1-1-1997

Parish Nursing: A Resource and an Opportunity

Janice W. Swing
San Jose State University

Parish Nursing: A Resource and an Opportunity

Janice W. Swing, MS, FNP
San Jose State University
School of Nursing
[redacted]

Ann Doordan, Ph.D., RN
Professor, San Jose State University
School of Nursing

Jayne Cohen, DNSc, RNC
Professor, San Jose State University
School of Nursing

Maggie Wollen-Olson, MS, PHN, RN
Director of Mission Services
[redacted]

Parish Nursing: A Resource and an Opportunity

Do you know people in the community who do not understand their health needs? Are you aware of people who do not have access to health services? Parish nursing draws on the strengths of people in a congregation to promote physical, mental, and spiritual health for the congregation and its local community. Hospital nurses may want to use parish nurses as a valuable resource for discharge planning. Community nurses may also need the support of parish nurses for clients. Additionally, for experienced nurses who belong to a faith community, serving as a parish nurse satisfies a need for something new. The authors surveyed some members of an urban church about their need for both parish nurse and family nurse practitioner services; this article presents the results.

The usefulness of parish nursing crosses economic strata. Our initial interest in faith-based health care came while working in community health. Working in areas where many people were living in poverty was very much like working in the developing world. By typical American standards, the needs in this impoverished community were great. We wanted to teach basic health promotion and self-care skills to people who did not have access to health services. Lifestyle changes were slow in coming because clients were living from crisis to crisis. Later we recognized that even people with many resources also live from crisis to crisis and are unable to change their unhealthy behaviors. Some people find the strength to make lifestyle changes in the church through faith and supportive relationships. In addition to assisting church members, the church can reach out to the community with interventions that support physical, mental, and spiritual health (Rydholm, 1997).

Churches are present in every community. Granger Westberg (1990), the "father of parish nursing," reminds us that churches a century ago were leaders in health care before science and business took over. Currently, even though information on health promotion is available, most people do not use this knowledge to make healthy lifestyle changes. Westberg identified the church as a place to motivate and support change that leads to healthy living. He noted that churches are already involved in crisis care: providing meals, cleaning house, and caring for children when someone is ill. Yet some churches want to do more. Parish nursing, in the context of a congregation's health ministry, provides the framework to integrate physical, mental, and spiritual health. Additionally, Weis, Matheus, and Schank (1997) offer faith-based health care as one way to stretch health care resources.

Parish nursing functions in the context of the health ministry team which consists of church member volunteers who are health professionals, health care recipients, and other interested persons. The team works together to mobilize health services in the congregation. A full-time or part-time parish nurse meets congregational health needs by drawing on the resources of the health ministry team, the church, and the community. Services may include wellness classes, support groups, spiritual services, counseling, physical assessment, case management, and volunteer training (Weis, Matheus, & Schank, 1997).

Defining Parish Nursing

All nurses, including parish nurses, must stay within the limits of their state Nurse Practice Acts and are accountable for professional standards. For nursing service in the context of the church, synagogue, or temple, the Health Ministries Association (1997)

developed the "Scope and Standards of Parish Nursing Practice." Parish nurses assess, plan, teach, demonstrate, refer, and evaluate, making adjustments in the plan as clients' needs change. Clients are individuals, families, or groups.

There are two models of parish nursing: (a) institution-based and (b) congregation-based. In both models, the parish nurse works with one or more congregations. In the institution-based model, a hospital, health department, or university contracts with one or more churches to provide health services for church members and the local community.

With the typical congregational model, nurse volunteers manage the planning and implementation of health care services. Of those parish nurses who are paid, many started as volunteers in their congregations. If a salary is not paid, some training and operating expenses are covered by the congregation of the church. The inclusion of some health ministry expenses in the church budget is important for gaining recognition of the ministry in the church. Church-based parish nurses, whether paid or volunteer, need to meet with other parish nurses for professional and spiritual support. The International Parish Nurse Resource Center (1-800-556-5368) in Park Ridge, IL, can assist people who want to locate parish nurses in their area.

In San Jose, a Northern California city with a population greater than 782,000, one religiously sponsored hospital believes strongly that parish nursing promotes the mission and values of their organization. The hospital subsidizes the salaries of parish nurses to assist churches that want to start health ministries. Each church pays the remainder of the salary and determines how many hours per week the congregation needs and is able to support a nurse. Each nurse is a hospital employee with employee benefits

in proportion to the number of hours employed. A biweekly staff meeting brings these hospital-employed parish nurses together for spiritual support and for the opportunity to share concerns, successes, and needs. The hospital's Parish Nurse Advisory Board provides ongoing guidance and program evaluation.

