

National Association of Complementary Therapists in Hospice & Palliative Care

# THE LINK

NEWSLETTER

ISSUE 53

Autumn 2018



Rhythmical Einreibung · Oncology Massage · Aromatherapy in the USA

## FROM THE EDITOR...

Welcome to the Autumn edition of The Link,

This edition features some of the interesting work being done by Fiona Simms on Rhythmical Einreibung and Susan Finlay in Oncology Massage. We also feature our first international guest author, Robin Kessler. Robin discusses her experience delivering Aromatherapy within a US Hospice.

I'd like to thank Katherine Grace and Elaine Carpenter at Sue Ryder Hospice Leckhampton, Lisa Pollock and her team at Great Oaks Hospice and Chris Boot at Shakespeare Hospice for kindly allowing me to interview them. They were so generous with their time and forthcoming with information. In future editions you will hear about the exciting work they are doing in their respective Hospices. I'd also like to thank Jo Cockburns for once again contributing her artwork for the front cover.

In the Spring/Summer edition I mentioned that the Autumn edition would feature a segment on Sound healing. However, it seems I was a little ambitious with my plans! While I was lucky enough to attend a sound therapy session at The Great Oaks Hospice I hadn't anticipated the work involved in putting the sound feature together. So, if all goes according to plan it will be the feature of next edition.

Please continue to send your articles, artwork, photos, poetry, case studies, research and anything else of interest through to me. Also, if you have any ideas for features or articles in future editions please be in touch.

Kallika Bruce  
Editor



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Cover Image:

The cover image is the work of Joanne Cockburn. Her work can be viewed at [www.artbyjo.co.uk](http://www.artbyjo.co.uk)

## LETTER FROM THE CHAIR

Hello, and welcome to the Autumn Edition of Nacthpc Link magazine. I hope you have been out and about enjoying the beautiful weather we have had this summer.

I would like to take this opportunity to thank our Editor Kallika for all her hard work putting together this very interesting Edition. I would like to thank everyone who has contributed and would ask that you assist her with the next and future editions by sending in articles of interest to share with our members.

We all recognise how important research is, so I would like to encourage you to assist Lorraine with her research which you can read about on page 9.

We the committee are continuing to look at the National Guidelines update and have been engaging with experts from the different Therapy Organisations. At the next committee meeting we will be collating the information and updates received and also planning for Conference. We will keep you informed of our progress in the Winter Edition of The Link

We are hoping to plan Conference and AGM for March 2019. Having listened to your feedback from our conference in 2017, we are hoping to return to the Woodbrooke Conference Centre in Selly Oak. If anyone has any suggestions about a theme or Speakers please get in contact with myself or Kallika before the end of the month. As soon as a date and venue is confirmed we will let you know via the Goggle Group, Facebook and the website.

We have been involved in supporting the Chamberlain Dunn Complementary Therapy Awards 2018, I hope at least a few of you have applied. Myself and Angela will be attending the Awards Day in London in October, if any of you are going please come introduce yourselves to us, we would be delighted to see you.

Lastly I would like to thank Moo Barry for her support to NACTHPC over the years and for her assistance with the organisation of the very successful Leads Day in May this year. I wish you well in your retirement.

To all our Members please let us know about all the good work that you are doing out there.

Best Wishes

Michele

## YOUR LINK NEEDS YOU!

**The link is YOUR newsletter and I need YOUR contributions!**

If you can provide an insight into your therapy: or would like to write an article on complementary therapy; or report on events that have happened in your region: an experience you would like to share or send in some poetry then I need to hear from you.

Please send all contributions to NACTHPC either by post or by e-mail

**THANK YOU**

## REGIONAL SUPPORT UPDATE

### Midlands Regional Group News

Moo Barrie, the current coordinator is retiring and therefore will be relinquishing her role as Regional Coordinator at the beginning of November. Anyone interested in this position please email your interest to Moo Barrie or Teresa Barr, Regional Group Liaison

Next meeting is arranged for September 27th 2018 to be hosted by Coventry Myton. Details of programme to be confirmed.

Please email your interest to [therapies@strichards.org.uk](mailto:therapies@strichards.org.uk).

Note: Moo has had great difficulty in getting emails through to some who are supposed to be in the group.

### Northern Ireland News

There are plans to hold a meeting at Northern Ireland Hospice in November, date to be confirmed.

Rhiannon Lewis will be in Belfast for a 2 day workshop on Supporting the Terrain on 3rd and 4th of October organised by Action Cancer and there will be a 2 day workshop for Complementary Therapists organised by MacMillan on Enhanced Skills for Treating Patient's with Cancer.

Please contact Michele Gordon for more details

### Central and Southern News

The Regional Meeting was hosted by Nicola Middleton at St Michaels Hospice Basingstoke on Monday 9th July. Six members attended the five-hour meeting and topics included training and development of therapists, National Guidelines, service development and governance.

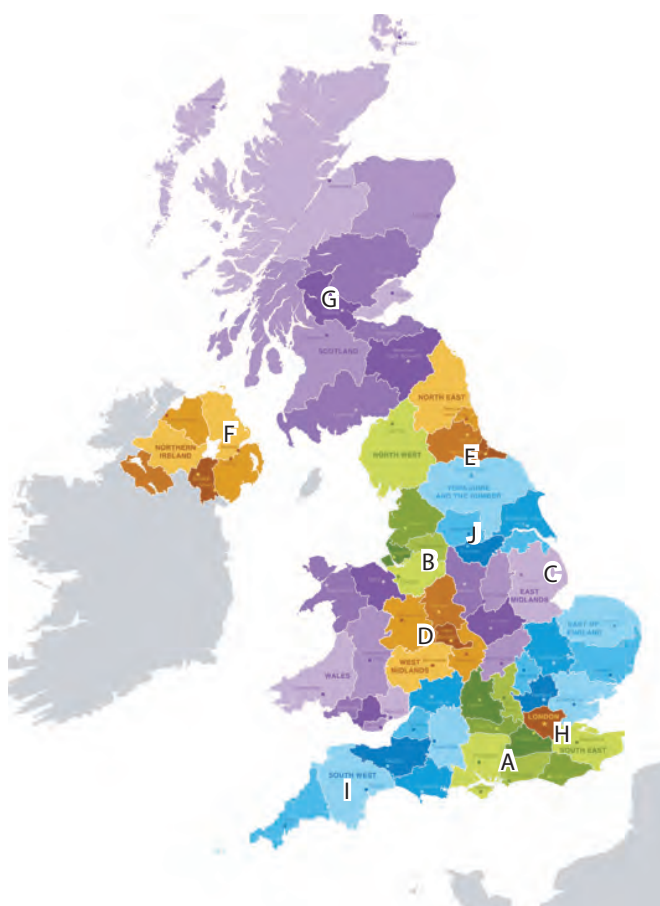
Next meeting: Wednesday 14th November at Countess of Mountbatten Hospice, Southampton contact Charlotte McDowell for more details

Regional Study Day: Friday 5th October 2018 9.30 – 3.15pm at Phyllis Tuckwell Hospice Care, Farnham. The program will include Feng Shui and the Emotional Body, Pranic Healing and Therapies Through Nature. The cost is £20 and it's open to all members staff and volunteers. Forward enquiries to: Angie Shepherd Complementary Therapy Team Lead [angela.shepherd@pth.org.uk](mailto:angela.shepherd@pth.org.uk) 01252 729437

### North West News

Pauline Burdsall is standing down as Regional Support Group Coordinator and applications are now open for the position. Please contact Regional Group Liaison, Teresa Barr for more information or to express your interest for the position.

