West Coast Health Missions and Ministry Conference 2011
Best Practice in Healthcare Missions: Nursing

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LEARNING OBJECTIVES Upon completion, the participant will be able to:

- List 3 elements of the 15 proposed 'Values and Best Practice in Nursing Missions'
- Discuss the current state of the literature to support practices in nursing missions
- Describe the United Nations 8 Millennium Development Goals, the UNICEF *Facts for Life* UNICEF curriculum and their relationship to improved morbidity/mortality in Moderate- and Low-Resource populations.
- Describe the proposed move from Evidence-Based Practice to Value-Based Practice in nursing missions today.

NURSES: Upon completion, the nurse will be able to LIST 2 CONCEPTS that could apply to their current Nursing practice or clinical setting.

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SECTION I: BEST PRACTICES IN NURSING MISSIONS

<>PROPOSAL: 15 VALUES AND BEST PRACTICES IN NURSING MISSIONS

(Bajkiewicz, 2011)

[] Nursing missions are first, to do no harm.

[] Nursing missions are to be practiced 'Corem Deo', in the Presence and before the face of the living God while actively pursuing Shalom in all relationships.

[] Nursing missions are to focus on the primary outcomes of improved long-term health and the extension of the Kingdom of God in target populations within regions served.

[] Nursing missions are to uphold the work, practice and integrity of national healthcare practitioners and pastoral leaders, with consideration to their long-term care of the target population in the region.

[] Nursing missions are to demonstrate competency in cross-cultural healthcare delivery specific to target populations prior to going or serving in a nursing mission capacity by all nurses and service-learner students.

[] Nursing missions are with and under national nursing professional oversight, approval and direct participation in both short-term activities and long-term projects.

[] Nursing missions are to engage the Nursing Process (assessment, planning, implementation, evaluation/APIE) in nursing missional activities. Care, education, screening, counsel and consultation are to occur with direct participation of national nursing professionals during all phases of the APIE continuum.

[] Nursing missions will actively incorporate ethical integrity, confidentiality and informed consent in all nursing activities involving patient/client/family care, especially if service-learning is a component.

[] Nursing missions will only allow nurses and service-learning students to practice and provide direct patient care at the level and scope of their training, preparation and licensure in their home country(s).

[] Nursing missions will comply and practice within the professional regulations and laws of the country/region, with nurses fulfilling appropriate local credentialing prior to patient care for both individual practice and outreach settings.

[] Nursing missions will insure that all distributed patient/client/family educational materials be pre-approved by national nursing professionals and carefully screened for cultural, contextual, graphic and linguistic accuracy with target populations.

[] Nursing missions will establish a plan of care for continuity and follow-up of patient/client/family after the nursing mission. Care planning will occur prior to initiation of direct care or screening activities.

[] Nursing missions will discourage nursing tourism. Rather, it will pursue the more difficult work of long-term international educational and experiential partnerships, practice support and equality.

[] Nursing missions will regard a positive nurse-participant experience as the secondary benefit of sacrificial service-leadership. Improved long-term health and extension of the Kingdom of God in the people of the region will serve as the intended primary outcome.

[] Nursing missions will serve under the counsel, guidance and praxis of the Holy Scriptures, the confession of the Apostle’s Creed and the weight of nursing’s long tradition of integrity, service and compassionate care to ‘the least of these’ internationally.

<>WHAT IS EVIDENCE-BASED PRACTICE (EBP)?
Evidence-based practice (EBP) is a problem-solving approach to clinical practice that incorporates the best evidence from well-designed studies, patient values and preferences and a clinician's expertise in making decisions about patient care (Melnyk & Fineout- Overholt, 2005).

