



Royal College  
of Nursing

# Complementary therapies in nursing, midwifery and health visiting practice

*RCN guidance on  
integrating complementary  
therapies into clinical care*



Royal College  
of Nursing

## Acknowledgements

### **Thank you to all those who have contributed to the development of this guidance:**

All participants in a workshop facilitated by the Prince of Wales's Foundation for Integrated Health, 5 June 2002, King's Fund, London

All members of the RCN Complementary Therapies Forum who identified and discussed issues at the Forum's national conferences from 2000-2003

Premi Bonomally, RCN Complementary Therapies Forum committee

Fiona Barrett, RCN Complementary Therapies Forum committee

Susan Day, RCN Complementary Therapies Forum committee

Julia Fearon, RCN Complementary Therapies Forum committee

Linda Graham, RCN Complementary Therapies Forum committee

Nasim Kanji, RCN Complementary Therapies Forum

Tom Lane, Skills for Health

Celia Manson, Nurse Adviser, Royal College of Nursing

Denise Tiran, Complementary Therapies in Maternity Care National Forum

Lorraine Williams, Prince of Wales's Foundation for Integrated Health

Maureen Williams, Nursing & Midwifery Council

Janet Woolner, RCN Complementary Therapies Forum committee.

### **Angela Avis MBE**

Chair, Royal College of Nursing Complementary Therapies in Nursing Forum

Published by the Royal College of Nursing, 20 Cavendish Square, London, W1G 0RN

© 2003 Royal College of Nursing. All rights reserved. No part of this publication may be reproduced, stored in a retrieval system, or transmitted in any form or by any means electronic, mechanical, photocopying, recording or otherwise, without prior permission of the Publishers or a licence permitting restricted copying issued by the Copyright Licensing Agency, 90 Tottenham Court Road, London W1T 4LP. This publication may not be lent, resold, hired out or otherwise disposed of by ways of trade in any form of binding or cover other than that in which it is published, without the prior consent of the Publishers.

# Complementary therapies in nursing, midwifery and health visiting practice

*RCN guidance on integrating complementary therapies into clinical care*

## Contents

<b>Introduction</b>	2
<b>Part 1. The changing environment for integrating complementary therapies</b>	3
The need for integration strategies	3
Which therapies are appropriate?	3
Putting patient needs first	4
Regulation and guiding principles	5
<b>Part 2: Principles of professional practice for integrating complementary therapies into clinical nursing and midwifery care</b>	6
Establishing parameters of practice	6
Identifying patient needs and outcomes	6
Choice of therapeutic intervention	7
Finding evidence for practice	7
Establishing an integration model	7
Education and training	8
Delivering and evaluating consistent and sustainable practice	10
<b>Conclusion</b>	11
<b>References and further reading</b>	11
<b>Useful contacts</b>	13

# Introduction

The Royal College of Nursing (RCN) Complementary Therapies in Nursing Forum has been inundated in recent years with queries from nurses who are interested in integrating a range of complementary therapies into clinical practice. The Nursing and Midwifery Council (NMC) has also received similar enquiries, many about where to find appropriate training.

It has always been nurses' professional responsibility to ensure that they are adequately prepared if they want to use complementary therapies within their practice – and patients may assume that because nurses are registered practitioners they know what they are doing and what is safe and good for the patient.

However, the NMC regulates nurses and midwives, but not complementary therapy practitioners, and it is outside the NMC's scope to give specific advice on issues such as training in complementary therapies. Because the regulation of complementary therapies is so unclear, the RCN has also been unable to give definitive advice.

This new RCN guidance, therefore, offers a framework that will ensure that nurses follow their professional code of conduct when integrating complementary therapies into clinical care. As well as providing background information, it sets out a model of good practice and explores the answers to key questions.

The *guidance* is just that: it does not set out to tell you what to do. You will need to discuss integrating complementary therapies into your practice with your colleagues, to make sure that the therapies you offer are responsive to clinical needs, conform to principles of clinical governance and meet the legal requirements of your employing organisation.

In an emerging field, there must be flexibility to explore possibilities for the enhancement of care, while at the same time ensuring practice that is safe, appropriate and effective and that is supported by employers and the nursing profession. We hope this guidance document will initiate discussion, and the RCN Complementary Therapies in Nursing Forum will continue to review it in light of responses from nurses, midwives and patients, and of national developments in complementary therapies.