Map of NACTHPC Regional Groups



*Scottish Regional Group*

## NACTHPC NEW EXECUTIVE COMMITTEE

Name	Committee Role(s)	Contact Details
Michele Gordon	Chair, Minutes Secretary	michele.gordon@nihospice.org
Awaiting appointment	Vice Chair	nacthpcchair@hotmail.co.uk
Julie Guest	Treasurer	nacthpc treasurer@hotmail.co.uk
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Michele Gordon	Conference Co-Ordinator	michele.gordon@nihospice.org
Kallika Bruce	Conference Assistance	nacthpc conference@hotmail.co.uk

## NACTHPC REGIONAL GROUPS

Group	Contact	Email & Telephone	Address
<b>A</b> Central Southern England	Charlotte McDowell	cmcdowell@nhs.net	Royal Surry County Hospital NHS Foundation Trust
<b>B</b> North West	Awaiting appointment		
<b>C</b> Lincolnshire	Sarah Holmes	sarah.holmes@stbarnabashospice.co.uk 01522 518 209	St Barnanas Lincolnshire Hospice, Hawthorn Road Lincoln, LN2 4QX
<b>D</b> Midlands	Moo Barrie	therapies@strichards.org.uk	St Richard's Hospice, Worcester, WR2 2QT
<b>E</b> North East	Amanda Kirton	amanda.kirton@butterwick.org.uk 01642 607 742	Butterwick Hospice Care Stockton on Tees TS19 8XN
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<b>I</b> South West	Angela Green	angelagreen99@yahoo.co.uk	
<b>J</b> Yorkshire	Julia Moore	juliamoore@suerydercare.com	Wheatfileds Hospice, Leeds

# HOSPICE IN THE SPOTLIGHT

## ST ANNS HOSPICE

At St Ann's Hospice our complementary therapy team has benefited from having a growing team of qualified volunteers to provide patients, their families and carers with aromatherapy, Indian head massage, reflexology, therapeutic massage or Reiki. They provide complementary therapy support over our three sites, Heald Green, Neil Cliffe Centre and Little Hulton.

The hospice is all about providing holistic care, so looking after the whole patient, be that physical, emotional, social or spiritual support.

St Ann's is really fortunate to have a group of experienced volunteers who work alongside staff to deliver therapies. We couldn't offer the range of services to the number of patients we do without them, and we're enormously grateful.

We currently have eight volunteers at Heald Green, four at Little Hulton and two at Neil Cliffe Centre. The volunteers are all from different backgrounds and have different specialities but what they do have in common is their passion for providing complementary therapies and making a difference to the people who use the hospice.

The volunteers see patients staying with us on the In Patient Unit, patients who attend day therapy, out patients, as well as family members, carers and bereaved carers.

Many of the patients we see have complex needs and our therapists are able to adapt the therapies to offer a bespoke service to them. Because of this, and the fact that some of our volunteers often work in isolation with patients or carers, I organise regular peer support

groups for the volunteers to attend so that we can all come together and share best practices and feedback from patients.

Previous sessions have included topics such as 'Grounding and Centring', 'Hands on Therapy' and 'Chanting Meditation'. All the volunteers said they have found having the support of their peers and colleagues has enhanced their experience of volunteering with us.

Our volunteers are also encouraged to access the comprehensive training opportunities provided here at St Ann's. For example, we have an excellent Dementia Care Study afternoon, as well as a specialised training day held twice a year which is tailored to support the therapists. St Ann's also hold regular 'Schwartz Rounds' meetings where people from across all areas of the hospice get together to share their experiences. All of these can, of course, count towards CPD points.

Our volunteer therapists are an essential part of the Complementary Therapy Team and I feel it is important to let them know how much they are valued.

We're currently appealing for anyone qualified in any of the disciplines mentioned to join us. Volunteers should have a minimum of one year's experience in their chosen therapy. A full induction is provided to all successful applicants who come to donate their time to us, and it's an extremely rewarding experience.

*For more information, or to apply to be a complementary therapy volunteer, please contact Louise Fleming, Volunteer Manager at the hospice on 0161 498 3653 or email [lfleming@sah.org.uk](mailto:lfleming@sah.org.uk)*

● **Written by Tina Dennett, Complementary Therapy Practitioner at St Ann's Hospice**



## DATES FOR THE DIARY

**27th September:** Midlands Regional meeting: see details in Regional Support Update

**3rd and 4th of October:** Rhiannon Lewis will be in Belfast for a 2-day workshop on Supporting the Terrain on organised by Action Cancer

**5th October:** Central and Southern England Regional Study Day: See Regional Support Update for further details

**8th – 12th October:** Module 1 Rhythmical Einreibung

**14th November:** Central and Southern England Regional Meeting: See Regional Support Update for further details

**11th – 15th February 2019:** Module 2 Rhythmical Einreibung

**14th – 16th June 2019:** Module 3 Rhythmical Einreibung



Countess  
Mountbatten  
Hospice  
Charity  
02380 475313  
www.cmhcharity.org.uk

### COMPLEMENTARY THERAPIST (VOLUNTEER)

Countess Mountbatten Hospice is expanding our Complementary Therapy service and seeking practitioners to deliver Reflexology, Massage, Aromatherapy or Reiki across our 27 bed inpatient unit, Hazel Centre (day care) and home hospice.

#### We offer:

- A dedicated Complementary Therapy Coordinator
- Ongoing support, mentoring and in house training/supervision
- Experience working within a multi disciplinary team

For an initial discussion please contact Kallika Bruce - Complementary Therapy Coordinator [kallika@cmhcharity.org.uk](mailto:kallika@cmhcharity.org.uk) or phone 07434 357403

## BOOKS AND RESOURCES

### LIFE IN A HOSPICE BY ANN RICHARDSON

*Life in a Hospice* sets out the stories of hospice nurses, doctors, managers and others, including some complementary therapists, in their own words. They talk with great honesty about the nature of their work, why they love it and how it affects their lives. First published by Radcliffe Press in 2007, the book was very well received, with a number of excellent reviews, and was Highly Commended by the British Medical Association in 2008.

Last year, the author re-launched the book with a new cover and a new introduction, at a much reduced price. It is now available as a paperback for £8.99 and as an e-book for £2.99.

*Life in a Hospice: Reflections on caring for the dying* by Ann Richardson (Foreword by Tony Benn) is available from Amazon and other e-book providers (Apple, Kobo and others).

## LIFE IN A HOSPICE

reflections on caring for the dying



Ann Richardson  
FOREWORD BY TONY BENN

**We're on the look out for reviewers. Have you read a book, seen a documentary or used another resource that would be of benefit to others. If so we would love to**

**hear from you,**

**please email**

**[nacthpceditor@hotmail.co.uk](mailto:nacthpceditor@hotmail.co.uk)**

# THERAPIES IN THE HOSPICE

## USING RHYTHMICAL EINREIBUNG IN HOSPICE

### What is Rhythmical Einreibung?

Rhythmical Einreibung (RE) is a method of gentle, therapeutic touch that supports health and relaxation through its warming, calming and harmonising qualities. The word Einreibung is German for “rubbing in” referring to the application of oils and ointments to the body. However the quality of touch used is refined and rhythmical, so to call it a “rub” is far from apt.

RE has been developed by anthroposophic nurses and is used in many clinical settings; it can also be used by members of other medical and allied professions, carers and non-professionals.

### What is Anthroposophic Medicine?

Anthroposophic medicine is an established integrative medical approach which is holistic and health-promoting in its focus. It is person-centred, addressing the physical body, the soul/emotional life and the individuality/spirituality of each person. A multi-disciplinary approach is used with massage therapists, movement, speech and art therapists, doctors, nurses and pharmacists working with this approach.

*For more information see [www.anthroposophicmedicine.org.uk/about/anthroposophic-medicine](http://www.anthroposophicmedicine.org.uk/about/anthroposophic-medicine)*

### My background

I worked for 21 years as a registered nurse at Park Attwood Clinic, which was an Anthroposophic In-patient and Out-patient clinic in Worcestershire. Patients with long term conditions were treated there using this integrated approach. We also offered some end of life care.

When the clinic closed in 2010 I began work at Marie Curie Hospice West Midlands. Initially I worked on the In-patient Unit (IPU) as a Staff Nurse and largely had to put aside my complementary skills. In 2016, supported by a new Nursing Manager and some of the Ward Sisters we began to introduce ‘M’ Technique and some RE into the IPU.

### RE and ‘M’ Technique – how do they compare?

There are quite a few similarities between the two disciplines, they have both been developed by nurses and while derived from massage they are not strictly speaking massage. They are both very low risk, being gentle and following a set sequence and can be used by professionals and non-professionals in certain circumstances. There are essentially no contraindications to using RE; if it is skin you can touch then

you can use RE, so although obviously it wouldn’t be used over a wound or sore, broken skin, it could be used around that area to encourage healing. Proceed with caution during the first trimester of pregnancy.