Expanding the Role for Nurse Practitioners

Traditionally, parish nursing does not allow hands-on care or fees for services; however, parish nursing could provide a unique opportunity for nurse practitioners. Souther (1997) noted that counties in Texas with a low percentage of doctors usually have a high percentage of churches. She created the role of the congregational nurse practitioner (CNP), blended from the roles of parish nurse (PN) and family nurse practitioner (FNP), as an answer to community health needs. Houston Baptist University established a Masters of Science in Nursing curriculum to prepare nurses for the CNP, PN, and FNP roles. Parish nurse students assess and refer clients to FNP students for diagnosis and treatment. A part-time clinic is maintained in a local church and is funded by a grant which not only gives students experience but also provides a valuable service to the community (personal communication, Brenda Binder, March 22, 1998).

Houston's Memorial Hermann Health Care System provides assistance for 10 to 15 churches that have active parish nurse programs. Two of those churches are beginning part-time health clinics with FNP services. Hospital assistance is possible because 10% of the hospital budget is committed to benefit the community. Other funding comes from churches and grants. Communities need additional primary care services for the uninsured. The FNP is prepared for collaborative and independent practice and cares for people over the lifespan. Those who can also integrate scripture and practice can work

successfully towards role expansion in the context of the church (personal communication, Renee Schumann, April 1, 1998).

Assessing the Need for Nursing Services in a Congregation

Nurses and government officials may see the need and the opportunity for faith-based health care, but do church members want health services? We decided to ask this question at one local, urban church with an average total weekend attendance of 2,300 people. The membership is ethnically diverse. Most speak English, but one mass is provided in Spanish. Education of those in the congregation ranges from grade school to doctoral preparation, and occupations are equally diverse. The impoverished, the wealthy, and the middle class worship here together. The church graciously provided space at their entrance to meet church members, and we conducted interviews after 10 worship services. Undergraduate baccalaureate San Jose State University nursing students enthusiastically assisted with the data collection. Fifty-one individuals with an age range of 20 to 75 years were surveyed.

We designed the written survey for the needs assessment by listing the potential services of parish nursing found in the literature and validated it with parish nurses in the field. Twenty-three items fell into four categories: individual services, group classes, support groups, and group training. We also wondered if there was a need for primary care, so we listed seven common FNP services. Subjects were asked to rate their personal interest in these services on a scale of 1 to 7 as follows: (a) 1 and 2 as "No"; (b) 3, 4, and 5 as "Maybe"; (c) 6 and 7 as "Yes". Church members read the survey and marked their own responses. Assistants answered any questions. Many people commented, "I think this is a good thing, but it is not something I need." People were encouraged to answer

only for themselves. Some people wanted to share information beyond the questions, and those responses are included in the discussion that follows.

Discussing the Results

Scores of "Yes" and "Maybe" were combined and reported as positive responses in tables I and 2. Church members had not experienced parish nursing, so perhaps members needed some time to think about the idea. Also, church members were encouraged to answer only for themselves, and if they did not directly say, "No," it seemed like there was some openness to the service. The fact of their openness made scores in the "Maybe" range seem more positive than negative. Conversely, unanswered items were rated as "NO" because comments made by subjects who left items blank suggested that the unmarked services did not personally apply. The questions were worded specifically to determine the personal usefulness of each service for each subject.

Individual parish nurse services were the most popular with 90% of the respondents indicating an interest for both routine blood pressure screening and a health fair at church. Other individual assistance regarding medications, specific disease education, and community resource referrals were well received with 80% or more positive responses. Perhaps interest in individual services ranked higher than interest in most classes, support groups, and training groups because the topics for individual services were more inclusive than topics in the other categories. It is also possible that people prefer individual assistance.

Three health classes that registered more interest than some individual services were: (a) stress reduction, (b) exercise, and (c) nutrition. Again, these topics naturally have a broader range of interest. The least desired class ($n = 17$) was for pregnancy and

childbirth. In general, support groups did not receive as favorable a response as individual services. However, smoking cessation, the least popular support group, included 18 interested individuals. This could be a very important service to offer. We did not ask the respondents about their habits, such as smoking, drinking, or drugs, so we do not know the actual need for services; we were looking for perceived need. The three training groups we offered were well received except for babysitting, which ranked number 18. Perhaps the interest in training for babysitting was low because we did not interview anyone younger than 20 years of age. Training for elder caregiving ranked number 11, while the support group for caregivers was number 9 on the list of services.

The FNP services that obtained 75% or more positive response were for: (a) screening cancer, (b) treating colds, and (c) managing blood pressure. Perhaps the demand for well child exams was low because the government funds this service. Specific disease management may have ranked low as fewer people are affected by diabetes and arthritis than have colds or need cancer screening. The people interested in blood pressure management generally were the same people who were interested in classes for nutrition, exercise, and stress reduction. Fifty-nine percent of the respondents were interested in receiving immunizations at church. It was not clear why twenty-nine people said yes to arthritis management and twenty-eight people said yes to diabetes management when only five people reported having arthritis and one person having diabetes. Perhaps they saw a future need for service or knew someone who needed help.

