COMPLEMENTARY THERAPY POLICY

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POLICY STATEMENT:-

To formalise the delivery of complementary therapies and ensure a consistent approach using best and safe practice measures.

To provide a framework for the provision, management and development of complementary therapies.

CORRESPONDING POLICIES:-

- Policy for informed patient consent
- Lone working policy
- Electronic patient record policy
- Hand decontamination policy
- Complementary Therapy Volunteer policy
- Waste management policy

SCOPE:-

This policy refers to complementary therapies being provided to inpatients, outpatients, patients at home, as well as carers, the bereaved and staff.

This policy refers to complementary therapies being provided in the Inpatient Unit, Complementary Therapy treatment rooms and off site locations to patients, carers, the bereaved and staff.

This policy refers to the provision of Massage, Aromatherapy, Reflexology, Shiatsu,

Relaxation techniques, Reiki, Mindfulness Based Stress Reduction and other Complementary therapies as agreed by the Executive Team.

DEFINITIONS:-

Complementary therapies are those therapies which are used in conjunction with conventional medical, nursing and allied health professional treatments, and counselling.

Qualified Complementary Therapists are staff and volunteers who are registered with a regulatory body [1,2] for the therapy practiced, and who are insured to practice the said therapy.

TRAINING:-

Complementary Therapists will be responsible for ensuring the knowledge and skills required for practice are current and up to date.

Therapists will complete mandatory training requirements in accordance with their practice setting.

RESOURCES:-

Rowcroft will make available current Guidelines and Code of Conduct and Professional Practice (Federation of Holistic Therapists, revised 2014)

EQUIPMENT:-

To include: massage table, back massage chair, Lafuma chair,reflexology stool, therapist's stool, Howarth trolley, CD player and range of CDs or Ipod, body and neck cushions, meditation mats, stools and cushions, Shiatsu mat, towels, pillows, blankets, aromastreams fan, therapist bag, laptop and Laundry bin.

Consumables to include oils and creams - essential oils, carrier oils, foot balm, hand cream.

CONTENT:-

1. **General**

1.1 Staff and volunteers refer all enquiries regarding complementary therapies to the Complementary Therapist Co-ordinator.

1.2 Staff and volunteers report incidents/accidents/adverse reactions in relation to the use of complementary therapies or the complementary therapy service to their Line Manager and Complementary Therapy Co-ordinator.

1.3 Staff and volunteers follow the risk management policy in relation to incidents and accidents involving carrier oils or essential oils for Aromatherapy.

2. Access

2.1 Rowcroft patients and their carers can self-refer for complementary therapies by contacting the Complementary Therapy Co-ordinator or any member of the MDT.

2.2 All members of the multi-disciplinary team (MDT) can refer patients and carers for complementary therapies either verbally via the Inpatient Unit (IPU) or by completing a referral form on Crosscare followed by Groupwise email to complementarytherapy@rowcroft-hospice.org.uk

2.3 Complementary Therapist completes an assessment for all referred patients, carers, the bereaved or staff for complementary therapies.

2.4 Complementary Therapist reviews all patients, carers, the bereaved and staff following completion of programme of treatment.

3. Practice

3.1 Complementary Therapy Co-ordinator inducts/trains qualified Complementary Therapists on the use of complementary therapies as practiced at Rowcroft.

3.2 Complementary Therapists follow the guidelines for the therapy practiced. Guidelines are held in the complementary therapy office.

3.3 Complementary Therapy Co-ordinator provides or organises supervision for Complementary Therapists, either in a group setting or one-to-one.

4. Aromatherapy Products

4.1 Complementary Therapy Co-ordinator orders essential oils and all other products.

4.2 Complementary Therapy Co-ordinator ensures data sheets are available for those essential oils used in the organisation.

4.3 Aromatherapists prepare blends, for individual patients, for use by massage and beauty therapists, or other complementary therapist practitioners.

4.4 Aromatherapists label blends of oils and creams clearly to include the content, dilution, instructions for external use only, date prepared and expiry date.

4.5 Staff and volunteers use essential oils in aromastreams as directed by the Complementary Therapist and in accordance with manufacturer's instructions.

4.6 Essential oils are stored in a locked and cool environment, in the treatment rooms or in Cedar (COSHH and Health & Safety compliance).

4.7 Staff and volunteers follow the procedure for dealing with accidents with essential oils (see 5.1 to 5.4).

5. Products Used in Other Therapies

5.1 Complementary Therapy Co-ordinator orders equipment and products used in other therapies e.g. CDs for relaxation, music CDs, in consultation with Complementary Therapists with specific expertise.

6. Other Policies

6.1 This policy is to be read in conjunction with all other policies at Rowcroft including confidentiality.

PROCEDURES:-

7. Dealing with Adverse Reactions and Accidents with Essential Oils

7.1 Skin reaction to undiluted essential oil – staff and volunteers add carrier oil or Diprobase to the area in order to dilute the essential oil, then wash the area with un-perfumed soap and water and dry; keep the bottle to show content, and seek medical assistance. The IPU maintain a stock of Diprobase.