RE uses mostly a light, sliding contact over the surface of the skin. Each movement is rhythmical, incorporating a slight increase and decrease in intensity; it speaks a language that the body understands. The guidelines for the movements are mostly found from the superficial muscle layer, there are a couple of exceptions, where the contact becomes more “massage-like” and dips into the deeper muscle layers. Like ‘M’ Technique there is an RE for each area of the body, in addition there are 3 different versions for the back – one in lying, one in sitting and one that specifically supports the breathing known as the “asthma back”. The part RE can be combined in a specific sequence to treat the whole body, this is known, unsurprisingly, as the Whole Body Einreibung (WBE). What is more unusual about RE are the organ Einreibung, gentle, brief treatments over specific organs – heart, liver, kidneys, spleen and bladder. There is also a Pentagram Einreibung which uses the essence of the RE quality on small areas at the periphery of the body – forehead, wrist and ankle pulse points and finishes with a touch over the heart, which is a special treatment used as kind of reminder of the inner balance and harmony of the human being.

### What do RE treatments all have in common?

1. They are relatively short, a single part, for example the feet, takes around 5 minutes. The WBE takes around 30 minutes.
2. They are always followed by a rest, which allows the effects of the movement to echo on physical, soul and spiritual levels.
3. Like ‘M’ technique and unlike massage, because the treatments are relatively short and undemanding on the body, they can be repeated several times per day if necessary to help someone who is short of breath or feeling panicky.

Like ‘M’ Technique therapeutic oils or ointments will most commonly be used for RE, however a simple carrier oil or body lotion could also be used, or for the skilled practitioner it is possible (though not easy!) to use no substance at all.

### Using RE in the hospice.

Some of the part RE which are particularly useful in the hospice setting are:

\* Sitting back – for those patients who can’t lie prone but can sit unsupported for a short time, this can be helpful to relax and reduce pain.



\* Asthma back – again this RE is done with the patient sitting upright or leaning forward supported by pillows, it calms and regulates the breathing and is useful for the many people who struggle with breathing difficulties.

\* Legs – as oppose to the positioning for the legs in 'M' Technique where the patient is lying prone, for RE legs the patient is supine with a knee roll positioned to gently support a flexion of the knees. This position is more appropriate and achievable for patients at end of life.

\* Abdomen - this uses gentle, circular movements and encourages a breathing of the tissues, it brings comfort and short-term relief for patients with ascites.

\* Shoulder and knee RE use similar movements to the abdomen and are warming and comforting. Many patients experience shoulder-girdle pain, and while this RE doesn't replace analgesia it can help soothe and relax. These movements can also be used when applying topical prescribed substances like Ibuprofen gel.

### Terminal Agitation

Both 'M' Technique and RE can be comforting for people struggling with terminal agitation, particularly if they have experienced the therapeutic touch previously; it seems that the body "remembers" the quality of touch and can relax.

'M' Technique is simpler to teach to a relative who is sitting at the bedside. It is fantastic to allow someone to feel that there is something they can do for their loved one as they are dying, that they are not just a powerless observer and can actively help.

### Feedback

I currently have 8 hours/week to deliver Complementary Therapies on the IPU and the feedback from patients, relatives and staff is positive. The majority of patients are older and have never experienced any kind of massage; they are mostly open to the idea and enjoy being "pampered" as they put it. More than that, they are grateful to be touched in a respectful, gentle way at what is a difficult time in their lives. They have usually been through some unpleasant, invasive procedures by the time they are admitted to the hospice and they appreciate being able to sit back and receive safe, comforting touch. Patients and relatives realise that these treatment are going beyond the basic necessities of care and appreciate the feeling that they are valued and you have gone the extra mile for them.

Some comments include: *"I feel much less anxious afterwards"*, *"It has really helped my pain"*, and *"I can't believe I can have something so nice here"*.

Nursing staff have commented that the patients are much more relaxed following a treatment and the doctors are very open to the complementary approach, being only too aware that there are limitations to the amount of difference drugs can make to some symptoms, particularly extreme anxiety.

With two other Staff Nurses who are also trained as 'M' Technique trainers for Hand and Foot in Hospice we run regular trainings for staff in all departments. This means that there is often someone on duty who can offer a treatment, in addition to my one day per week and our experienced volunteer therapist who works one evening per week.

I run training in RE at Emerson College in East Sussex; they are Crossfields Institute Quality Mark Courses at Level 4, a new 1 year Foundation Course will begin in October 2018. [www.emerson.org.uk/rhythmical-einreibung](http://www.emerson.org.uk/rhythmical-einreibung)

For more information on RE see "Handbook for Rhythmical Einreibung according to Wegman/Hauschka" edited by Monica Layer published by Temple Lodge.

*Fiona can be contacted at [fiona.sim@mariecurie.org.uk](mailto:fiona.sim@mariecurie.org.uk)*

Fiona Sim qualified as a Registered Nurse in 1986, working initially with children with Special Needs, then with in a Complementary Health Clinic using Anthroposophic Medicine for 21 years. Since 2010 she has been a Staff Nurse at Marie Curie Hospice West Midlands working on the In-patient unit, and for the past 2 years has been implementing Complementary Therapies on the IPU. Since 2008 she has been involved with creating and delivering accredited and recognised courses in Anthroposophic Health Care and operating a small private practice offering Rhythmical Einreibung in clients' homes and at Elysia Therapeutic Centre in Stourbridge. She can be contacted by email: [fiona.sim@live.co.uk](mailto:fiona.sim@live.co.uk)



● Fiona Sim



# Rhythmical Einreibung Foundation Course

Gentle, Therapeutic, Healing Touch

Crossfields Institute  
Quality Mark Course  
at level 4



*'Often the hands will solve a mystery that  
the intellect has struggled with in vain'  
~ Carl G. Jung ~*

[www.emerson.org.uk/rhythmical-einreibung](http://www.emerson.org.uk/rhythmical-einreibung)

## About the Rhythmical Einreibung

Rhythmical Einreibung is a method of gentle, therapeutic touch that focusses and strengthens the patient's powers of self-healing through rhythmical movement.

It is used to support health through its warming, calming and harmonising qualities.

Rhythmical Einreibung is an appropriate treatment for people of all ages and can benefit a wide range of physical and emotional health problems. It can be used as part of nursing care, to apply an oil or ointment to a problem area, as a gentle whole body treatment or as part of the nurturing of family and friends.



## Who can apply?

Originally developed for use by nurses and carers this course is open to everyone; members of medical and allied professions, carers and non-professionals.

No prior experience is required.



## Course Programme

This is a hands-on course, participants will learn by giving and receiving RE. The course comprises of two 5-day and one 3-day module.

Participants need to successfully complete all three modules along with written and practical assessments and report on ten RE treatments to achieve the CI Quality Mark Certificate.

## During the course you will learn:

- RE for different parts of the body.
- Key qualities of RE – anatomy of relevant muscles, how to find the correct orientation for each part,
- How to work with warmth, rhythm and flow
- How to position and cover clients to ensure comfort.
- The indications and contraindications for RE, how and when to use each part.
- Which oils and ointments to use.
- Self-reflection and how to learn from mistakes.

## Course Dates

Module 1: 8th - 12th Oct 2018  
Module 2: 11th - 15th Feb 2019  
Module 3: 14th - 16th June 2019\*

\*Full attendance is required to achieve the Quality Mark Certificate.

For more information or to apply for the course, please email [registrar@emerson.org.uk](mailto:registrar@emerson.org.uk).

Or visit:

[www.emerson.org.uk/rhythmical-einreibung](http://www.emerson.org.uk/rhythmical-einreibung)

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Forest Row, Sussex, RH18 5JX  
+44 (0)1342 822238

Emerson College is part of the Emerson College Trust, registered charity number 312101.

[www.emerson.org.uk/rhythmical-einreibung](http://www.emerson.org.uk/rhythmical-einreibung)



## A THERAPISTS PERSPECTIVE

### ONCOLOGY MASSAGE ARTICLE

My career began in Canada where I trained as a nurse (RGN), I spent a decade working in various departments, from acute medicine to gerontology. I found all of these experiences valuable but unfortunately, when I came to the UK 25 years ago, job satisfaction took a nosedive, but luckily my passion evolved into teaching and providing massage skills to both cancer clients and therapists.

Massage and cancer have never been easy bedfellows, historically massage was considered a contraindication when a client received a cancer diagnosis. In the past, we didn't have the knowledge to work safely, our responsibility as massage therapists, then and now, is to observe and practice 'duty of care', the same principles we operate under for other pathologies like diabetes, arthritis, acute injuries, thus enabling us to offer suitable modifications when planning a session. Knowledge is the key factor that will help us to make adaptations to accommodate our clients' health.

