.

The healthcare organization's overall voluntary turnover goal is 19.44% and the RN bedside voluntary turnover goal is 18.25%. One department, referred to as Unit X (which will remain anonymous to maintain the confidentiality of the healthcare organization), had a voluntary turnover rate of 18.60% for June 2023, 36.64% for July 2023, and 45.80% for August 2023. Unit X was one of the top three areas between June 2023 and August 2023, with the highest voluntary turnover rate. The other units in the top three during the same time frame varied. There was no data from the surveys documenting any nursing staff from Unit X participating in the project. These results do not support the investigator's PICOT question.

Descriptive Data

The demographic information requested included primary unit/department assigned, age, gender, educational level, years as a nurse, years employed at the hospital, and ethnicity. Not all the nurses participating in the project completed all the demographic information. All the participants in the survey were women; White nurses had the greatest participation in the project, the average age range was 43-58, the majority of the nurses received their education through a diploma or Associate Degree nursing program, and the majority of the nurses had been a nurse and had worked at the healthcare organization for twenty years or more (see Table 2).

Table 1

Nursing Stress Scale Scores by Phase

	Pre-Phase *M (SD)* *21*	Pre-Phase *M (SD*) N=2	Post-Phase M(SD) N=2
Average Score	40.9(13.8)	28.5 (7.78)	22.5 (4.94)

Table 2

Survey Respondent Descriptive Data

Description	**Frequency**	**Percentage**
Gender		
Male	0	0
Female	21	100%
Education		
LPN	1	4.8%
RN-ADN/Diploma	9	42.9%
RN-BSN	7	33.3%
RN-MSN	2	9.5%
RN-PhD/DNP/APRN	1	4.8%
Age Group		
27-42	7	33.3%
43-58	9	42.9%
59-77	4	19.0%
Years as a Nurse		
0-5	2	4.8%
5-10	5	14.3%
10-15	4	9.5%
15-20	2	28.6%
20 or more	7	33.3%
Years at the Hospital		
0-5	2	9.5%
5-10	5	23.8%
10-15	4	19%

15-20	2	9.5%
33.3%20 or more	7	33.3%
Race		
American Indian or Alaska Native	2	9.5%
Black or African-American	1	4.8%
Hispanic/Latin/Spanish	1	4.8%
White	16	76.2%

Results

The investigator could not answer the clinical question of whether thrice compared to no daily prayer affects nurses' stress levels and patient outcomes (patient falls) within five weeks. There were 42 fewer patient falls during the five weeks of the project as compared to the previous two months. However, due to the minimum number of participants not being met, the investigator could not determine any correlation between the prayer intervention and patient falls. Of the 20 participants, only two completed the pre- and post- Nursing Stress Scale survey. Based on those two nurses' pre- and post-Nursing Stress Scale survey, Nurse A read seven of the 15 prayers and had a 15-point decrease in her stress level. Nurse A's stress level went from a 34 to 19. Nurse B read one of the 15 prayers and had a three-point increase in her stress level. Nurse B's stress level went from 23 to 26.

Summary

An error in the project was one participant accessing three of the 15 prayers without giving consent and completing the pre- and post-Nursing Stress Scale survey. The project did not have 52 nurse participants, the minimum number, to ensure a 99% reliability of the hypothesis testing. As a result, the investigator could not determine if there is a correlation between prayer, nurses' stress levels, and patient outcomes. Although the project produced no

relevant statistical data, there are implications for prayers as a stress management strategy for nurses. The Nursing Stress Scale is a valid and reliable survey instrument to assess nurses' levels and sources of stress. The implications and sustainability of prayer is discussed in the next chapter.

Chapter 5: Implications for Practice, Sustainability, and Conclusions

Nurses were stressed due to the COVID-19 Pandemic, the RaDonda Vaught verdict, race relations in the United States, and a merger between two local healthcare organizations. This project aimed to use thrice weekly prayer to help decrease nurses' stress levels and improve patient outcomes. Nurses who participated in the project completed a pre- and post-Nursing Stress Scale survey to assess their stress levels. Other data collected included nurse call-ins, retention rates, and patient falls.

Summary

This project was conducted using Google Forms and QR codes for nurses to access the thrice weekly prayers. The nursing profession is stressful; it can be demanding physically, mentally, and spiritually (Boston-Leary, 2023). Nurses are prone to stress, which may lead to moral distress, compassion fatigue, and burnout. Burnout can have unfavorable mental, physical, and spiritual results on nurses and patient outcomes if left untreated. To prevent burnout, healthcare organizations should be proactive; this includes routinely assessing nurses' stress levels and offering coping strategies to decrease stress.

Findings

Unfortunately, this project did not demonstrate statistical significance in determining if thrice weekly prayers helped decrease nurses' stress levels and improve patient outcomes. The investigator did not meet the minimum number of 52 nurse participants. Twenty nurses consented, created a six-digit numerical code, and completed the pre-Nursing Stress Scale survey. Unfortunately, only two nurses completed the post-Nursing Stress Scale survey after five weeks of thrice weekly prayer. Nurse A completed the pre- and post-Nursing Stress Scale

survey, read seven of the 15 prayers, and had a decrease in her pre-Nursing Stress Scale survey score by 15 points. Nurse B completed the pre- and post-Nursing Stress Scale survey, read one of the fifteen prayers, and her post-Nursing Stress Scale survey increased by three points.