**Angela Avis MBE**

*Chair, RCN Complementary Therapies in Nursing Forum*

July 2003

## 1

# The changing environment for integrating complementary therapies

## The need for integration strategies

Complementary therapies are gaining in popularity (Ernst & White, 2000; Thomas et al, 2001) and finding a more substantial place in health care (Peters et al, 2002). Increasing interest amongst the public (Ong & Banks, 2003) and health care professionals seems to have created an assumption that complementary therapies are widely integrated into nursing and midwifery. Whether this is true is impossible to quantify, because there is no national strategy to collect data, and we have to rely on occasional articles in journals that describe the use of complementary therapies within nursing or midwifery. A small proportion of these articles are based on research projects, but many are anecdotal. A number of trusts have already allocated time and effort to developing integration policies, and it is through such work that standards will be defined and patients assured of care that is safe, appropriate and effective.

In 2000, a report on complementary and alternative medicines (CAM) by the House of Lords Select Committee on Science and Technology (endorsed by the Department of Health in 2001), strongly encouraged the nurses' regulating body (the NMC) and professional organisation (RCN) to collaborate in making familiarisation with complementary and alternative therapies part of the pre-registration nursing and midwifery curriculum. The report also suggested that these organisations should provide more specific guidance on appropriate education and training for integrating complementary therapies into clinical care.

This is no easy task. Many factors contribute to its

complexity, namely:

- ◆ a lack of cohesive strategies for integration at both national and NHS trust level
- ◆ a lack of policy development within trusts to support integration and define parameters for effective and safe practice
- ◆ a lack of understanding about what might be appropriate therapies for integration by nurses within particular clinical areas
- ◆ a wide variation in the education and training available in therapies such as massage, aromatherapy and reflexology.

## Which therapies are appropriate?

Without national or local strategies, there are many instances where particular therapies are being used as the result of the enthusiasm of one or two nurses or midwives. There has been no authoritative, generic definition of which therapies might be appropriate to use in nursing or midwifery practice. The literature suggests that a diverse range of therapies is used (Tiran & Mack, 2000; Rankin-Box, 2001), often determined by the nature of a particular clinical area. In cancer and palliative care, for example, nurses helped develop national guidelines on the integration of complementary therapies, published by the Prince of Wales's Foundation for Integrated Health (PWFH) (Tavares, 2003).

The House of Lords Select Committee Report (2000) classified therapies according to their evidence base and the level of professional organisation in relation to regulation – see *Figure 1 on page 4*. These classifications contain some debatable allocations but, having been presented at national level, with Government support, they have formed a constructive framework for discussion.

The report identified a category that covers therapies most often used to complement conventional care in nursing and midwifery. The authors felt the therapies mentioned in this 'comfort' category gave appropriate help and support to patients, in particular in relieving stress and alleviating the side effects of drug regimes. They were concerned about the lack of scientific evidence as measured by random controlled trials

**Figure 1: Categories of complementary and alternative medicine (CAM) disciplines**

(House of Lords Select Committee Report, 2000)

<b>Group 1: Professionally organised alternative therapies</b>	<b>Group 2: Complementary therapies</b>	<b>Group 3: Alternative disciplines</b>
Acupuncture	Alexander technique	<b>3a: Long established and traditional systems of health care:</b> Ayurvedic medicine Anthroposophical medicine Chinese herbal medicine Traditional Chinese medicine
Chiropractic	Aromatherapy	
Herbal medicine	Bach and other flower remedies	
Homeopathy	Massage	
Osteopathy	Reflexology	
	Healing including Reiki	<b>3b: Other alternative disciplines:</b> Crystal therapy Dowsing Iridology Kinesiology Radionics
	Hypnotherapy	
	Shiatsu	

(RCTs), but recognised that there was a growing body of qualitative information.

The therapies most frequently used by nurses and midwives, such as massage, aromatherapy and reflexology, came within the ‘comfort’ category. The most recent annual survey of RCN Complementary Therapy Nursing Forum members (RCN, 2003a) shows that the use of Reiki healing by nurses has gained in popularity, and that acupuncture and acupuncture techniques are also used by a number of respondents in a variety of clinical settings. Members also showed a general interest in homeopathy.

Issues have been raised about whether nurses can deliver the ‘whole’ therapy, and whether this is appropriate, or even possible, within clinical practice. For instance, nurses using essential oils are often not functioning as full aromatherapists – but they are using essential oils to enhance nursing care (Avis, 1999). Putting patients’ best interests first is the key that will help nurses to clarify the scope of intended practice.

## Putting patient needs first

When introducing complementary therapies, it is vitally important that the use of any therapy is always in the best interests and safety of patients/clients, and that informed consent is obtained. The Nursing and Midwifery Council (NMC, 2002) *Code of Professional Conduct* requires that nurses and midwives must be convinced of the safety and relevance of any therapy and be able to justify its use. This must be achieved without compromising or fragmenting existing areas of practice and care.