Unfortunately, ignorance spread the unfounded rumour that massage spreads cancer, this is a rumour that is still being refuted, research continues to demonstrate this is not the case, massage is no more carcinogenic than any other normal movement such as brushing your teeth or walking to the bus, yet there is an unwavering belief held by both the public and conventional medicine today that it is.

This has led to a legacy of misunderstanding, one that has resulted in cancer clients being deprived of a therapy that has been proven to impact treatment in significant ways, the benefits ranging from shortening a client's hospital stay to providing valuable support in the form of a greater sense of wellbeing. Massage is not a cure but what we do offer can be of great help.

So what was the next step in my education? The UK did not have any formal provision or training for working with this special group, so I read, observed, worked with oncology clients, used my background in nursing, remedial massage therapy, and teaching to put together something that is useful for both my clients and other therapists. One of the most important conclusions I came to was that clients want to be empowered and to experience those priceless moments of normality, massage has a valuable role to play here.

Eventually, I realised that I had to change my attitude toward clients, it was hard but I had to stop trying to fix them (that is the legacy of working as a remedial therapist), instead, I had to move to simply being there for them. As a result, I adjusted my techniques, but at no point did my clients feel they were getting less, if

anything they understood they were getting more, my sessions became client specific by meeting their individual needs.

Oncology massage is not simply working lighter, slower and observing endless restrictions, it is about seeing what can be offered under the circumstances and implementing a plan that meets their needs. I do think that oncology has defined me as a therapist, it has changed my life and brought greater purpose to what I do. What I could not achieve as a nurse, I now can as a massage therapist.

*References and sources for further reading:*

- 1. Curties, Debra. Could Massage Therapy Promote Cancer Metastasis?*
- 2. MacDonald, Gayle. The Spread of Cancer*
- 3. Cancer Council Australia [www.cancercouncil.com.au](http://www.cancercouncil.com.au)*
- 4. Walton, Tracy. Ethics (Mine), Massage Therapy, and Cancer Spread*
- 5. American Massage Therapy Association <https://www.amtamassage.org/>*

Susan's first love is dance, sport, anything to do with the joy of movement. She trained as a nurse in Canada but soon left the profession when she came to the UK as she wanted a deeper connection with her clients. For many years she worked in both health and fitness, teaching 20+ classes a week and running GP referral schemes. She wanted to make better use of all her knowledge which led her to retrain as a Sport and Remedial Massage Therapist. Currently she is the director of NLSSM The School of Sport and Remedial Massage Therapy and specialises in teaching Oncology Massage. She is the author of Sports Massage: Hands on Guide for Therapists and is the Sports Massage feature writer for Massage World. She is a board member of GCMT, and a PSB member of CNHC. Most importantly she still has a clinic in North London and keeps current with new skills. Join her on Massage Mondays for free weekly massage videos [www.susanfindlay.co.uk](http://www.susanfindlay.co.uk)



● Susan Findlay

**Contributions welcome from staff and  
volunteers welcome (500 – 750 words)  
email [nacthpceditor@hotmail.co.uk](mailto:nacthpceditor@hotmail.co.uk)**

## RESEARCH

### COMPLEMENTARY THERAPISTS NEEDED FOR RESEARCH STUDY



### What Does it Mean to Be a Complementary Therapist Practising in Palliative Care?

*“Phenomenology supports the re-examination of a taken-for-granted experience and, through examining the qualities of the experience, allows us to identify its essence” (Balls, 2009)*

#### Introduction

The proposed study will seek to better understand the experience of Complementary Therapy Practitioners (CTP) working in palliative and end of life care. The primary aim of the research will be to hear the voice of the CTP and the meaning they ascribe to their work.

There is a lack of research into the world of CTP working in palliative care settings and this presents the opportunity to further develop rich data which may contribute to national objectives for palliative care. Objectives include the requirement for organisations to consider the wellbeing of all staff engaged in “this difficult and emotionally demanding work” (National Palliative and End of Life Care Partnership, 2015, p31).

This study intends to identify indicators to support and develop CTP in their role as contributors to multi-disciplinary care (NHS England, 2017). By listening to the voice of complementary therapists in palliative care, can we identify indicators for improved patient care articulated in the strategic aim that “All staff are prepared to care”? (National Palliative and End of Life Care Partnership, 2015, p30).

#### Potential benefits of the study.

As we strive towards the goal of holistic, multi-disciplinary patient care, we may seek to address how Allied Health Professionals and others working in healthcare “can be best utilised to support future health, care and wellbeing service delivery” (NHS England, 2017, p6). Specifically, we may be able to inform how employers can act “to help their staff

avoid the debilitating effects of burn out, avoidance or helplessness resulting from lack of education, training and support” (National Palliative and End of Life Care Partnership, 2015, p30).

The intention to conduct the research will be publicised via the NACTHPC to include participant selection criteria and a downloadable application form. The researcher will not select participants from her employing organisation where she is in the role of CTP Team Leader. This will mitigate issues of coercion, compliance, or the potential to limit a participant’s freedom of expression.

To ensure that the research can be conducted robustly within the given timescale, a maximum of 6 participants who meet the following criteria will be selected.

- \* In current practise and with at least 2 years’ experience of working/volunteering in palliative or end of life care.
- \* Minimum of at least 3 hours equivalent per fortnight of patient contact
- \* Practising one or more of the most common complementary therapies in palliative care: aromatherapy, massage or reflexology (National Association of Complementary Therapists in Hospice and Palliative Care, 2015)
- \* Preparedness to participate in a minimum 1.5-hour interview either face to face or via SKYPE between late September, early October 2018.

Candidates are asked to consider their access to support structures, for example clinical supervision or peer support.

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- **L Millard, 2018.**

*More information on how to get involved will be posted on the NACTHPC google groups in September*

# The efficacy of complementary therapy for patients receiving palliative cancer care

SH Cedar, Melanie White and Anita Atwal

## Abstract

Involving patients in their own care is associated with improved health outcomes. Complementary therapies are popular among patients and enable them to receive the palliative care they want and need. However, the range of complementary therapy services available to patients need to be evaluated for efficacy. This study evaluated the complementary therapy services offered at one cancer outpatient clinic in the UK, with the aim of evaluating the effect of complementary therapies on patient wellbeing and to systematise concerns and categories of wellbeing in order to improve service provision. A sample of 60 patients rated their feelings of wellbeing on a Likert scale before and after a series of six complementary therapies. They were also asked which concerns they had and, after treatment, were asked about factors that may influence their wellbeing. The data were analysed quantitatively by t-test and Wilcoxon signed ranks and the results show a statistically significant improvement in wellbeing. The concerns were assigned into super categories to aid service provision and the other factors that influence general wellbeing were assessed to categorise areas of patient needs that may be addressed in patient care. These results highlight important areas for investigation, which have implications for service provision in palliative cancer care.

**Key words:** ● Cancer ● Complementary therapy ● Patient evaluation

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Many patients with a cancer diagnosis have unmet supportive care needs, resulting in poor quality of life (Wen and Gustafson, 2004), as well as being susceptible to increased problems with quality of life measures, such as insomnia and anxiety (Anderson and Taylor, 2012). The use of quality of life as a primary outcome measure to assess the efficacy of NHS treatments is gradually increasing (Heydarnejad et al, 2011), with patient experience identified as one of the central pillars of quality in health care (Deshpande et al, 2011; NHS, 2017).

The impact on patients' symptom management and wellbeing can be significant evidence to support the ongoing efficacy of a service (Vandergrift, 2013). Nationally, there is an increased emphasis on the need to address palliative care needs using individualised patient-centred approaches (National Institute for Health and Care Excellence (NICE), 2004). The Department of Health (2015) also identified the key principles of palliative care, such as compassionate care, focus on the individual's wellbeing, empowerment and independence, which are now key standards that underpin the NHS in England.

Complementary therapies, such as aromatherapy massage, reflexology and meditation, which run alongside conventional

therapies, focus on the wellbeing of patients, offering benefits for the management of anxiety and stress reduction, to improve patient experience and support quality of life (Anderson and Taylor, 2012; Selman et al, 2012). The objectives of complementary therapy include giving support and comfort, improving wellbeing and helping patients to recapture a sense of control (Browne et al, 2016). This allows for shared decision-making and the co-production of care, i.e. collaboration between service providers and users in developing and implementing care.