<>WHAT ARE BEST PRACTICES?
Best practices are purposeful practitioner clinical behaviours and decision-making approaches, derived from and informed *by rigorous Evidence-Based Practice (EBP) processes* that are intended to optimize patient and family outcomes along the health continuum.
(derived from Melnyk and Fineout-Overholt, 2005)

EBP Roots:
Dr. Archie Cochrane suggested that because resources would always be limited, they should be used to provide forms of health care which had been shown in properly designed empirical studies to be effective
(Cochrane Collaboration , 2003: http://www.cochrane.org/cochrane/archieco.htm)

'Best Practice Protocol' for selecting most acceptable treatment from group of interventions intended to treat same problems: sound theoretical base, general acceptance in clinical practice, considerable anecdotal/clinical literature, absence of evidence of harm, at least one randomized controlled study, descriptive publications, a reasonable amount of necessary training, possibility of use in common settings (The Kaufman Best Practices Project, 2004)

<>LEVELS OF EVIDENCE

LEVEL I: Evidence from a systematic review or meta-analysis of all relevant randomized controlled trials (RCTs), or evidence-based clinical practice guidelines based on systematic reviews of RCTs
LEVEL II: Evidence obtained from at least one well- designed RCT
NOTE: Regulations from governmental or regulatory agency given "high level" evidential ranking
LEVEL III: Evidence obtained from well-designed controlled trials without randomization
LEVEL IV: Evidence from well-designed case-control and cohort studies
LEVEL V: Evidence from systematic reviews of descriptive and qualitative studies
LEVEL VI: Evidence from a single descriptive or qualitative study
LEVEL VII: Evidence from the opinion of authorities and/or reports of expert committees

(Melnyk & Fineout-Overholt, 2005; Guyatt & Rennie 2002; Harris et al., 2001)

<>Nursing and EBP: Perspective
EBP as value
EBP based in empirical scientific method, limited to 5 senses
EBP replacing nursing philosophical, theoretical, historical and theological foundations

<>Nursing History

Faith-Based Practice	(A.D. 30 to 1860's)
Virtue-Based Practice	(1860's to1940's)
Efficiency-Based Practice	(1940's to 1970's)
Theory-Based Practice	(1970's to 1990's)
Evidence-Based Practice	(1990's to present)
Values-Based Practice	(future)

Values-Based Practice: compassion, integrity, character, service, holism, critical thinking/discernment, courage, servant leadership, Sabbath rest.
(Grypma, 2009)

<>Christian Nursing

Christian nursing is a ministry of compassionate care for the whole person, in response to God's grace toward a sinful world, which aims to foster optimum health (shalom) and bring comfort in suffering and death for anyone in need.
(Shelly and Miller, 1999, p. 18)

<>Cultural Competency: *Composite Definition*

A composite definition of provider *cultural competency* and it's operation as *culturally competent care*, is "a process in which the healthcare provider continuously strives to achieve the ability to effectively work within the cultural context of a client/individual, or family, or community" (Campinha-Bacote, 1999, p. 203) including, "culture care values, beliefs and lifeways to provide meaningful, beneficial and satisfying care" that is patient-focused (Leininger, 2002a, p. 58). This competence has the cultural components of awareness, knowledge, skill, encounter and desire, all of which must be integrated into the individual provider (Braithwaite, 2005; Leonard, 2001) enabling care within the context of a patient's diverse culture (Giger et al., 2007) and engaging the provider's three cognitive/knowledge, affective/awareness and psychomotor/skill domains (Callister, 2005).

(Bajkiewicz, Kim & Noble, 2009 unpublished manuscript)

SECTION II: SELECTIVE REVIEW OF LITERATURE 2009

Bajkiewicz, C. T. (2009). Evaluating short-term missions: How can we improve? *Journal of Christian Nursing. 26*(2), April-June 2009, 108-112.