We were excited that, even when some people did not respond positively to proposed services for themselves, they did comment on the need for parish nurse services for other church members. Among these, two experienced grade school teachers reported

a need for classes to help the parents of the children they teach. These teachers reported that an increasing number of children are coming to school without breakfast or appropriate clothing. They were also concerned about pregnant women who smoke and an increase in the number of mothers who discipline children poorly. These teachers did not answer "Yes" to many of the questions for themselves, but reported a great need for parenting classes and support. The teachers' comments were important considering their opportunity to observe a large number of families each year.

Additionally, one respondent who regularly took communion to the homebound advised us that we were missing the input of a large number of people who might have very different answers than our sample. He did not personally need many of the proposed services, but he visited people who do need health service through the church. He suggested including homebound members in the survey. A local parish nurse supervisor concurred that lay ministers who visit the sick sometimes find conditions that they believe to be a problem, but they do not know what to do about them. If the lay minister could call a parish nurse, the parish nurse could make a home visit to assess, teach, and refer as needed. Parish nurses train family members to care for their frail elderly or chronically ill members. Caring families do a number of complex things for their homebound members when telephone support is provided for problem solving.

Planning for a Future in Health Ministry

Many people in this church did not participate in the needs assessment. It is difficult to know the needs and wants of persons not represented in this sample, particularly those who have nominal education and those who do not have insurance. Those who responded were feeling good about their health, and only two individuals

requested Spanish language surveys. Additionally, the homebound were not surveyed. Perhaps face to face interviews in a casual setting would elicit a response from people who have less education. Home visits would permit the homebound and their caregivers to respond.

Further study is necessary to understand how identified congregational needs are affected by demographic or cultural characteristics. Beginning a program in the targeted church to evaluate the use and effect of the parish nurse and FNP services could be an additional study.

Concluding Thoughts

Acceptance of the parish nurse is a process that happens over time, beginning with a needs assessment to suggest the services that are possible and a service such as blood pressure screening at the end of worship. One to one encounters lead to individual health assessments. As church members find success in working with a parish nurse, they refer friends and family. Classes and support groups which address specific needs are facilitated by church members with strengths in those areas of need. Private counseling leads to community referrals. Finally, the church neighborhood is surveyed to determine perceived need for health promotion services among those who do not attend the local church, and to inform the neighborhood of health services.

Family nurse practitioners are an excellent resource for parish nurse clients as the FNP works independently and collaboratively providing primary health care services across the life span. Medically underserved areas benefit when churches arrange for FNP primary care services. Parish nurses refer clients to the FNP for diagnosis and treatment

of common illnesses, cancer screening, immunizations, well child exams, and management of chronic diseases e.g., diabetes, arthritis, and hypertension.

Parish nursing is a valuable resource as hospitals and communities face diminishing resources and increasing demands for health services. Local churches already have members who provide physical, emotional, and spiritual support in their congregations. Parish nursing organizes and builds on health services that already exist in faith communities. Parish nurses and their health ministry teams refer church members to community resources, teach church families how to care for their frail members, and organize health services to fill gaps in service.

Parish nursing is a professional opportunity on the cutting edge of health care and church life because support for this service is coming from many levels. Church members are interested in health services at church. Local parish nurse groups provide professional and spiritual support for their members. Institutions recognize the value of parish nursing and sometimes provide financial support for parish nurses. Churches are beginning to provide services which could integrate physical, mental, and spiritual health as churches seek relevance in the lives of their communities. Parish nursing is an important resource for clients and an opportunity for professional growth.

References

Health Ministries Association (1997). Scope and standards of parish nursing practice. Huntington Beach, CA: Author.

Rydholm, L. (1997). Patient-focused care in parish nursing. Holistic Nursing Practice, 11,(3), 47-60.

Souther, B. (1997). Congregational nurse practitioner: An idea whose time has come. Journal of Christian Nursing, 14,(1), 32-34.

Weis, D., Matheus, R., & Schank, M. J. (1997). Health care delivery in faith communities: The parish nurse model. Public Health Nursing, 14, 368-372.

Westberg, G. E. (1990). The parish nurse: Providing a minister of health in your congregation. Minneapolis: Augsburg Fortress.

Table 1

The 10 Most Requested Parish Nursing Services Expressed as Percentages (N = 51)

Service	% Positive	% Negative
Health Fair	90	10
Blood Pressure Screening	90	10
Individual Community Resource Referral	88	12
Nutrition Classes	88	12
Stress Reduction Classes	84.5	15.5
Exercise Classes	82.5	17.5
Individual Medication Education	81	19
Individual Chronic Disease Education	80	20
Caregiver Support Group	80	20
Conflict Resolution Training	78.5	21.5

Table 2

Perceived Need for FNP Services Expressed as Percentages (N = 51)

Service	% Positive	% Negative
Minor Illness Treatment	76.5	23.5
Cancer Screening	75	25
Blood Pressure Management	75	25
Immunizations	59	41
Arthritis Management	57	43
Diabetes Management	55	45
Well Child Exams	49	51