7.2 Undiluted essential oil splashed in the eye – staff and volunteers irrigate the eye with milk or carrier oil (to dilute), then with water; keep the bottle to show content, and seek medical assistance.

7.3 Ingestion of unknown or excessive quantity of essential oil – staff and volunteers to seek medical assistance, give the person milk to drink and keep bottle to show content.

7.4 Undiluted essential oil spillage and breakages – staff and volunteers to wear gloves to prevent skin from contamination with undiluted oil, soak up the oil with paper towel and collect glass, dispose of glass in sharps container or wrap in layers of newspaper and dispose in secured polythene bag in sharp's container. Ventilate the area.

Increasing Range of Therapies

7.5 Complementary Therapy Co-ordinator discusses proposal with their directorate, providing information on the suggested therapy such as a description of the therapy; evidence base for use in supportive and palliative care; qualifications and training of therapists; patient information leaflet.

7.6 Complementary Therapy Co-ordinator submits the proposal to the Executive Team.

7.7 Complementary Therapy Co-ordinator provides training or information to staff on the use of the new therapy and referral process as agreed by the Executive Team and Q&PS.

REFERENCES

1. National Guidelines for the Use of Complementary Therapies in Supportive and Palliative Care, Marianne Tavares, The National Council for Hospice and Specialist Palliative Care Services (2003).

2. Complementary Therapy Guidance (2012). Peninsular Cancer Network 6.1, 6.2, 6.3, 6.4, 6.5, 6.6. Criteria for Complementary Therapies Guidelines, version 3.0. 28/7/12

3. Guidelines and Code of Conduct and Professional Practice. Federation of Holistic Therapists, revised 2014

APPENDICES

1. Protocol for the Use of Complementary Therapies.

2. Guidelines for the Use of Aromatherapy/Massage/Shiatsu/Reiki in Palliative Care.

3. Guidelines for the Use of Reflexology in Palliative Care.

4. The Use of Essential Oils in Diffusers.

5. List of Essential Oils & Carrier Oils currently used by the Complementary Therapy Team at Rowcroft for use in Massage.

APPENDIX 1

PROTOCOL FOR THE USE OF COMPLEMENTARY THERAPIES

1. Specialist Palliative Care patients and their carers can self-refer by contacting Rowcroft Hospice, the Complementary Therapist Co-ordinator or other members of the Multi-Disciplinary Team (MDT).

2. All members of the MDT can refer patients, carers and the bereaved either verbally via the Inpatient Unit or by completing a referral form on Crosscare, followed by Groupwise email complementarytherapy@rowcroft-hospice.org.uk

3. Each referral to have an individual holistic assessment of their needs, encompassing physical, emotional, psychological and spiritual needs.

4. Co-ordinator to inform outpatients' General Practitioner of referral to the service.

5. When treatment programme agreed, patient to be given a verbal explanation of the therapy and the expected outcome. Written information to be available.[1]

6. Verbal consent to be obtained and recorded in the patient notes on Crosscare. If verbal consent is unobtainable treatment may be given after consultation with the family/MDT and if deemed to be in the patient's best interest.[2]

7. After liaising with the patient, treatment will be planned and delivered as per the guidelines.

8. Evaluation of treatment to be carried out prior to further sessions.

9. All treatments to be documented on Crosscare. This will include details of any therapeutic benefits and outcomes.

10. Treatments given with regard to patients' dignity at all times.

References

1. Peninsular Cancer Network, Complementary Therapy Guidance (2012) 6.9 Written Information
2. National Guidelines for the Use of Complementary Therapies in Supportive and Palliative Care (2003). Prince of Wales's Foundation for Integrated Healthcare and National Council for Hospice and Specialist Palliative Care Services. 8.3 Consent
3. Peninsular Cancer Network, Complementary Therapy Guidance (2012) 6.10 Consent
4. Patient Documentation Completion Policy. Rowcroft Policies. Approved Sep 2009
5. Peninsula Cancer Network, Complementary Therapy Guidance (2012) 6.11 Record Keeping

APPENDIX 2

GUIDELINES FOR THE USE OF AROMATHERAPY, MASSAGE, SHIATSU, REIKI IN PALLIATIVE CARE

Aromatherapy massage, Massage without the use of essential oils, Shiatsu and Reiki are Complementary therapies used within the hospice to promote relaxation and an increased sense of well being. The sensitive use of massage and therapies encourages release of tension within the muscular system and calms the respiratory and nervous systems. This can contribute to a person's perceived quality of life.