"Selective Review of Literature" N = 44 final sources
Area of inquiry:
What does the literature and evidence say about missional nursing?
What outcomes are being regarded in modern-day healthcare missions?
How is effectiveness being measured (metric)?
Search done Jan 2008, included Jan 1990 to Dec 2007 and some 'classic' works
Expert opinion, peer-reviewed (PLNU, JCN),
'wide net' of sources (CINAHL, mission literature, organizational publications)
Found only small descriptive studies, small/limited samples, mostly expert opinion

Boolean terms: healthcare missions, short term missions, nursing missions
Eliminated works r/t nursing student experiences
'significant gap in literature', Level V-VII works

History
<>shifting realities in developing world (Fountain, 2004)
<>shift from long-term service to short-term trips (Hershberger, 2004)
<>Long history nursing missionaries (Shelly & Miller, 2006; Van Reken, 1987)
<>Historically, one-way trip (McKaughan, 1997)
<>Cross-cultural/language acquisition, close relationships (Tazelaar, 2001)

Shift… Then… Now…
<>Cunningham and jet travel, weeks/months duration (Loobie, 2000)

Short term involvement

1965	540
1989	120,000
1998	500,000
2003	2,500,000

(Honig, 2005; Loobie, 2000)

Full-time workers from United States

1988	65,000
2005	35,000

(Lucas, Stern & Sterns, 2006)

Medical outreach:
2004, MAP Intl, 880 medicine kits, reported 15,840 partic
(Dohn & Dohn, 2006)

BEST PRACTICE: Theoretical Basis
Culturally congruent care: careful consideration in crossing cultures/working abroad
(Leininger, 2002)
Culturally incongruent care: detrimental outcomes violates ethical beneficence
(Cameron-Traub, 2002)

Literature: Characteristics of Healthcare/Nursing Missions
[1] Relief in Complex Human Emergencies
Quick, prepared international response needed
Triple incidence last decade
(Gustavsson, 2006)
Well trained, difficult circumstances, high cost, immediate deploy
(Duininck & Williams, 2006)
[2] Surgical-Dental Teams
Work with national professionals/health-care systems
In-country facilities or ship/plane

(Carter, 2004; Clair, 1996)

[3] Mobile clinic

Set-up, walk-up

Uncomplicated, common ailments/pallative

HX/PE, limited lab, empirical tx brought pharmaceuticals

Nursing roles: intake/assessment, dispensing, Rx education

In the literature found:

Only 1 discussion of existing mission hospital or clinic nsg care (APN)

Descriptive reports of service-learning with nsg students (excluded)

Effectiveness of Healthcare/Nursing Missions [1-2]

[1] Relief in Complex Human Emergencies

Profound absence of basic human necessities

Must-save-lives

Recent large-scale responses improving

[2] Surgical-Dental Teams

Procedures (otherwise not available) beneficial

(Kim, 2005)

Necessitate working with national health systems

Effectiveness of *General* Short-Term Missions

<>controversial

<>predominant metric: perceived effectiveness and self-efficacy

<>descriptive reports immediately after outreach, positive

(Graves, 1997; Honig, 2005; Ver Beek, 2005)

<>Friesen (2005) 116 short-term participants

Longitudinal pre-trip, immediately after and 1 year

Prayer, Bible reading, faith community involvement and evangelism to pre-trip or below, negative psycho-social impact

<>Ver Beek (2005) Honduras post-hurricane

30 US churches, 30 Honduran churches

studied attitudes and church attendance

no appreciable difference, locals “send the $, 12 more homes”

Effectiveness of Healthcare/Nursing Missions [3]

<>Gap in literature

<>Descriptive, outcomes perceived effectiveness, self-efficacy, + benefit partic

<>Graves (1997) review 41 articles published 1986-1996

reports disaster relief, surgical campaigns, mobile medical

all positive outcomes, personal benefits of participation

noted that NO discussion health improvement in region or those served

<>Little patient/community/regional outcome data

<>Montgomery (1993) 2 medical-dental outreaches, evaluated effect on community health,

negligible improvement, ? harm to health delivery system

<>Freire (1970) negative result from interference local processes
<>Hershberger (2004) undesirable impacts on frail, developing healthcare networks
<>Dohn and Dohn (2006) visiting HCPs conflict and interfere with tx by local practitioners