In recent years there has been an increase in patient demand for complementary approaches (Browne et al, 2016). However, a study by Berger et al (2013) highlighted the availability of complementary therapies in palliative care services as sporadic, while a survey by Rossi et al (2015) showed variability in treatments and results offered to cancer patients across Europe.

Despite increasing demand for the service, the use of complementary therapies alongside traditional medicine in treating patients with cancer is not extensively supported by evidence from clinical trials (Sheppard, 2015). Although randomised clinical trials may be the gold standard in evidence-based practice, evidence is gathering that supports the concept of patient experience and improved wellbeing for cancer patients using complementary therapies as valid

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methodologies (Briscoe and Browne, 2013). A patient reporting their own increased sense of wellbeing and quality of life is considered valid evidence for services to improve service provision and is therefore considered valuable data to inform recommendations and development (Richardson, 2001; Joly et al, 2007; Black, 2013).

In order to be continually commissioned, improved according to need and to run efficiently, all NHS services should be subjected to ongoing audit and evaluation (NICE, 2004). Moreover, evidence of efficacy to justify delivery is crucial in all fields of health care, including complementary therapies (Briscoe and Browne, 2013).

Designed explicitly for complementary therapies and evaluating supportive cancer care, the Measure Yourself Concerns and Wellbeing (MYCaW) questionnaire analyses patients' views and wellbeing outcomes and measures symptom management (Paterson et al, 2007). Regarded favourably, it has been extensively used and validated in a variety of studies (Paterson et al, 2007; Jolliffe et al, 2015; Browne et al, 2016). The MYCaW questionnaire is the tool used by the service in this study to evaluate treatments. It has been collected for the past 11 years in this service, but has not been fully analysed.

### Clinical setting

The complementary service evaluated in this study was introduced into an NHS outpatient clinic for patients with palliative care needs in 2005. The service rapidly expanded and developed to include individuals with any cancer diagnosis and their carers.

A range of treatments are offered to patients including relaxation and guided visualisation, reflexology, massage, aromatherapy and *shiatsu*. Patients are usually offered a course of six treatments. Patients that are referred to the service are frequently referred for symptom management of anxiety and stress.

Between 2015 and 2016, the complementary therapy service provided 2425 treatments, an increase of 272 treatments on the previous year. The surge of treatments indicated a 13% increase in service activity.

### Aim

A need to evaluate the service was identified in order to enhance the service, gain a better understanding of its reception and gain a sense of patient benefit and wellbeing. This study aims to evaluate the effect of complementary therapies on wellbeing in an outpatient palliative care clinic and to highlight concerns in order improve service provision.

Current evidence has also been drawn upon to make conclusions about the complementary services at NHS Trust and its patient outcomes. Additionally, this analysis seeks to evaluate how well the service is achieving its intended aims of improving patient experience and supporting symptom management and wellbeing.

### Methods

Of those that received complementary therapy between 2012 and 2016, a total of 373 participants completed a MYCaW questionnaire. The sample consisted of a range of patients with cancer, patients receiving palliative care and carers. The inclusion criteria for this study were cancer patients in palliative care and their carers. Many patients who are palliatively unwell do not complete the full course of six treatments, either because they have become too unwell to attend or they may have become housebound. In such cases, follow-up forms were not completed, so these forms were excluded from the selection numbers. A total of 313 forms were excluded from this study. This study draws on data from (n=60) patients.

Using the inclusion and exclusion criteria (Table 1), MYCaW questionnaires were selected for the purposes of data analysis and service evaluation. There was no drop-out group, as questionnaires were selected retrospectively on the basis that they were pre-completed either in whole or in part.

The questionnaires were given out and collected by the therapists twice, once before and once after a course of six complementary therapies. On the first occasion, before any complementary therapy, the therapist helped the patient to fill in the form relating to any concerns or problems they had and how they would assess their wellbeing. The MYCaW questionnaire uses a seven-point Likert scale. This tool allows patients to express and score their perceptions of their wellbeing. Patients' concerns and wellbeing were scored on a Likert scale of 0 (not bothering me at all) to 6 (bothers me greatly).

On the second occasion, the patient was not shown their original form, but was told their

**Table 1. Inclusion and exclusion criteria**

Inclusion criteria	Exclusion criteria
Male and female cancer patients	Carers
Aged 18 years or older	Patients with non-malignant conditions
Completed the MYCaW questionnaires	Cancer patients who are not considered to be palliatively unwell

**Table 2. Paired difference for wellbeing scores (t-test)**

MYCaW score	Before treatment	After treatment	Change in score mean (95%CI)	95% confidence interval of the difference		Sig. (2-tailed)	t-value
	Mean (SD)	Mean (SD)		Lower	Upper		
Wellbeing (n=60)	3.98 (1.408)	2.50 (1.408)	1.483	1.090	1.877	0.001	-5.501

Note: Significant at  $p < 0.01$ , Sig=significance/p; CI=confidence interval; SD=standard deviation; n=number

original concerns. The second form allowed them to re-score their wellbeing after complementary therapy.

On the second form there were two ‘free’ questions that participants were able to answer freely, in their own words. The questions were:

- (i) ‘Other than the concerns or problems gathered and measured previously, what other concerns or changes have been most important for you?’.
- (ii) ‘Reflecting on your time with this centre, what were the most important aspects for you? (Write overleaf if you need more space)’.

These two questions were not scored on the Likert scale, but were used to look at the range of concerns and to add to the qualitative analysis.

In order to interpret the information and address the research aims, a mixed methods approach for quantitative and qualitative analysis was used, including the t-test and the Wilcoxon signed ranks (De Winter and Dodou, 2010).

Data was anonymised in accordance with the Data Protection Act (1998) and the NHS Trust and University Clinical Governance procedures.

### Results

The information contained in this study does not identify any individual or organisation and cannot be used to determine any identities. Data that was collected by the complementary therapies service has not previously been systematically or rigorously reviewed.

This study included 60 participants: 73% female (n=44), mean age 62 years and 16% male (n=16), mean age 64 years. Table 2 shows the age distribution chart: 55% of patients aged

61–85 (n=33), 42% of patients aged 41–60 (n=25) and 3% of patients aged 18–40 (n=2).

### Wellbeing

All patients (n=60) answered: ‘How would you rate your general wellbeing now?’. Table 2 shows the wellbeing scores before and after complementary therapy treatment. Mean changes in scores were significant:  $p < 0.01$ , a mean change of 1.483 (95% confidence interval (CI) 1.090–1.877).

For the purpose of this study, the probability ( $p$ ) value has been used in a two tailed test. This showed a statistically significant difference that after complementary therapies, patients felt increased wellbeing. The associated  $z$  value of the difference between before and after scores equals -5.501. This is significant and shows that there is an improvement in concerns scores after receiving complementary therapies. Further analysis of these scores was performed using Wilcoxon signed ranks (Table 3).

From the 60 questionnaires analysed, a ‘before’ score for wellbeing was documented on a scale of 0 (not bothering me at all) to 6 (bothers me greatly). The ranked data has produced two totals, one for ‘before treatment’ and for ‘after treatment’. The results indicate that scores ‘before treatment’ had an average rank of 28.57 and ‘after treatment’ had an average rank of 13.21. The Wilcoxon signed-rank test statistic ( $W$ ) is the smaller of the rank totals. Using the sum of ranks, the Wilcoxon critical value for  $W$  is significant for  $n=42$  (0 scores are discounted). As the Wilcoxon signed-rank critical value shows that the observed difference between both measurements is significant, the results indicate that there is an improvement in wellbeing scores after receiving complementary therapies.

The 60 completed MYCaW questionnaires reported a wide range of 21 concerns that patients most wanted support with (Figure 1).

### Category breakdown of concerns or problems

Using framework analysis, a breakdown of the 21 ‘concerns or problems’ was performed. The initial

**Table 3. Wellbeing scores (Wilcoxon)**

Wellbeing		n	Mean rank	Sum of ranks
After score - before score	Negative ranks	45	28.57	1285.50
	Positive ranks	7	13.21	92.50
	Ties	8		
	Total	60		



categories identified from the questionnaires were then organised into super categories:

- Super category 1 (psychological and emotional) = anxiety, stress, confidence, agitation, grief, mood, depression, anger, body image, general wellbeing, insomnia and relaxation
- Super category 2 (physical; respiratory) = breathlessness
- Super category 3 (physical; nervous system) = pain, neuropathy and pruritus
- Super category 4 (physical; musculoskeletal) = fatigue, comorbidities and weakness
- Super category 5 (physical; gastrointestinal) = constipation, nausea

Other things affecting your health

After a series of complementary therapies, 31 patients out of 60 (52%) answered this question (*Figure 2*).