General Contra Indications for Touch

- Areas of unexplained pain, inflammation, swelling.
- Areas of septic foci, contagious skin conditions, rashes and lesions.
- Locally over varicosed veins, phlebitis.
- Recent scar tissue, sites of recent surgery.
- Avoid limb with recently diagnosed or suspected deep vein thrombosis.
- Avoid stoma sites, dressings, catheters, TENS machines.
- Friable and sensitive skin
- Confusion

Specific Precautions / Contra Indications for People with Cancer

Radiotherapy

- Entry and exit sites to be avoided for up to two weeks after treatment has been completed. Check with patient to assess if skin is tender, sore or sensitive
- Be aware of possible side effects, such as fatigue, soreness of skin and digestive disturbance.

Chemotherapy

- If undergoing active treatment use only gentle massage
- Be aware of possible side effects, such as extreme fatigue, nausea, altered sense of smell, lowered immune function, increased risk of bruising, altered sensation of extremities.

- Modify pressure, approach and duration of session to take into account the patients preference and their physical and emotional condition.

- Be guided by patient's body language and consider part body massage/treatment and shorter session.

- Massage not to be used directly over tumour sites or lymph nodes affected by cancer.

- Only treat lymphoedematous limbs or areas if working in conjunction with the Chronic Oedema Team.

- Avoid areas of bone metastases. Gentle touch may be appropriate.

- Essential oils may be added to dressings or a tissue within the patient area.

- Patients with skin allergies to be patch-tested prior to administration of essential oils.
- Be aware of sensitive, friable skin.

It may be appropriate to continue to use massage/gentle touch as the patient condition changes/deteriorates, or when dying. This should be with sensitivity and consideration of the individual, the family and the staff involved in the care.

APPENDIX 3

GUIDELINES FOR THE USE OF REFLEXOLOGY IN PALLIATIVE CARE

Reflexology is based on the principle that certain points on the feet, hands or face, called reflex points, correspond to all parts of the body. By applying pressure to these points in a systematic way, a practitioner can help to release tensions, promote the flow of energy and encourage the body's natural healing processes. This sophisticated system of touch aims to treat the individual, with a view to alleviating physical and emotional symptoms by promoting relaxation, relief from tension and anxiety, and improving well-being.

General Contra Indications

- Areas of unexplained pain, inflammation, swelling.
- Areas of septic foci, contagious skin conditions, rashes or lesions.
- Locally over varicosed veins, phlebitis.
- Recent scar tissue, sites of recent surgery.
- Friable and sensitive skin.
- Avoid during the first 3 months of pregnancy.

Specific Precautions/Contra indications for People with Cancer [1]

- Modify pressure, approach and duration of session to take into account the patient's preference and their physical and emotional condition.
- Be guided by patient's body language and consider light pressure and a shorter session.
- Only gentle and sensitive palpation or holding over the reflex points related to tumour site(s).
- Only treat lymphoedematous areas if working in conjunction with the Chronic Oedema Team.
- Adjust pressure for patients with low platelet count, taking note of any existing bruising and skin viability.
- Be aware that peripheral neuropathy may be a symptom of disease or treatment side effects.
- Be aware that peripheral sensation may be affected by the person's psychological state, medication or chemotherapy.

- Establish a working pressure that is comfortable for the patient at all times.
- Consider Reflexology to the hands or face if unable to treat the feet.
- Sensitivity to the patient's emotional state may require change of pace and the use of a reassuring holding technique.
- Use oils or creams as appropriate, consider patient preference.
- Discontinue treatment if patient dislikes the touch on the feet, or becomes very uncomfortable.

Reflexology can be offered as a vital source of comfort, nurture and healing for people in emotional distress. It is essential that people feel positive about the potential of the treatment. A full explanation and the sensitivity of an experienced practitioner can lead to a positive experience for the patient.

References

1. National Guidelines for the Use of Complementary Therapies in Supportive and Palliative Care (2003). Prince of Wales's Foundation for Integrated Healthcare and National Council for Hospice and Specialist Palliative Care Services. 13.2 General Contraindications b) Reflexology

APPENDIX 4

THE USE OF ESSENTIAL OILS IN DIFFUSERS

1. Introduction

1.1 There are situations when there may be offensive odours surrounding patients with particular conditions. These odours are often distressing and embarrassing for the patient and their carers. Essential oils may mask or absorb these odours, and are an aid to preserving the dignity of patients, as well as promoting their comfort.

1.2 Inhaling the aroma of essential oils may also be calming, uplifting or relaxing, and may help patients to sleep better.

1.3 Essential oils are dispensed via electrical diffusers and can also be placed on a tissue, external dressing or on bedclothes.

1.4 Burners that require candles and are not used due to the risks involved in having an open flame left unattended.

2. Electrical Diffusers

2.1 Aromastreams or Aromastones are electrical diffusers used to diffuse essential oils, which are then inhaled.

2.2 An Aromastream is a fan-assisted diffuser which has a cartridge at the bottom to which essential oils are added. The cartridge is removable and essential oils are added to the side which faces upwards. The whole cartridge is changed between patient-use, or alternatively, the gauze in the cartridge is renewed.