Towards Improvement/Best Practice
Nature of medical outreach is relief; development is need (Dohn and Dohn, 2006)
Developing on-site structures more needed (Ramstad, 2003; Ferranti, 2002)
More than knowledge, treatment/pharmaceuticals, technology (Fountain, 2004)
Best Practice in HealthCare Missions (csthmbest-practices.org)

Towards Effective Missional Nursing
Make disciples and teach
Long-term commitment/engagement required: Time + proximity
(Shelly, 2004)

Education/Educator
"Teaching may be the nurse's most effective role currently" (p 113)
Health educator, colleague internationally
Nursing Process (APIE)
Preparation and training for cross-cultural work (proven competencies)
Language, literacy and congnitive process within culture
Involvement/exchange nursing structures (STT, 2005)

Direct Patient Education on Outreach
Positive outcome on family health r/t common illness in Haiti (Brakke, 1997)
Given by/with nationals, reflect regional realities (Dohn & Dohn, 2006)
Leave it all in the local hands (Bajkiewicz, 1999)
Space-edit, not addressed in article: Health Fairs, Screening Clinics

Community Health Development
Under-developed regions unique, outside Western experience
Millennium Development Goals
UNICEF Facts for Life

Prolonged Engagement
From 10-day trip to 30-day (Nah, 2000)
From 'do' to 'learn' to 'exchange'
Adequate assessment, careful plan, outcome focus, outcome data to guide
Return same location/work

SECTION III: RECENT WORKS OF IMPORTANCE

<>Seager, G., Seager, C., & Tazelaar, G. (2010). The perils and promise of short-term healthcare missions. *Journal of Christian Nursing 27*(3), 262-266.
Expert opinion, selective literature use

<>Tazelaar, G. (2011). Challenges and trends in global healthcare missions. *Journal of Christian Nursing, 28*(3), 152-157.
Expert opinion, selective literature use

<>Department of Health and Human Services
Office of Minority Health
Culturally and Linguistically Appropriate Service standards
Apply same standards to nursing missions? Provocative idea.
www.omhrc.gov
http://minorityhealth.hhs.gov/templates/browse.aspx?lvl=2&lvlid=15

<>Green, T., Green, H., Scandlyn, J. & Kestler, A. (2009). Perceptions of short-term medical volunteer work: A qualitative study in Guatemala. *Globalization and Health, 5*(4). Electronic journal, 13 pages.
Landmark study: Qualitative, N=72, modified GT
"Perceived impact of short-term medical volunteer projects in Guatemala is highly variable and dependent upon the individual project… positive or negative"
Long-term projects (NGO+governmental), short-term volunteers.

<>Walsh, D. S. (2004). A framework for short-term humanitarian health care projects. *International Nursing Review 51*, 23-26.
Expert opinion/descriptive, 'map' for short-term trips to regular project in Jamaica.
Addresses Best Practices and international regulatory needs.

<> Stanley, O. L. & Stanley, M. (2008). Healthcare missions: Mobilizing communities for health. *Journal of Christian Nursing 25*(2), 87-91.
Descriptive/expert opinion example of faith-based community development project.

<>Campinha-Bacote, J. (2005). A Biblically based model of cultural competence in healthcare delivery. *The Journal of Multicultural Nursing and Health 11*(2), 16-22.
Expert opinion, cross-application to cross-cultural work internationally, cultural competencies.