Data were reviewed from these 31 questionnaires, and the clear themes which arose were arranged into categories. The responses for this question were lower, as not all follow-up forms were completed. It appears that not all participants felt that they had significant information to include in this section (*Figure 2*).

What were the most important aspects of the treatments for you?

After the course of six complementary therapy treatments, 50 patients of 60 (83%) answered this question. Data were reviewed from these 50 questionnaires. Clear themes arose which were arranged into categories upon advice from the complementary therapy clinical lead. Similar to the ‘other things affecting your health’ question, the response rates for this question were lower as not all follow-up forms were completed. It also appears that not all participants felt that they had significant information to include in this section. The responses were: ability to relax (53%), symptom control (21%), having confidence in the therapist and service (14%), positive experience (10%) and understanding and support received (2%) (*Figure 3*).

### Discussion

From these results, it appears that complementary therapies were clinically significant contributors to patients’ feelings of wellbeing. From the qualitative analysis, many of the factors that emerged as aspects of wellbeing (*Figure 3*) improved after complementary therapy. However, one

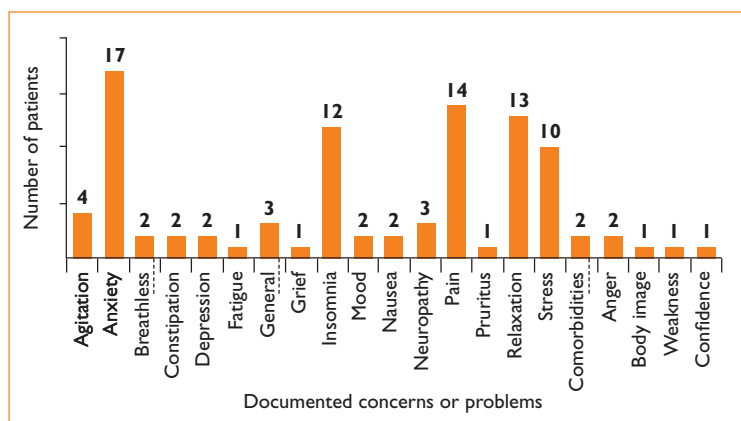


Figure 1: Concerns or problems (n=60)

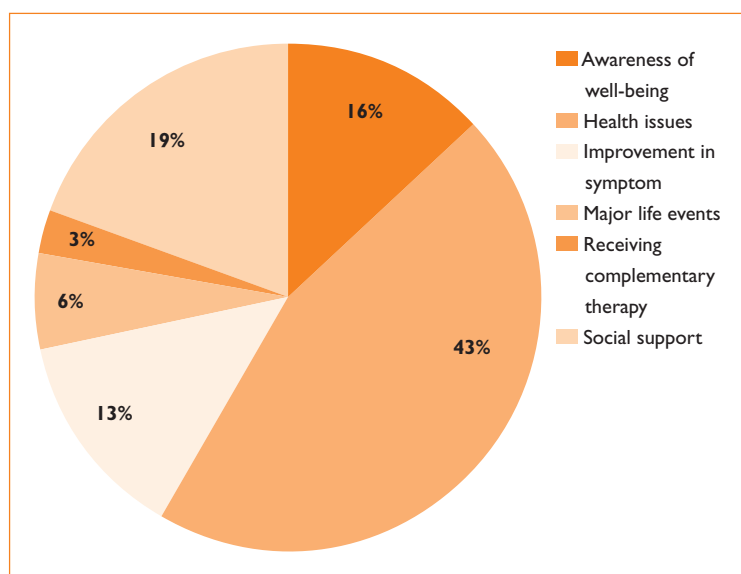


Figure 2: Other things affecting your health

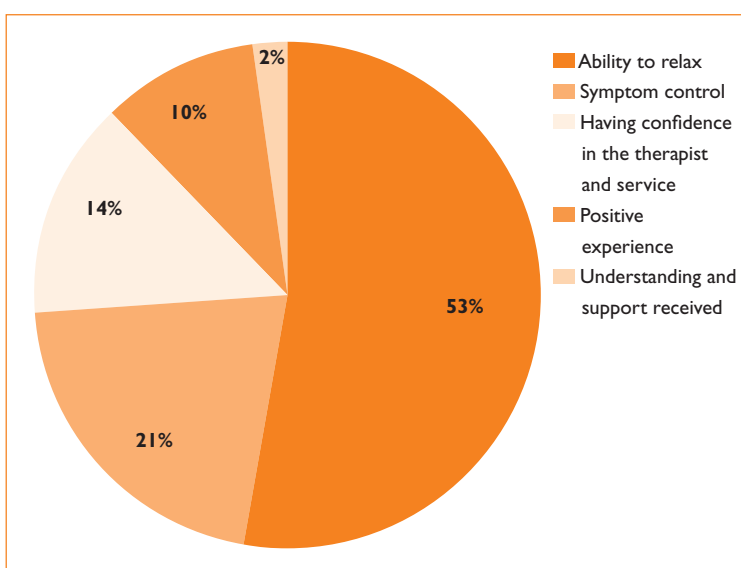


Figure 3: What were the most important aspects of the treatment for you?

limitation of the research is that patients' understandings and perceptions of their own wellbeing can differ. The state of being 'happy' or 'healthy' is subjective and may change at any time, which could have impacted on the scores recorded.

Many different concerns and problems affected the patients (*Figure 1*). Themes emerged and were sorted into super categories, and it is hoped that these super categories can assist service providers in targeting provision of complementary therapies appropriately. These super categories may also be of use to service providers as prompts to guide conversations with patients about their concerns. In this way, a more comprehensive view of the concerns of the patient can be obtained, as topics are less likely to be forgotten by the patient or service provider.

*Figure 2* shows that patients' main focus was their health. However, it also shows that there are a wide range of other concerns for patients, such as social support (19%), awareness of wellbeing (16%), improvement in symptoms (13%), major life events (6%) and receiving complementary therapies (3%). This highlights the complexity of factors which contribute to patient wellbeing, aside from the patient's health.

Super category 1 (psychological and emotional) contained one of the most common concerns for patients' wellbeing: relaxation. In *Figure 3*, the ability to relax was ranked as the most important aspect of receiving complementary therapy by patients. This demonstrates the efficacy of complementary therapies for addressing patient concerns and improving aspects of patient wellbeing.

These findings suggest that complementary therapies can have an impact on symptom management and wellbeing in cancer patients. The results suggest that the complementary

therapy service reviewed is successful in meeting its objectives and aims of improving quality of life for patients with a cancer diagnosis. However, further research into the efficacy of complementary therapies is required.

It should be noted that the improvement in patients' reported wellbeing after receiving complementary therapies may be due to factors other than the complementary therapies alone. The extra time, care and attention given to patients during these treatments may also have had a positive effect on their wellbeing. Comparing the different types of complementary therapies with one another may be useful in establishing this.

### Recommendations

On the basis of the information obtained from this service evaluation, the following recommendations have been made for improving complementary therapy service provision. Many patients spend their last year of life at home. Patients want to be informed about service availability and envisage services to be available, well coordinated and accessible, particularly at the end of life (NICE, 2004). With this in mind, short term recommendations to ensure that services are equitable to all, including those that are housebound, include:

- Home visiting service
- Availability of NHS transport for appointments

The NHS have stated that one of their priorities is to improve patient choice in outpatient services by 2020 (NHS, 2016). To achieve this aim, the following short term recommendations are made:

- Extending the courses of treatments on offer
- Broadening the types of complementary therapies available

### Ethical considerations

Information obtained during this service evaluation has not deviated from local standards or clinical practice requirements or posed any risks to patients or health care professionals (Data Protection Act, 1998) and conforms to NHS and Nursing and Midwifery Council standards.

### Conclusion


Evaluations of services provide evidence of efficiency which guides providers, informs on objectives, assesses financial value and identifies opportunities for improving current practice. The necessity of evaluation in improvement of support services is paramount to improving patient care. Patients' preferences and experiences can be as

### Key points

- The use of complementary therapies and involving patients in their own care is associated with improved health outcomes
- This study evaluated the complementary therapy services offered at one cancer outpatient clinic in the UK
- Conclusions suggest that complementary therapies are beneficial in the palliative care setting to improve symptom management and wellbeing for patients with a cancer diagnosis

important as evidenced clinical outcomes in instructing a more well-rounded body of knowledge of patient-centred care.