Collaboration is also part of professional practice, hence the need to discuss the use of any complementary therapy with members of a patient’s multidisciplinary health team. It is essential to have a formal strategy for integration, ratified by the employing organisation, which incorporates the use of substantial evidence (Richardson et al, 2001) and a valid audit process – otherwise it is difficult to see how nurses and midwives can present a convincing rationale for the integration of complementary therapies into clinical practice (see Part 2).

The key principles of professional practice that are important when considering integrating complementary therapies into your practice include:

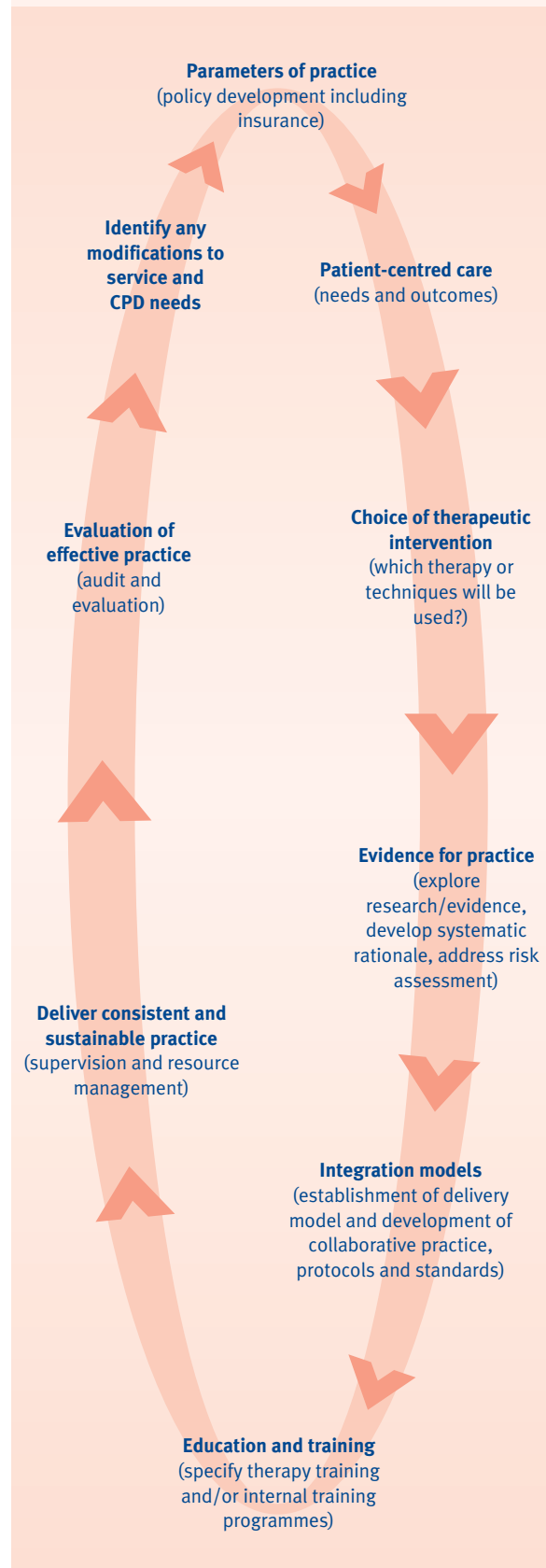
- ◆ providing patient-centred care
- ◆ making an appropriate choice of therapeutic intervention
- ◆ identifying parameters of practice
- ◆ identifying evidence that supports your rationale for integration
- ◆ identifying an appropriate integration model
- ◆ identifying education and training needs to provide safe and effective practice
- ◆ developing effective evaluation strategies
- ◆ keeping abreast of on-going development needs to support a sustainable service.

Providing patient-centred care means identifying patients' needs or problems and the subsequent outcomes of care. In other words, you need to begin by knowing what you are trying to achieve for patients. This is key; it will ensure that any complementary therapy or technique is integrated because it will meet patient needs – and not because nurses, midwives or health visitors think it would be a good idea.

## Regulation and guiding principles

Work is underway to support the regulation of therapies such as aromatherapy, massage and reflexology, facilitated by the Prince of Wales's Foundation for Integrated Health (PWFH, 2003). However, until single therapy registers have been established and the criteria for registration identified, education and training requirements have not yet been defined. In the meantime, nurses and midwives who want to integrate complementary therapies into their clinical practice need to follow guiding principles that emerge from the NMC *Code of Professional Conduct* (2002) and the framework of clinical governance (Department of Health, 1998; RCN, 2003b). These principles are illustrated in Figure 2, then expanded and discussed in Part 2.