Strengths and Limitations

The strength of the project is the cost. The hospital maintains a pastoral services department; a Chaplain is on-site Monday through Friday during regular business hours. The hospital also has an information technology department. Nurse leaders, in collaboration with the chaplain services and information technology, could create and disperse prayers to the nurses via intranet or QR code. The healthcare organization would not have to hire or educate employees or purchase new equipment to implement prayers. A chaplain could offer prayer at specific times and locations for the nurses and other hospital staff to attend. The nurses who participated in the project had positive comments about the prayer. While hanging up the flyers for the project, the nurses were receptive to prayer. The project was supported and advertised by the nurse leaders. The Chief Nursing Officer emailed nursing leadership, encouraging the nurse leaders to inform the nurses about the project. Nurse leaders also mentioned the project during the daily unit huddles.

A limitation of the intervention of daily prayer is the hospital does not broadcast prayer over its PA system. Another limitation is the investigator did not create a reminder to notify the nurses when the prayers were changed (Monday-Wednesday-Friday) and to complete the post-Nursing Stress Scale survey. Instead, nurses had to remember to access the QR code three times a week and to take the post-Nursing Stress Scale survey. Not being able to post an announcement on the hospitals' intranet may have limited the number of nurses aware of the project. Efforts to minimize the limitations were to discuss the project with the nursing staff when posting the

flyers on the different nursing units. The staff was also encouraged to email the investigator with questions or issues with the QR codes.

A major limitation of the project was the survey size. The minimum number of participants, 52, was not reached. The sample size for the project was 20. Not all 20 participants accessed the thrice weekly prayers or completed the post-Nursing Stress Scale survey.

Plans for Sustainability

This project is sustainable. It will take a collaborative effort between the pastoral services, nurse leaders, informational technology, and healthcare administrators. Prayers or words of devotion may be offered, not required or mandated, to the hospital's staff by pastoral services at specific dates, times, and locations throughout the campus. The hospital could also include community clergy members volunteering to lead the prayers. Thus opening up lines of communication between the hospital and local clergy members in the community and giving the hospital a larger pool of "prayer partners." Diverse clergy members could facilitate the prayers to include all religions, such as Christianity, Islam, Catholicism, and Judaism. For example, during Lent, have a Catholic priest deliver the prayers.

The healthcare organization could periodically assess the nurses' stress levels by using the Nursing Stress Scale or creating a scale to measure stress among the nurses. The hospital should encourage nurses to take time off to relax and rejuvenate, leave the nursing unit for lunch breaks, and offer hospital-sponsored wellness activities. Consider creating a Palliative Team for Nurses or a Nurses Anonymous group.

Leadership at the hospital should work on re-establishing trust with the nursing staff and to be in-tuned with their staff. The hospital should be proactive instead of reactive on nurses'

stress levels. Prayer is an intervention the hospital could implement to reduce nurses' stress levels; this could be done on individual units, the PA system, social media, or a QR code.

Implications for Practice and Recommendations

Prayer is an inexpensive intervention healthcare organizations can offer to nurses to help decrease their stress levels. Most larger healthcare organizations employ chaplains. In collaboration with the nurse leaders, the chaplains could be champions for access to prayers for the nursing staff. Healthcare organizations could provide prayers to the nursing staff via a QR code, PA system, intranet, and email. As previously stated, there is numerous research demonstrating the benefits of prayer on patients. Prayer should not be limited to the patients. Nurses could also benefit from prayer. There is limited research on prayer and how it helps nurses. One participant in the project had a 15-point reduction in the pre-and post-Nursing Stress Scale survey; the investigator could not correlate the drop to the daily prayers due to insufficient participants. Further research is needed to determine whether prayer effectively lowers nurses' stress levels. Although this project was not statistically significant in proving the relationship between prayer and nurses' stress levels, it shows interest in learning more about the relationship between prayer and nurses.

Numerous surveys are available that are valid and reliable for assessing nurses' stress levels. Healthcare organizations could create their own self-assessments to measure stress among the nursing staff. The healthcare organizations could have the nurses perform self-assessments every 30, 60, 90 days, or whatever the facility sees fit to evaluate nurses' stress levels.

The results were not statistically significant; therefore, the investigator could not make a decision based on the survey data if thrice prayers were effective at lowering nurses' stress. As previously stated, further research is needed. Project limitations include insufficient participants

and the investigator's inability to utilize the healthcare organization's intranet to inform nurses about the project. Here are some comments left by the nurses:

- The prayer helped me see how blessed I am to be a nurse blessed by God.
- I liked the prayer - said it twice for extra reinforcement 😊
- Thanking God for all his blessings. I am asking for admits for job security, but also asking for adequate staffing with a strong skills and good knowledge base. I feel comfort knowing our Heavenly Father watches over all of us. Thank you for your words.
- Very nice, a good reminder. It is also reassuring when it is a busy crazy night God is there to help. Thank you for the reminder.

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