It is acknowledged that the costs and implications of cancer are immeasurable. Death incidence rates are steadily increasing and there are substantial annual NHS costs, along with additional costs associated with loss of productivity.

Conclusions from this service evaluation suggest that complementary therapies are beneficial in the palliative care setting to improve symptom management and wellbeing for patients receiving palliative cancer care. The NHS Trust complementary therapies service evaluated here appears to be meeting its objectives to improve the quality of life of its patients and provides a model for these services in other settings. 

#### Declaration of interests:

The authors have no conflicts of interest to declare

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## Continuing professional development: reflective questions

- What role do you think complementary therapies have in delivering good palliative care?
- Which other clinical areas do you think the use of complementary therapies could improve?
- How do you know if a patient's wellbeing improves?
- Think of time when complementary therapy could have helped a patient in your care.

# AROMATHERAPY

## HOSPICE AND AROMATHERAPY IN THE USA- MY EXPERIENCE

### What is Hospice?

The short version, Hospice is a specialized type of care for those facing a life-limiting illness, their families and their caregivers. Hospice care addresses the patient's physical, emotional, social and spiritual needs. Hospice care also helps the patient's family caregivers.

### What you need to know before you even decide on working with Hospice Patients.

The first thing you need is lots of compassion and patience. You will be seeing things you will probably never saw before and some of it can be very scary. Those in hospice are probably not going home. They are in Hospice because they can no longer take care of themselves and need round the clock care. Some will pass slowly while others will pass in a matter of days. Also most of these patients are on lots of medication and some are not able to communicate to you at all.

This is where the compassion and patience comes in. You also have to detach yourself from them or you will become so stressed out you will not be able to deal with any of it.

That is the first step. If you can get through this, you can get through any challenge that comes your way.

I highly recommend that you become a Certified Aromatherapist. You will need to know all about essential oils and all their chemical makeups. You will need to know which essential oils can interfere with the prescription drugs they are taking. You will need to know what dilution to use. For the elderly and those in hospice it is recommended to go no higher than a 1% as per dilution Robert Tisserand's recommendations (1) because these people have very thin skin and you do not want to harm any of them. So you will need to understand what and how to blend with percentages.

I also highly recommend you get the book *Complementary Nursing in End of Life Care* written by Madeleine Kerkhof-Knapp Hayes. This book gives you everything clinical you need to know. It is also written with great compassion. It has become my bible. Before you decide you want to get into this field you really need to read this book and of course be certified otherwise you will not understand a lot of what Madeleine writes about. Madeleine describes everything you need to know about which are the best oils to use.

I also recommend you get the book by Robert Tisserand- *Essential Oil Safety: A Guide for Health Care Professionals 2nd Edition*. Besides giving you a

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description of all the oils, he give you the interactions with prescription drugs.

### So what's next?

Now that you are all equipped you need to find a Hospice Centre willing to trust you and understand what Aromatherapy is all about. In the Northeastern part of the USA where I live it is very hard to get into this field. Most have absolutely no clue what Aromatherapy is and how it can help hospice patients. I have gotten many slams in the door. Either I am told, "We do not need this type of therapy" or they do not have the funds to pay for the service. Also unless you are a Massage Therapist or nurse you will have a hard time getting hired. These people have licenses. Aromatherapists do not, so they are more to open a door if you are one. You can incorporate your aromatherapy into your practice. If you are a Hospice nurse and have the correct certification in aromatherapy, you are home free. I am neither, so for me it was way harder.

### So What do you do?

The best way is to get your foot in the door is to volunteer. Lots of hospice centres need volunteers as helpers. Most beg for those who are willing to volunteer their time. You will have to take a course through the hospice centre on the do's and do nots you can do. What to do in an emergency situation. What to do if you see something not right, as if the patient is not getting the correct care or is being harmed in any way. What part of the body can you touch?

I had to go through an extensive course which was about 2 hours AFTER I read all guidelines and instructions. I even took a mini test. As an Aromatherapist and not a nurse or massage therapist, I cannot touch any part of a client's body. I can explain how to use something and use my own body as an example. As a hospice trained volunteer I am allowed to touch ones hands and face to give assurance and compassion. Once you are a volunteer you can gain the respect and trust of the centre or organization and then you can ease in aromatherapy by explaining how you might be able to help the patient. You have the credentials behind you which helps greatly. If they open an ear- you now have that one foot in the door.

For me, Stein Hospice was actually looking for an Aromatherapist, but more on a volunteer basis. They went through many applicants. Most were not certified and did not have the experience nor education working with essential oils. Luckily I did and that was a huge plus, besides working in a nursing home when I was younger as a volunteer.

Because most of these organizations rely on funding, aromatherapy gets the back burner, and what they are willing to pay you was no way near what my consulting

fee is for my other clients. That is where compassion and love for working with those who really need it comes into play.

### Now comes the next hard part.

Once you are hired and have gone through their training, you need to sign HIPA forms. You are not allowed to discuss your patient with anyone other than the hospice person you are assigned too. This is basically what you are when you are certified and working with a client.

I worked it out with Stein that I needed an intake form. So we worked on it together to get the information I needed. I need to know what they are looking for and a diagnosis of why the patient is in hospice. I needed to know what medicines the patient is on. What are they allergic to? What smells did they like or did not like. Were they in a private room or with other patients?

I wanted the person who was close to them, ie a husband or wife, a sibling etc and that person's phone number so I could learn a bit more about the patient. Most cannot communicate well and this really helps me to figure out what essential oils I can use by going back to their younger years through talking to their family. This really helps because if they hated the smell of lavender, well then I could not put it into a blend I wanted to make. Once I receive the form I get to work. Most in hospice have lots of stress and anxiety issues, or have trouble sleeping. Some have dementia or Alzheimer's Disease with major laps of memory loss and that makes them extremely fretful.

### Methods of Using Aromatherapy

#### Diffusing:

Those in private rooms I will use a diffuser. Most rooms are very small with just a bed and a dresser and a comfortable chair for a loved one. I have found by putting 3-4 drops of a blend this is enough, when I put more oils in the diffuser I found by feedback from caretakers is way to strong smelling, it was actually effecting them also. I put strict instructions to run the infuser no more than 1 hr on 2-3 hours off. These instructions sit on the wall pinned near their bed so whoever is there from hospice knows what to do. Unfortunately when a diffuser is used in a nursing home environment, sometimes they tend to disappear. When a patient is in "in home hospice care" it is much easier to use the diffuser, less chance of theft.

#### Sprays:

For those not in private rooms and also where I find the diffusers disappear, I will use a spray bottle. I will normally start with a 2 oz bottle just in case the blend I make does not work. I will fill the bottle with Vodka/ Distilled Water, Castile Liquid Soap, Polysorbate 20 as an emulsifier plus the essential oils at a 1% dilution. I instruct to spray lightly the patient on both shoulders (as

long as they are wearing clothing), bedding and also the tops of blankets. They can do this depending on what I am using it for 3-4 times a day. Again instructions are placed on the wall near a bed for the caretakers and the hospice nurse.

#### Inhalers:

I only use inhalers if the patient is homebound so that the caretaker or the loved one can put the inhaler up to their nose so they can inhale the blend. I do not like to do this in the nursing home because there is less control and they tend to get thrown in the garbage or get lost.

#### Patch:

A patch placed on the shoulder so that the patient can smell it all day and no one else can, has become my best friend. I have experimented with some of these and found they tend to fall off. I wore them myself and some fell off after a few hours and some after a few minutes. I finally found one that you can wear all day and when taking it off you can actually re use it, up to a week. The company name is Bioesse and it is the only one I found that actually works the best. You place 2-3 drops of a blend onto the pad and the smell will last all day. You can remove it when clothing is changed and put the same one back on. I found it will last about 2 weeks as long as the clothing that it is going on is not wool. The instructions on how to use it is right on the patch but I reinforce it with instructions that is placed again on one's wall.