**Figure 2: Principles of professional practice and clinical governance**



## 2

# Principles of professional practice for integrating complementary therapies into clinical nursing and midwifery care

## Establishing parameters of practice

Before you can attempt to use a complementary therapy in clinical practice, you must identify your employing organisation's policy on integrating complementary therapies into your practice. To begin with, is there such a policy? And if so, what does it stipulate? You need to be sure what the parameters of such practice would be.

### Developing a policy

There may be no integration policy in place. Development of policy often occurs as a result of potential developments in practice, so may come as a result of your interest. To achieve such a development, you will need to think strategically and understand the internal politics of your organisation. Leadership and negotiating skills are essential attributes for success, together with patience and a sense of humour (to maintain sanity and commitment!).

Your employer's policy for integration of complementary therapies should answer the following questions.

- ◆ Are there limitations or conditions for using complementary therapies? The policy will contain a

statement regarding the scope of your employer's vicarious liability in relation to your use of complementary therapies.

- ◆ What competencies have been identified in relation to the outcomes you are hoping to achieve?
- ◆ Are there specific education requirements that would make you 'fit for purpose'?
- ◆ Does the policy make recommendations about the amount and type of experience you should have in relation to any complementary therapy you wish to integrate?
- ◆ Is there a supervision framework in place?
- ◆ How does your employing organisation want you to demonstrate informed consent?
- ◆ Is there any special documentation required for consent or for the assessment process? (Rankin-Box and McVey, 2001).

### Are you insured to practice?

Members of the RCN are covered by RCN indemnity insurance provided that the nurse or midwife:

- ◆ has undertaken a period of training which ensures that they are fully competent in this area of practice
- ◆ works within protocols and policies which have been agreed with their employer and manager
- ◆ works within the principles outlined in the NMC Code of Conduct (2002), which clearly states the responsibilities involved when undertaking nursing activities in Paragraph 3.11:

*'You must ensure that the use of complementary or alternative therapies is safe and in the interests of patients and clients. This must be discussed with the team as part of the therapeutic process and the patient or client must consent to their use.'*

## Identifying patient needs and outcomes

Putting patient-centred care into practice in the clinical environment means first identifying patient need. What is it you hope to achieve to meet this need? For example, a patient can't sleep; the desired outcome would be for them to experience a restful night's sleep. Consider first

whether the patient's concerns or needs can be met within the scope of conventional nursing or midwifery practice. Take a straightforward approach: using complementary therapies won't miraculously sort out every problem, but simple measures can make a world of difference (Grealish *et al*, 2000; Hattan *et al*, 2002).

## Choice of therapeutic intervention

When you are deciding which therapy might help a patient, look first at what the health care team has already tried for this patient. Why didn't these strategies succeed? What can you learn from reviewing the care given? What would be the most appropriate therapeutic intervention – would a complementary therapy be more appropriate than a nursing or midwifery intervention? Which therapy would be most appropriate? In our example, would the patient benefit from a simple massage or would the addition of essential oils improve the outcome? Is the patient able to choose from a range of options or is only one therapy/part therapy available?

## Finding evidence for practice

When choosing a therapy, you will need to find out if evidence is available that will inform your decision – in this example, whether to use simple massage techniques, an essential oil, or a combination of the two to help the patient sleep. What type of evidence can you find – and do you know where to look for it? You will need to establish a systematic rationale for assessing the kind of therapy required.

To find evidence, you will need to become familiar with a number of databases and reputable websites that are outside the normal range used for nursing (Richardson *et al*, 2001). Assess whether the research used an appropriate methodology, and if its findings are applicable to your clinical area. If all you can find is anecdotal evidence, how does that influence your decision-making? It's important to consider research that shows that some complementary therapies are incompatible with conventional treatments, to avoid harming the patient. How will you incorporate risk-management into the assessment process?

## Establishing an integration model

There are many examples of the successful integration of complementary therapies using a variety of models (Russo, 2000; Tavares, 2003). In some models, the nurse or midwife delivers the therapy (for instance, giving a simple massage or applying essential oils). In others, the nurses will facilitate volunteer therapists who deliver the therapy. Sometimes nurses and midwives run a discrete service offering therapies to a particular client group, such as in an outpatients department. Individual trusts and clinical areas will develop the model that suits their service imperatives.