2.3 An Aromastone is a ceramic dish used to diffuse essential oils. The oils are added to a small amount of water, and are diffused in steam as the liquid is warmed. Aromastones are cleaned when essential oils are changed, and in-between patient-use. Aromastones are unplugged for cleaning with a cream cleanser.

2.4 The electrical diffusers are stored in Cedar and the Complementary Therapy office.

2.5 In case of break down with the equipment, the Complementary Therapist Co-ordinator is informed and a replacement organised.

3. Choice of Oils

3.1 Apart from the properties of the different essential oils, the choice of oil is also guided by the patient's preference.

3.2 The following is a list of oils and criteria for use (see List of Essential Oils Appendix 5 for references for each of the oils below):

Essential Oil	Criteria for use/ properties	Number of drops	Notes
Bergamot FCF (Citrus Bergamia)	Uplifting, refreshing, relaxing, use with offensive odours	Up to four drops (light smell)	
Lemongrass (Cymbopogon Flexuosus)	Use with offensive odours	Up to three drops (very strong smell)	
Lavender (Lavendula Angustifolia)	Calming, uplifting, relaxing, aids sleep, use with offensive odours	Up to three drops (very strong smell)	Not everyone likes lavender
Peppermint (Mentha Piperita)	Stimulating – do not use at night, may disturb sleep, use with offensive odours	Up to 3 drops (strong smell)	
Sandalwood (Santalum Album)	Calming, relaxing, uplifting, aids sleep, use with offensive odours	Up to three drops (strong smell)	

3.3 Use a maximum of two oils at any one time, and a maximum of five drops in total.

4. Method of Use

4.1 Any of the following three methods can be used to diffuse essential oils. Choice of method may depend on the availability of equipment, and the condition of the patient and/or room.

4.2 In a shared room, consideration is given to the smell preferences, allergies and conditions of other patients. For example, the smell of the oils may exacerbate the breathing difficulties of other patients. It may be more appropriate to diffuse essential oils via a tissue in a shared room.

4.3 If the patient develops a headache after inhaling the oils, this may mean that the smell or dose is too strong. Either reduce the number of drops or change to a different oil or turn off the appliance. In any event open the window to air the room, and encourage the patient to drink a glass of water, if appropriate.

4.4 If the offensive odour is such that the appliance is left on for the whole day, oils will need to be replenished every three to four hours. If the patient develops a headache with the continuous use of essential oils for inhalation, refer to 4.3.

4.5 Change the oils to a different aroma every three to four days.

Aromastream

4.6 Aromastream is the safest appliance if the patient can reach out and touch the equipment. The Aromastream diffuses aroma of essential oils in the room, via the inbuilt fan.

4.7 Remove the cartridge at the base; add essential oils (one drop of oil to one segment) to the side facing upwards. Some oils, e.g. lavender and lemongrass have a very strong smell, so always check the patient's smell preference).

4.8 Change the cartridge or the gauze in the cartridge when the Aromastream is used with a different patient.

Aromastone

4.9 Aromastone is placed away from the patient's reach, as the ceramic dish may be warm/hot to touch if left on for more than 30 minutes. The Aromastone diffuses aroma of essential oils in the room, via heat.

4.10 Add a small amount of water to the Aromastone before adding the essential oils.

4.11 Clean the Aromastone with a cream cleanser when changing essential oils, after using the dish and when used with a different patient.

Via a tissue, external dressing or bedclothes

4.12 If the odour is very strong and distressing for the patient or carers, consider dispensing one or two drops of the essential oil on a tissue, external dressing or bedclothes, as well as using the Aromastream or Aromastone.

4.13 If essential oils are used to help the patient calm down or sleep better, this method allows the aroma to be inhaled immediately.

4.14 The patient's smell preference is particularly important as the aroma from the oils will be very close to the patient.

5. Documentation

5.1 The use of essential oils to be included in the patient's Crosscare notes.

6. Storage

6.1 Essential oils are stored in a cool and dark place, in the cupboard in Cedar.

6.2 Essential oils should be kept in a locked cupboard, when not in use, in order to comply with COSHH and Health & Safety requirements.

6.3 A record of oils must be kept (COSHH regulations 2002)

7. Advice

7.1 If in doubt, consult Complementary Therapist Co-ordinator or the Aromatherapist.

8. Accidents and Adverse Events

8.1 These are reported under the Policy for Reporting of Adverse Incidents and to the Complementary Therapist Co-ordinator and according to the Complementary Therapy Policy (see 5.1 to 5.4).