#### Topical:

Hospice patients are bedridden or in wheel chairs. Their skin tends to be very dry. Because I am not allowed to massage one's body, only one's hands, this can get to be a dilemma on what to do. What I have been doing is making a lotion with Shea butter (3), fat extracted from the nut of the African shea tree (*Vitellaria paradoxa*), coconut oil (extracted from the kernel or meat of mature coconuts harvested from the coconut palm (*Cocos nucifera*)). (4) and jojoba oil which is the liquid produced in the seed of the *Simmondsia chinensis* (Jojoba plant) (5). All 3 are very soothing to the skin. I will whip it all up so that it is very light and fluffy. I can massage on hands but that is as far as I can go. So I will ask the caretakers or nurse assigned to this patient to massage it into the rest of the body.

I tend to not use topical applications with essential oils because I am the one who know how to do this and with so many untrained in aromatherapy I do not want to take the chance and have it applied incorrectly. What I will use for hurting hands is to make a Frankincense *Boswellia Carterrii* or Serrata Resin salve that has been infused in jojoba oil. Carterri Resin is excellent for skin conditions (6) and Serrata is good for muscle aches and joint pain(7). There are less safety precautions when

using resins. I will still instruct the caretaker and nurse how to apply it.

### Armed now what?

Now that you have swallowed all this information what is next?

As said I get the intake form from the Hospice Organization. I determine what the problem is. I will give you an example. The names are made up and the information I am giving are just examples of how I proceed.

Jane Doe is 95 years old. She is in Hospice because she can no longer take care of herself and she needs the extra care only that a hospice organization can give her. She has terrible stress and anxiety because she has dementia and finds she cannot place where she is. The hospice organization would like something to keep her calmer and less stress. She also does not like to be touched. I will receive an intake form describing all the problems including everything I talked about earlier.

Normally when I get a new patient I will go to the nursing home or the patient's home to observe what is going on and to get a "feel" of what she is all about. This observation gives me a better way of determining what I want to make for her. Once I am back at my office, I go through all her paperwork then I call the nurse in charge to get any other information I should know about her. I call her family member, in this case I called her daughter. I will ask her "What did your mom do when she was younger. Was she a homemaker or did she work and what was her job? What did she like to do for hobbies and do you know anything about her childhood?"

In this case Jane was a stay at home mom. She was Italian decent and loved to make lots of dishes with rosemary and loved the smell of it. She also loved to work in the garden and plant flowers. You might think why would I want this information? Think about what she liked.

When I went to visit Jane for the first time she was in bed. I started talking to her and she almost bit my head off and told me to get out. Well I did not because I really wanted to get a feel of

what she was like. She totally ignored me but I was able to watch her movements and the tension around her.

When I left her and got back to my office, I knew what I wanted to do. I decided on the oils I would use and checked them to the 20 different prescription drugs she was on and checked her medical history. As a side note, because so many of these patients are on all kinds of drugs for their illness, I have created an excel spreadsheet to keep track of what interferes with which oils and it is so easy to refer too. I add to it when new drugs come into play.

I decided on using Rosemary Verbenone (*Rosmarinus officinalis var verbenonea* *Rosmarinus officinalis ct. verbenone*), a soft and gentle rosemary that energizes and stimulates the mind. (8)

Jane cooked with Rosemary in her soups so I also thought she would like the smell

Coriander (*Coriandrum sativum*) it is calming and balancing and can help with depression.(9)

She used Coriander in her chicken as a spice, so this oil would work too. It would also hopefully bring her back to a happy time

Geranium (*Pelargonium graveolens*) it invites acceptance and can create a relaxing and harmonizing atmosphere (10)

Neroli-Petitgrain Co-distillation Essential Oil (*Citrus aurantium var. amara*)

I came upon this oil by accident and it has become one of my favorite oils. I normally would use Neroli but it is so expensive and I wanted an alternative that was similar but not so expensive. A colleague of mine told me to try this one, so now I am hooked. It is soothing and so relaxing for the mind. (11)

She loved the smell of sweet flowers, Geranium and the Neroli-Petitgrain would work for this.

So I used the drop by drop technique, and put it all together into a bottle, then made a 1% spray in 2 oz of the ingredients I put in a spray bottle.

Three days later I went to the nursing home. This time she was sitting in a wheel chair in the lounge area at a table. On the table was a photo book with her family in it. I sat down next to her and she looked at me with hateful eyes. She did not remember who I was but this was part of her problem. I started talking to her in a low peaceful voice and asked her to tell me who was in some of the pictures. She started to explain some and lots she got wrong. I took out the spray bottle and put it on the table. She asked what that was and I now told her I was the Nice Scent Lady and what was in that bottle she for her and she would like the smell. I sprayed it near but far enough so she could get the scent. She looked directly at me and said she liked it. When she turned to the side I quickly sprayed the top of her blanket. I sat with her a while and she dozed asleep. Now I could spray her shoulders and her pillow. I sat with her to see if she would wake up, when she did she smiled. I then asked her again if we could look at the pictures. This time she allowed me to sit closer to her. Some she got correct some not. I was actually able to joke with her a bit too. Then she stood up. I told her she could not stand up without someone helping her and at that point I called a caretaker that was nearby. They allow her to walk only if two people are holding on to her. She was determined to walk and actually allowed me to hold her left side while the caretaker held her right side. The caretaker

was shocked Jane allowed me to hold her. No one “new” could go near her no less hold her. We passed her room. She actually turned and said that was her room. That was another first that she actually remembered where her room was.

Two minutes later she forgot but this was a very good start for one spray.

We went back to the chair and she fell asleep. I put the instructions on how and when to spray her in her room on her wall. She is still using the spray and the nurses there love me. Jane is less agitated and less stressed. I get reports from the hospice nurse every few days to see how she is doing and when she needs more spray.

I also make a patch for those transitioning into the next realm. When it is almost time to pass, the nurse or hospice organization will email or call me. I try my hardest to get there prior to their passing to try to make it a bit easier. If they are already a patient, it makes it a bit easier because I have all their medical information and everything about them. At this point I would make a custom blend and use the patch and put 3 drops daily on it. Once a patient is in the transitioning phase, normally the caretakers will not change their clothing and this way the patch stays there till they pass on. I will use essential oils of: Roman Chamomile (*Chamaemelum nobile*) which is very relaxing, Lavender (*Lavandula angustifolia*), also soothing and calming, Neroli (*Citrus aurantium* var. *amara*) highly relaxing, Sweet Marjoram (*Origanum marjorana*) helps with the ability to let go, and Frankincense *Boswellia neglecta* which balances and helps with anxiety. If it is a man and he does not like sweet smells, I will sub out the Lavender and Neroli and put in Cedarwood Atlas (*Cedrus atlantica*) (12-14) which is more of a woody smell but still relaxing and calming. I use the drop by drop method till I feel there is enough of a mix in the oils, then I put it into a 2 ml amber glass bottle and it is given to the nurse or caretaker who oversees that particular patient.

I have been using this as a generic for those I cannot get there in time and I am told it is working. The patient is more at peace and relaxed before passing. If I can make it to their bedside before they pass, and I know what smells they like or do not, then I custom fit it to their likings, trying to stay with some of the essential oils above.

I also make a blend in an inhaler for the loved ones who are grieving once the person has passed, I will 5 drops Neroli/Petitgrain Co-Distill (*Citrus aurantium* var. *amara*)- provides rest in though and calming, 5 drops Rhododendron (*Rhododendron anthopogon*) provides settlement and emotional pain and 3 drps Sandlawood (*Santalum albu*) it is good for deeper mediation and to bring back unity. This helps one cope with the passing and also everything else thrown at them.(12-14)

I get reports weekly on how everyone is doing and also if someone needs more or if that particular blend is not working and I have to come up with a different one. Different strokes for different folks, everyone is different so I am determined till I hit the right one.

It gives me great pleasure to help those in need.. One day I might be in their situation and I hope there is someone like me around to use Aromatherapy to help me be more comfortable and to pass on sweetly.

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● Robin Kessler

## NEXT EDITION...

In the next edition of The Link we will be featuring Sound Therapy and Music. If you use music in any way within your hospice I'd love to hear from you. Maybe you run Sound Healing sessions for patients, host concerts or music events, have a Hospice Choir or perhaps you gig as a fundraising exercise. I'm looking for articles, photos, stories and anecdotes.

Please email me with ideas [nacthpceditor@hotmail.co.uk](mailto:nacthpceditor@hotmail.co.uk)

**Deadline for Winter edition of  
The Link is:**

**Friday 16th November**

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