### Issues to consider:

- ◆ **Consultation.** Attempts to introduce complementary therapies by nurses and midwives on an individual whim are often not successful. Is everyone on your team aware of your plans? If not, you may receive a negative reaction among colleagues that will hamper future, better-planned initiatives. The consultation will also be vital in examining the other issues set out here about how the service will work
- ◆ **Who will deliver the therapy?** When volunteers are to provide therapies, you must develop an appropriate framework of training and supervision, including identifying the staff responsible and accountable for the service provided. There are many areas where this has already happened effectively (Tavares, 2003).
- ◆ **Equity and access to provision.** How will you decide which patients are offered the therapy/ part therapy? For example, in some clinical areas nurses may offer a limited range of complementary therapies that might provide a legitimate first-line of treatment, such as in the treatment of mild depression and anxiety. In other areas, the complementary therapy interventions may be circumscribed by the availability of suitably qualified staff.
- ◆ **Informed consent.** Will each patient need to sign a specific form? How realistic is this in the chaos of practice? Would information leaflets about the complementary therapies you offer pre-empt the need for forms, and would such leaflets help you gain consent as part of the development of each

patient's care-plan? If you plan to offer multiple therapies, informed consent is complex – you will need to inform patients that you may use several therapies or part therapies in any given clinical interaction, so that patients can withhold consent for a particular therapy.

- ◆ **Resources.** What about space, equipment and staff time? Is there a suitable environment to deliver the therapy, and is a separate area required? If you offer a simplified interpretation of a therapy, such as a hand massage, does this need any extra resources – what about time?
- ◆ **Clinical protocols.** You must establish these in each clinical area, so that issues regarding integration are quite clear (Shuttleworth, 2003). The protocol will identify parameters of practice and the staff involved. You will need to demonstrate your rationale for introducing the therapy, substantiated by research evidence
- ◆ **Education and training**
- ◆ **Consistency and evaluation.**

## Education and training

When you have identified patients' needs and concerns that could be addressed through using complementary therapies, and which complementary therapy might be suitable based on the best available evidence, the next step is preparing for this type of practice. There could be two scenarios, where nurses, midwives or health visitors use:

- ◆ a simplified version of a therapy (for example, hand and/or foot massage)
- ◆ the full range of knowledge and skills that make up a particular therapy, functioning at practitioner level.

The complexity of the guidance given on education within this guidance reflects the somewhat chaotic reality in terms of the regulatory process, and therefore we can't give definitive advice.

### Training for using simple techniques

Nurses, midwives or health visitors will not necessarily need complex external training. It may be appropriate for the member of the multiprofessional clinical team who is experienced in the therapy to devise an internal

training programme, providing other staff with knowledge and skills to support the protocols developed in a particular clinical area. This is sometimes called 'cascade training', and use of this type of training will be defined by the employing organisation.

Staff will be taught simple techniques to be used in that clinical area. They will NOT be 'qualified' therapists, but will be nurses who have extended their therapeutic range by incorporating complementary therapy techniques in order to enhance care. They will NOT be able to train other staff, and their knowledge and skills are NOT automatically transferable but are relevant to that particular clinical area only. Examples where this model of training could be used are for the use of a limited range of essential oils within midwifery practice (Burns *et al*, 1999), the use of hand massage in surgical areas for pre-operative anxiety (Kim *et al*, 2001), and for the short-term relief of pain (Wilkie *et al*, 2000).

### Training for practitioner level

Here, you must obtain full professional qualification in a particular therapy – for nurses and midwives this is likely to be in aromatherapy, reflexology and massage. There are a wide variety of courses available and you will need to consider the level of knowledge and skill that will be required in the clinical area before making a choice. Broadly speaking, courses are available at three levels:

1. **Awareness level** – appropriate for nurses and midwives who want to understand a range of complementary therapies, so they can talk knowledgeably with patients and clients about choices for health. Courses usually run over one or two days. This level also applies to the familiarisation sessions that are increasingly included in pre- and post-registration nursing courses
2. **Introductory level** – appropriate for nurses who want to explore for themselves (rather than for practice) the therapeutic potential of a particular therapy. Courses are usually weekly evening classes for six to eight weeks, provided by colleges of further education, the Workers Education Authority (WEA) and some independent complementary therapy schools. They do not provide a qualification but give limited skills to use as self-help techniques and for relaxation on family and friends. Many of the courses are used as preparation for the beauty profession or as tasters prior to professional training.

3. **Practitioner level** – this is the minimum recommended level of education required if you want to integrate a therapy into clinical practice. Training should be selected depending on the particular circumstances in your clinical area and your own experience:

(a) where a particular complementary therapy is already well established in your clinical area, and you will be giving treatment under the direction of a nurse/midwife/health visitor (or other member of the clinical team, for example, physiotherapist) who has a qualification and substantial experience.