APPENDIX 5

LIST OF ESSENTIAL OILS AND CARRIER OILS CURRENTLY USED BY THE COMPLEMENTARY THERAPY TEAM AT ROWCROFT HOSPICE FOR USE IN MASSAGE

1. Documentation

1.1 The use of essential oils to be included in the patient's Crosscare notes.

2. Storage

2.1 Essential oils are stored in a cool and dark place, in the cupboard in Cedar or in the Complementary Therapy office.

2.2 Essential oils should be kept in a locked cupboard, when not in use in order to comply with COSHH and Health & Safety requirements.

2.3 A record of oils must be kept (COSHH regulations 2002)

3. Accidents and Adverse Events

3.1 All accidents and incidents to be reported as per Rowcroft policies and procedures. Also these are reported to the Complementary Therapist Co-ordinator and according to the Complementary Therapy Policy (see 7.1 to 7.4).

4. The choice of oils on this list reflects:-

- currently available scientific research (see Reference list)
- the professional judgement of the practitioners
- past experiences of patient needs
- the practicality of safely storing and using a limited quantity of oils
- the cost of the oils

This is not a definitive list of essential oils that may be used on people with cancer or with Palliative Care patients. It will be updated annually to take into account changing circumstances.

Benzoin *(Styrax benzoin)*
Bergamot (FCF) *(Citrus bergamia)*
Black Pepper *(Piper nigrum)*
Chamomile, Roman *(Chamaemelum nobile)*
Clary Sage *(Salvia sclarea)*
Eucalyptus *(Eucalyptus radiata)*
Frankincense *(Boswellia carteri)*
Geranium *(Pelargonium graveolens)*
Ginger *(Zingiber officinalis)*
Lavender *(Lavendula angustifolia)*
Lemon *(Citrus limon)*
Mandarin *(Citrus reticulata)*
Marjoram *(Origanum majorana)*
Myrrh *(Commiphora myrrha)*
Neroli *(Citrus aurantium)*
Patchouli *(Pogosteman patchouli)*
Peppermint *(Mentha piperita)*
Petitgrain *(Citrus aurantium)*
Rose absolute *(Rosa centifolia)*
Rosehip *(Rosa mosqueta)*
Rosemary *(Rosmarinus officinalis)*
Sandalwood *(Santalum album)*
Tea Tree *(Melaleuca alternifolia)*
Thyme *(Thymus vulgaris)*
Ylang-ylang *(Cananga adorata)*
May Chang *(litsea cubeba)*

LIST OF OILS TO BE USED IN THE DIFFUSERS

Bergamot (FCF) *(Citrus bergamia)*

Lemongrass *(Cymbopogon flexuosus*

Lavender *(Lavendula angustifolia)*

Peppermint *(Mentha piperita)*

Sandalwood *(Santalum album)*

JUSTIFICATION FOR THE CHOICE OF ESSENTIAL OILS USED AT ROWCROFT HOSPICE

- Indications for use.
- Relevant information.

Benzoin *(Styrax benzoin)*

Comforting for griping pains in stomach and urinary tract infections (Davis 2000).

Good for nervous tension and stress (Lawless 2014).

Non-toxic and non-irritant (Lawless 2014).

Bergamot FCF *(Citrus bergamia)*

Has a relaxing, refreshing and uplifting quality and has been used in the treatment of depression and stress related conditions and anxiety (Komori et al 1995).(Lawless 2014).

Rectified bergamot oil is furano-coumarin free (FCF). This oil (unlike unrectified bergamot) is not phototoxic (Tisserand and Balacs 1995).

Non-irritation and non-toxic (Lawless 2014).

Black Pepper *(Piper nigrum)*

Mildly analgesic (Price 1999) and useful in the treatment of pain (Buckle 1997).

Has antiviral and bactericidal properties, is a good expectorant and stimulating to the nervous system (Caddy 2000).

No irritation or sensitization at 4% when tested on humans (Price 1999).

Non-toxic, non-sensitising (Battaglia 2002)(Lawless 2104).

Chamomile Roman *(Chamaemelum nobile)*

Found useful in palliative care (Evans 1999), to help reduce anxiety in cancer patients (Wilkinson 1999) and for pain relief (Buckle 1997).

No irritation or sensitization at 4% when tested on humans (Lis-Balchin 1995).

Non-toxic, non-irritant (Lawless 2014).

Clary Sage *(Salvia sclarea)*

General tonic for mental and nervous fatigue (Lawless 1992).

Helpful where muscular tension arises from mental or emotional stress (Davis 2000).

Non-toxic, non-irritant and non-sensitising (Battaglia 2002)(Lawless 2014).

Avoid during pregnancy (Lawless 2014).

Eucalyptus *(Eucalyptus radiata)*

Good for people who are tired, run down or prone to frequent colds (Davis 2000).

Helps disperse negative feelings (Mojay 1996).

Non-toxic, non-irritant and non-sensitising (Lawless 2014).