<>Community Health Development: Far Away, So Close
International Non-Governmental Organizations/Regulatory Agencies
U.N. (www.un.org)
W.H.O. (www.who.int)
UNICEF (www.unicef.org)

Global Mortality/Morbidity
- Big 5 Communicable Killers: Resp infection, HIV/AIDS, diarrhea, TB, malaria
- Vaccine-preventable deaths: 1.5 million/year

UNITED NATIONS Millennium Development Goals 2015

UNICEF 'FACTS FOR LIFE' www.unicef.org/ffl

*Timing Births	*Immunizations	*HIV / AIDS
*Safe Motherhood	*Diarrhoea	*Injury prevention
*Child Development	*Coughs, colds & serious illness	*Disasters and Emergencies
*Breastfeeding	*Hygiene	
*Nutrition and Growth	*Malaria	

SECTION IV: 2011 'RE-VISIT' OVERVIEW OF THE LITERATURE

Key word search (CINAHL, Medline, EBSCO) 2001- June 2011:
Healthcare missions, Missionary nursing
Excluded UN, UNICEF, WHO, PAHO and World Vision-produced works, Office of Minority Health standards

Results:
649 articles reviewed:

0 LEVEL I: systematic review or meta-analysis, evidence-based clinical practice guidelines based on systematic reviews of RCTs
0 LEVEL II: Evidence obtained from at least one well- designed RCT
0 NOTE: Regulations from governmental or regulatory agency given "high level" evidential ranking
0 LEVEL III: Evidence obtained from well-designed controlled trials without randomization
9 LEVEL IV: Evidence from well-designed case-control and cohort studies (study expatriate and outreach participants, psychologic impact)
1 LEVEL V: Evidence from systematic reviews of descriptive and qualitative studies
584 LEVEL VI: Evidence from a single descriptive or qualitative study
55 LEVEL VII: Evidence from the opinion of authorities and/or reports of expert committees

<>'Descriptive'/Qualitative/Opinion: characteristics
"583 LEVEL VI: Evidence from a single descriptive or qualitative study"
"55 LEVEL VII: Evidence from the opinion of authorities and/or reports of expert committees"
Characteristics found:
History of organization, volunteer demographics, 'honoring' long-term service members
'Service learning' program description (focus on student/learner experience, patients means to end of learning)
Case studies: describe outreach trip and care rendered/patient numbers, types of services on outreach, types of patients seen, methodologies employed (advertisement, gathering supplies, pre-trip preparation, location description)
Self-efficacy of impact on local population and outreach (no pre- and post-intervention data analysis seen)
Note: Self-efficacy subjective, over-estimated (Coffman, Shellman and Bernal, 2004)
One case report of malignant hyperthermia during 'jungle OR' case

Noted overlap/repeat of 10 works used in Selective Review (Bajkiewicz, 2009)

<>Caveat: Community Health
Key word search (CINAHL, Medline, EBSCO) 2001- June 2011:
Community health development
International community health development
Results: 250 studies, 84 cross-reference with 'international', 2001-June 2011
Excluded UN, UNICEF, WHO, PAHO and World Vision-produced works, Office of Minority Health standards
All descriptive/case report/expert opinion

<>Participant-Focused Outreach: Best Practice?
Graves (1997): No mention of impact on regional health, improved indicies
Should participant outcome be THE focus of healthcare missions? Provocative topic.
Outcomes measured by satisfaction/experience of traveler
- Self-actualization goals
- "Self-efficacy" evaluations, altered impact assessment
- Outreach characteristics influenced /'medical tourism' (Scarisbrick, 2002)
- Tourism values over professional cross-cultural nursing

<>INSERT: Re-occurring Theme found
McCarver, P. K. (2008). Healthcare missions: Receiving more than you give. *Journal of Christian Nursing 25*(1), 48-51.

<>Summary: EBP for Best Practices in Nursing Missions
Few 'higher-level' empirical works contributed 2001-June 2011 to guide/inform
Current foundation small descriptive studies/reports, expert opinion
Majority of reports focus on outreach participant
Gap in literature
Significant discordance, disagreement on methodologies and program design
Conflicting data on patient and regional outcomes (descriptive reports –vs- health indicies of regions visited)

<>CLOSING: 15 VALUES AND BEST PRACTICES IN NURSING MISSIONS

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