- ◆ This training could be taken at S/NVQ Level 3 Health Award at a college of further education. The award should be recognised by a professional body, for example, Association of Reflexologists (AOR), International Federation of Professional Aromatherapists (IFPA), British Massage Therapy Council (BMTc) and is likely to be accredited by organisations such as the Association Qualifications Alliance (AQA), the International Therapy Education Council (ITEC), or the Vocational Training Charitable Trust (VCTC). The Prince of Wales's Foundation for Integrated Health has produced a student guide to choosing a course that provides useful information (Williams, 2003).

(b) where you want to integrate a therapy into a clinical area for the first time, there is no access to expert advice or supervision, and you will be using autonomous clinical judgement to identify appropriate use of a therapy or part therapy.

- ◆ The recommended minimum level of training and education is Diploma in Higher Education (Level 2), ideally at Level 3 (HE), at a university, where the course is accredited by one of the professional organisations mentioned in (a). If you can't access a course at Level 3, we recommend that you also access an appropriate Level 3 (HE) research module to give the skills in critical appraisal that are essential to facilitate evidence-based practice.

(c) where you want to be involved in the process of integrating any complementary therapy into

clinical practice, but your complementary therapy training was undertaken some time ago.

- ◆ You have a responsibility to maintain and develop clinical competence and demonstrate this as part of continuing professional development (CPD) in fulfilment of NMC PREP requirements. You must check that your employing organisation provides a system whereby your experience in the use of the therapy can be validated so that your subsequent practice is supported by current policy.

- ◆ If your previous training did not include research appreciation, you should undertake a Level 3 module at your local university that provides knowledge and skills in critical appraisal, so that you can access and evaluate research. This will help to ensure that the use of complementary therapies is based on a systematic rationale that takes into account safety and efficacy. It may also be necessary to up-date your knowledge of bio-science. For example in aromatherapy, this includes organic chemistry and principles of pharmacokinetics and pharmacodynamics.

(d) if you plan to take a leadership role in the development of the use of complementary therapies within a clinical area or trust.

- ◆ We recommend degree or masters level education, and we assume that you already possess a professional qualification in a particular therapy with an appropriate period of consolidation and a specialist qualification in the clinical specialty.

(e) if you are using more than one therapy, you MUST obtain education at practitioner level in each therapy.

### Supervision in practice

When choosing a course to suit you, ask about:

- ◆ the amount of supervised practice required (Mackereth, 2001)
- ◆ the level of supervision provided
- ◆ whether a period of consolidation is offered.

It is inappropriate for nurses/midwives/health visitors who have only just 'qualified' in a therapy to use their

skills on patients immediately without supervision. How will skills and knowledge be consolidated?

### Ensuring a course is relevant

Some courses are seeking approval from the RCN Accreditation Unit, which means that from an educational point of view, these courses are of a reputable quality and relevant to nursing. However, even where RCN accreditation is given, you are still responsible for taking a close look at a course's curriculum to see whether it is really applicable to caring for patients with complex personal and psychological needs who are undergoing complicated medication regimes. It is likely that no one course will meet all your needs, and you must make sure you identify the full range of knowledge and skills you will need and find education undertaken to achieve these. You will be able to demonstrate your need for a variety of training more effectively if there are policies and protocols in place that set the parameters of practice.

## Delivering and evaluating consistent and sustainable practice

When you have trained in a particular complementary therapy, you can get on with integrating the therapy into clinical practice or delivering a discrete complementary therapy service. It is at this point when any logistical weaknesses in your set-up will emerge. Can staffing be managed to provide the planned service with no detriment to conventional care? Is the service accessible and equitable? Do patients understand what the service offers and how to access it? How is informed consent managed? How is care documented? It is important to monitor problems and ensure resources and supervision are properly managed.

### Evaluation of effective practice

Before the integration of the therapy or service started, you will have set an agreed date for audit, agreed what factors will be evaluated and by what criteria. Where standards have been established these will form the benchmark for evaluation. Audit will show you whether the service achieved what you hoped. If not, how can standards be improved or how will the discontinuation of an ineffective service be managed?

### Identify modifications to service and CPD needs

Skills in critical reflection are vital in developing and modifying practice that is appropriate, safe and effective (Mackereth, 2001), and these skills should be supported by a system of clinical supervision.

As you monitor and evaluate the service, you must identify whether it needs to be modified in any way. For example, are there additional resource implications? As a result of the process of supervision, what CPD needs have been identified and how will they be met?

### CPD

There are very few formal CPD opportunities in aromatherapy, reflexology and massage that are suitable for nurses and midwives in clinical practice. Current course content is often not appropriate, and does not encourage critical analysis and reflection. You will need to be imaginative and find a wide range of activities that can be used for CPD, including undertaking projects, audits, visits, writing articles and attending seminars and conferences. Explore the possibility of taking a higher degree specifically involving complementary therapies or related to a particular clinical specialty that incorporates complementary therapies.