Frankincense *(Boswellia carterii)*

Found useful for respiratory problems (Price 1999; Buckle 1997), depression (Price 1999), and has a mild analgesic effect (Price 1999; Buckle 1997).

No irritation or sensitization at 8% when tested on humans (Lis-Balchin 1995).

Non-toxic, non-irritant, non-sensitising (Lawless 2014).

Geranium *(Pelargonium graveolens)*

Found useful in palliative care (Evans 1999) and for anxiety and depression (Price 1999).

No irritation or sensitization at 10% when tested on humans (Price 1999).

Non-toxic, Non-irritant and generally non-sensitising (Lawless 2014).

Ginger *(Zingiber officinale)*

Found useful in palliative care (Evans 1999).

Has deodorant and analgesic properties (Price 1999).

Remedy for nausea (Buckle 1997).

Non-toxic, non-irritant (Lawless 2014).

Lavender *(Lavandula angustifolia)*

Lavender as part of a blend found to ameliorate anxiety in cancer patients (Corner et al 1995) and found useful in palliative care (Evans 1999).

Diffused lavender found to be anxiolytic in dialysis patients (Itai et al 2000), and to aid sleep in the elderly (Hudson 1996 and Hardy et al 1995).

Lavender was relaxing in a massage for patients with brain tumours (Hadfield 2001), slowed and deepened respiration in post cardiotomy patients (Buckle 1993), and improved mood and levels of anxiety in intensive care patients (Dunn et al 1995).

No irritation or sensitization at 10% when tested on humans (Lis-Balchin 1995).

Non-irritant, non-toxic and non-sensitising (Lawless 2014).

Lemon *(Citrus limonum)*

Lemon as part of a blend found to ameliorate anxiety in cancer patients (Corner et al 1995).

Diffused citrus fragrance (including lemon) had a positive effect on depression (Komori et al 1995).

Vaporised oils including lemon used to deodorise and disinfect hospital air (Bardeau 1976).

No irritation or sensitization at 10% when tested on humans (Lis-Balchin 1995).

Non-toxic. Phototoxic so avoid using on skin and then exposing to the sun (Lawless 2014).

Mandarin *(Citrus reticulata)*

Promotes relaxation and sleep (Buckle 1997; Price 1999)

Good for indigestion (Price 1999).

No irritation or sensitization at 8% when tested on humans (Price 1999).

Non-toxic, non-irritant and non-sensitising (Lawless 2014).

Marjoram *(Origanum majorana)*

Found useful in palliative care (Evans 1999).

Vaporised oils including marjoram used to deodorise and disinfect hospital air (Bardeau 1976).

Has a tranquillising, sedative effect (Price 1999).

Antimicrobial properties (Deans and Svoboda 1990).

No irritation or sensitization at 6% when tested on humans (Lis-Balchin 1995).

Non-toxic, non-irritant and non-sensitising (Lawless 2014).

Not to be used during pregnancy (Lawless 2014).

MayChang *(Litsea cubeba)*

Useful for relieving fatigue and lethargy with a refreshing, stimulating, uplifting action. Known as the 'oil of tranquility'. Useful for stress and inability to switch off (Lawless 2014).

Non-toxic, non-irritant (Lawless 2014).

Myrrh *(Commmiphora myrrha)*

Useful remedy for treating dyspepsia and loss of appetite (Lawless 1992).

Installs a deep sense of calm and tranquillity of the mind (Mojay 1996).

Non-irritant and non-sensitising (Lawless 2014).

Not to be used during pregnancy (Lawless 2014).

Neroli *(Citrus aurantium)*

Found useful in palliative care (Evans 1999).

Intensive care patients perceived psychological benefit including relief of anxiety from the addition of neroli oil to foot massage (Stevenson 1994).

Sedative, good for anxiety and depression (Price 1999).

No irritation or sensitization at 4% when tested on humans (Lis-Balchin 1995).

Non-toxic, non-irritant, non-sensitising and non-phototoxic (Lawless 2014).

Patchouli *(Pogosteman patchouli)*

Antiseptic, anti-inflammatory and mild bacterial actions (Dye 1992).

It is helpful for all forms of depression, anxiety and stress related conditions (Davis 2000).

Non-toxic, non-irritating and non-sensitising (Lawless 2014).

Peppermint *(Mentha piperita)*

Found useful for nausea, headaches (Price 1999); has an analgesic effect with reduction in sensitivity to headache (Gobel et al 1995).

Vaporised oils including mint used to deodorise and disinfect hospital air (Bardeau 1976).

Peppermint generally considered safe at 4% (Lis-Balchin 1995).

Non-toxic, non-irritant (Lawless 2014).

Petitgrain *(Citrus aurantium)*

Useful for stress and anxiety (Price 1999) and for chronic bronchitis (Buckle 1997).

Strong antibacterial and anti fungal action (Price 1999).

No irritation or sensitization at 7% when tested on humans (Lis-Balchin 1995).