## Conclusion

This guidance must be seen within the context of the NMC's Code of Professional Conduct (Semple and Cable 2003), which clearly puts the responsibility of extending the range of practice or maintaining competence in a particular field on the practitioner. The importance of proper preparation and sound knowledge as a basis for practice has been covered, as well as the relevance of consent and personal accountability. These are important reminders of the personal responsibilities a practitioner accepts when offering complementary therapies as part of their nursing care.

The guidance has brought together a range of issues associated with the integration of complementary therapies into nursing practice, and we hope they will promote discussion. They are not exhaustive and it is the responsibility of each clinical area within employing organisations to define the parameters of practice, and to develop a framework for integration so that services are offered under the principles of clinical governance and professional nursing practice. The overarching philosophy must be the enhancement of safe, effective and appropriate patient care.

## References

- Avis A (1999) When is an aromatherapist not an aromatherapist? *Complementary Therapies in Medicine* 7 (2), 116-8
- Burns E, Blamey C and Lloyd A (2000) Aromatherapy in childbirth: an effective approach to care. *British Journal of Midwifery* 8 (10), 639-643
- Department of Health (1998) *A First Class Service: quality in the new NHS*. London: The Stationery Office
- Department of Health (2001) *Government Response to the House of Lords Select Committee on Science and Technology's Report on Complementary and Alternative Medicine. CM5124*. London: The Stationery Office
- Ernst E and White A (2000) The BBC survey of complementary medicine use in the UK. *Complementary Therapies in Medicine* 8, 32-36 (data provided by ICM Research Ltd)
- Grealish L, Lomasney A and Whiteman B (2000) Foot massage: a nursing intervention to modify the distressing symptoms of pain and nausea in patients hospitalised with cancer. *Cancer Nursing* 23 (3), 237-243
- Hattan J, King L and Griffiths P (2002) The impact of foot massage and guided relaxation following cardiac surgery: a randomised controlled trial. *Journal of Advanced Nursing* 37 (2), 199-207
- House of Lords Select Committee on Science and Technology (2000) *Complementary and alternative medicine. HL Paper 123. November*. London: The Stationery Office
- Kim M-S, Cho K-S, Woo H-M and Kim J-H (2001) Effects of hand massage on anxiety in cataract surgery using local anaesthetic. *Journal of Cataract and Refractive Surgery* 27 (6), 844-890
- Mackereth P (2001) Supervision and complementary therapies, in Rankin-Box D (2001) *The Nurse's handbook of complementary therapies*. London: Ballière Tindall
- Nursing and Midwifery Council (2002) *Code of Professional Conduct*. London: Nursing and Midwifery Council
- Ong C-K and Banks B (2003) *Complementary and alternative medicine: the consumer perspective*. London: The Prince of Wales's Foundation for Integrated Health

Peters D, Chaitow L, Harris G and Morrison S (2002) *Integrating complementary therapies in primary care*. Edinburgh: Churchill Livingstone

Rankin-Box D (2001) *The nurse's handbook of complementary therapies*. London: Ballière Tindall

Rankin-Box, D and McVey, M (2001) Policy development, in Rankin-Box, D ed (2001) *The nurse's handbook of complementary therapies*. London: Ballière Tindall

Richards J, Jones C and Pilkington, K (2001) Complementary therapies: what is the evidence for their use. *Professional Nurse* 17 (2), 96-99

Royal College of Nursing (2003a) *In Touch: Newsletter of the Complementary Therapies in Nursing Forum*. Autumn 2003. London: Royal College of Nursing.

Royal College of Nursing (2003b) *Clinical governance: an RCN resource guide*. London: RCN. Publication code 002 036

Russo H (2000) *Integrated healthcare: a guide to good practice*. London: Prince of Wales's Foundation for Integrated Health

Simple M and Cable S (2003) The new Code of Professional Conduct, *Nursing Standard* 19 (17) No 23, 40-48

Shuttleworth A (2003) *Protocol Based Care*. London: Nursing Times Publication, Emap Healthcare Ltd

Tavares M (2003) *National guidelines for the use of complementary therapies in supportive and palliative care*. London: The Prince of Wales's Foundation for Integrated Health & National Council for Hospice & Specialist Palliative Care Services

The Prince of Wales's Foundation for Integrated Health (PWFH) (2003) *Setting the agenda for the future*. London: The Prince of Wales's Foundation for Integrated Health