Non-toxic, non irritant, non-sensitising and non-phototoxic (Lawless 2014).

Rose absolute *(Rosa centifolia)* **Rose otto** *(Rosa damascena)* **Rosehip (***Rosa Mosqueta)*

The most diverse therapeutic properties of all essential oils, effective for all levels of life, for the soul, spirit and body (Worwood 1995).

Mild sedative and anti-depressant, excellent for emotional shock, bereavement, grief and treatment of melancholy (Davis 2000).

Rosa mosqueta promotes tissue regeneration and is good for scars, burns, wrinkles (Lawless 2014).

Rose absolute, Rose otto, Rosehip are non-toxic, non-irritating and non-sensitising (Lawless 2014).

Rosemary *(Rosmarinus officinalis)*

Vaporised oils including rosemary used to deodorise and disinfect hospital air (Bardeau 1976).

Useful for indigestion, headaches and migraine (Price 1999).

Has analgesic effects (Buckle 1997).

For the commonly held belief that Rosemary should not be used on people with high blood pressure: “there is no support to be found anywhere in available literature” (Guba 2000).

No irritation or sensitization at 10% when tested on humans (Lis-Balchin 1995).

Non-toxic, non-irritant and non-sensitising (Lawless 2014).

Avoid during pregnancy (Lawless 2014).

Sandalwood *(Santalum album)*

Sedative, calming (Price 1999); comfort to the dying, used in incenses and meditation (Caddy 2000).

No irritation or sensitization at 10% when tested on humans (Lis-Balchin 1995).

Non-toxic, non-irritant and non-sensitising (Lawless 2014).

Tea tree *(Melaleuca alternifolia)*

Excellent antimicrobial and antifungal action and useful in the treatment of MRSA carriage (Nelson 1997; Carson et al 1995).

No irritation or sensitization at 1% when tested on humans (Lis-Balchin 1995).

Non-toxic, non-irritant, possible sensitisation in some individuals (Lawless 2014).

Thyme *(Thymus vulgaris)*

Urinary tract antiseptic, useful for all infections of the bladder and urinary tract (Davis 2000).

Good for energising emotional and mental levels (Lawless 1998).

Non-toxic and non-irritating (Lawless 2014).

Ylang ylang *(Cananga odorata)*

Useful for stress (Price 1999), anxiety, fear and shock (Caddy 2000).

No irritation or sensitization at 10% when tested on humans (Lis-Balchin 1995).

Non-toxic and non-irritant (Lawless 2014).

CARRIER OILS

JUSTIFICATION FOR USE OF CARRIER OILS (VEGETABLE OILS) USED IN MASSAGE.

Definition

Carrier oils act as a lubricant making it possible to carry out massage movements and also as a base oil to dilute essential oils used in Aromatherapy.

Sweet Almond Oil *(Prunus amygdalus var dulcis)*

This is available cold pressed or refined; it is one of the most used carrier oils.

Sweet almond oil finds use as an emollient in many pharmaceutical and cosmetic products (National Formulary Board 1975).

Food allergy involves almost exclusively the protein component of foods. Full refining of oils results in the almost complete removal of protein (Creuel et al 2000).

Suitable for all skin types, especially dry, ageing and inflamed skin (Beckman H & Le Quesne, 2005).

Grapeseed Oil *(Vitus vinifera)*

This is not available cold pressed. The refined oil has no known contraindications and is non-toxic (Price 1999). Good emollient (Beckman H & Le Quesne, 2005).

Note

In the consultation process every patient seen by the Complementary Therapy team is asked about allergies. Any allergy, which might affect the choice of vegetable oil, is noted and considered when choosing the oils for a patient.

ESSENTIAL OILS USED IN DIFFUSERS

All these oils have a strong smell useful for masking malodours. The amount of essential oil absorbed from diffusers used in the way suggested in Rowcroft Policy will be smaller than the safe limit for each oil (Guba 2000).

Bergamot *(citrus bergamia)*

The vaporised oil helps prevent the spread of germs in the atmosphere and creates a pleasing uplifting fragrance (Lawless 2014).

It is an effective deodorising agent (Battaglia 2002).

Non-irritation or sensitisation. Non-toxic (Lawless 2014).

Lemongrass *(Cymbopogon citratus)*

A powerful antiseptic and bactericide, refreshing and deodorant (Davis 2000).

The antiseptic properties of lemongrass indicate that it would be excellent in a vaporiser to disinfect the air (Battaglia 2002).

Non-irritant, non-sensitising (Tisserand and Balacs 2000).

Non-toxic (Lawless 2014).

Lavender *(Lavendula angustifolia)*

Used in hospital wards as an airborne fragrance to refresh and purify the air and generally create a relaxed atmosphere (Lawless 1998).

It has long been used to freshen rooms. (Davis 2000).

Non-toxic, non-irritant and non-sensitising (Lawless 2014).

Peppermint *(Mentha piperita)*

Ideal for use in an oil burner in situations in which clear thinking and mental stimulation are required (Battaglia 2002).

Vaporized oils including mint used to deodorise and disinfect hospital air (Bordeau 1976).

Non-toxic, non-irritant (Lawless 2014).

Stimulating may disturb sleep (Battaglia 2002).

Sandalwood *(Sandalium album)*

Has a sweet powerful lasting odour (Ryman 1997).

It gives off fragrant fumes, its slightly spicy scent is purifying (Lawless 1998).

Non-toxic, non-irritating and non-sensitising (Lawless 2014).

REFERENCES

Bardeau F (1976). Use of essential oils to purify and deodorise the air.
Chirugien-Dentiste de France (Paris) 46(319):53

Battaglia S (2002). The Complete Guide to Aromatherapy 2nd Edition. The International Centre of Holistic Aromatherapy Brisbane Australia.

Beckman H & Le Quesne (2005) The Essential Guide to Holistic and Complementary Therapy.
Habia & Cengage Learning.

Buckle J (1997). Clinical Aromatherapy in Nursing. Arnold.

Caddy R (2000). Essential Oils in Colour. Amberwood Publishing Ltd.

Carson C F, Cookson B D, Farrelly H D, Riley T V (1995). Susceptibility of methicillin-resistant *Staphylococcus aureus* to the essential oil of *Melaleuca alternifolia*. J Antimicrobial Chemotherapy 35(3):421-424.

Corner J, Cawley N, Hildebrand S 1995. An evaluation of the use of essential oils on the wellbeing of cancer patients. Int J Pall Nurs 1(2):67-73.

Creuel R W R, Kerkhoff M M G 2000. Allergenicity of Refined Vegetable Oils Food and Chemical Toxology 38.

Davis P 2000. Aromatherapy – An A-Z. The C D Daniel Company Ltd Saffron Walden UK.

Deans S G, Svoboda K P 1990. The antimicrobial properties of Marjoram (*Origanum majorana L.*) volatile oil. Flavour and Fragrance Journal 5(3):187-190.

Dunn C, Sleep J, Collett D 1995. Sensing an improvement: an experimental study to evaluate the use of aromatherapy, massage and periods of rest in an intensive care unit. J Adv Nurs 21(1):34-40.

Dye J 1992. Aromatherapy for Women and Children. The C D Daniel Company Ltd Saffron Walden UK.

Evans B 1995. An audit into the effects of aromatherapy massage and the cancer patient in palliative and terminal care. Comp Ther in Med 3:239-241.

Gobel H, Schmidt G, Dworschak M, Stolze H, Heuss D 1995. Essential plant oils and headache mechanisms. Phytomedicine 2(2):93-102.

Guba, R. 2000. Toxicity myths – the actual risks of essential oil use. Int J Aromatherapy, 10;1/2:37-49.

Hadfield N 2001. The role of aromatherapy massage in reducing anxiety in patients with malignant brain tumours. Int J Pall Nurs 7(6):279-285.

Itai T, Amayasu H, Kuribayashi M, Kawamura N, Okada M, Momose A, Tateyama T, Narumi K, Uematsu W, Kaneko S (2000).

Psychological effects of aromatherapy on chronic haemodialysis patients. Psychiatry and Clinical Neurosciences 54:393-397.

Komori T, Fujiwara R, Tanida M, Nomura J, Yokoyama M M (1995).

Effects of citrus fragrance on immune function and depressive states. Neuroimmunomodulation 2:174-180.

Lawless J 2014. The Encyclopaedia of Essential Oils. Harper Thorsons: London UK

Lawless J 1998. Aromatherapy and the Mind. Thorsons London UK.

Lis-Balchin M L 1995. The Chemistry and Bioactivity of Essential Oils. Amberwood Publishing Ltd.

Manley C H (1993). Psychophysiological effect of odour. Critical Reviews in Food Science and Nutrition 33(1):57-62.

Mojay G (1996)

Aromatherapy for Healing the Spirit.

Hodder and Stoughton UK.

National Formulary Board (1975).

The National Formulary 14th Edition. American Pharmaceutical Association Washington USA.

Nelson R R S 1997. In vitro activities of five plant essential oils against methicillin-resistant *Staphylococcus aureus* and vancomycin-resistant *Enterococcus faecium*. J Antimicrobial Chemotherapy 40:305-306.

Price S and Price L 1999. Aromatherapy for Health Professionals. Churchill Livingstone.

Price S (2000).

Aromatherapy and your Emotions. Thorsons London UK.

Royal Marsden NHS Trust Policy 356.

Tisserand R and Balacs T (1995).

Essential Oil Safety

Churchill Livingstone.

Woorwood V (1995)
The Fragrant Mind
Doubleday UK.