Thomas K, Nicholl J and Coleman P (2001) Use and expenditure on complementary medicine in England: a population based survey. *Complementary Therapies in Medicine* 9, 2-11

Tiran D and Mack S (2000) *Complementary therapies for pregnancy and childbirth*. 2nd ed. London: Baillière Tindall

Wilkie D et al (2000) Effects of massage on pain intensity, analgesics and quality of life in patients with

cancer pain: a pilot study of a randomised clinical trial conducted within hospice care delivery. *Hospice Journal – Physical, Psychological and Pastoral Care of the Dying* 15 (3), 31-53

Williams L (2003) *Choosing a course in complementary healthcare: a student guide*. London: The Prince of Wales's Foundation for Integrated Health

## Further reading

Barracough J (2000) *Integrated cancer care: holistic, complementary and creative approaches*. Oxford: Oxford University Press

Buckle J (2003) *Clinical aromatherapy: essential oils in practice*. 2nd ed. Edinburgh: Churchill Livingstone

Ernst E (2001) *The desktop guide to complementary and alternative medicine: an evidence-based approach*. Edinburgh: Mosby

Field T (2000) *Touch Therapy*. Edinburgh: Churchill Livingstone

Holey E and Cook E (2003) *Evidence-based therapeutic massage*. Edinburgh: Churchill Livingstone

Lewith G, Jones W and Walach H (2000) *Clinical research in complementary therapies*. Edinburgh: Churchill Livingstone

Libster M (2001) *Demonstrating care: the art of integrative nursing*. Albany, USA: Delmar

Mackereth P and Tiran D (2002) *Clinical reflexology: a guide for health professionals*. Edinburgh: Churchill Livingstone

Micozzi M (2001) *Fundamentals of complementary and alternative medicine*. 2nd ed. New York: Churchill Livingstone

Mitchell A and Cormack M (1998) *The therapeutic relationship in complementary health care*. Edinburgh: Churchill Livingstone

Rich GJ (2002) *Massage therapy: the evidence for practice*. Edinburgh: Mosby

Stone J (2002) *An ethical framework for complementary and alternative therapists*. London: Routledge

Vickers A (1996) *Massage and aromatherapy: a guide for health professionals*. London: Chapman and Hall

## Useful contacts

### **The British Acupuncture Council**

63 Jeddo Road  
London W12 9HQ  
Tel: 020 8735 0399  
Website: [www.acupuncture.org.uk](http://www.acupuncture.org.uk)

### **The Acupuncture Association of Chartered Physiotherapists**

Website: [www.aacp.uk.com](http://www.aacp.uk.com)  
(Useful for courses in acupuncture for pain relief)

### **European Herbal Practitioners Association**

45a Corsica Street  
London N5 1JT  
Tel: 020 7354 5067  
Website: [www.euroherb.com](http://www.euroherb.com)

### **Council of Organisations Registering Homeopaths**

Email: [corh@dial.pipex.com](mailto:corh@dial.pipex.com)  
(Single regulatory working group)

### **Society of Teachers of the Alexander Technique**

Website: [www.stat.org.uk](http://www.stat.org.uk)

### **The British Society of Medical & Dental Hypnosis**

Website: [www.bsmbh.org](http://www.bsmbh.org)

### **The General Council for Massage Therapy**

Website: [www.gcmt-uk.org](http://www.gcmt-uk.org)  
(Single regulatory working group)

### **The Reflexology Forum**

PO Box 2367 South Croydon  
Surrey CR2 7ZE  
Tel: 0800 037 0130  
Email: [reflexologyforum@aol.com](mailto:reflexologyforum@aol.com)  
(Single regulatory working group)

### **Reiki Regulatory Working Group**

Sequoia Elton Road  
Hertford SG14 3DW  
Tel: 01992 587169  
Email: [marirav@aol.com](mailto:marirav@aol.com)  
(Single regulatory working group)

### **The General Shiatsu Council**

Email: [Rosewell@cix.co.uk](mailto:Rosewell@cix.co.uk)  
(Single regulatory working group)

### **Research Council for Complementary Medicine**

27a Devonshire Street  
London W1G 6PN  
Tel: 020 7935 7499  
Website: [www.rccm.org.uk](http://www.rccm.org.uk)

### **Skills for Health**

Goldsmiths House  
Broad Plain  
Bristol BS2 0JP  
Tel: 0117 9221155  
Website: [www.skillsforhealth.org.uk](http://www.skillsforhealth.org.uk)  
(For information about National Occupational Standards (NOSs) and National Vocational Qualifications (NVQs))

### **RCN Complementary Therapies in Nursing Forum**

RCN Adviser Celia Manson  
[celia.manson@rcn.org.uk](mailto:celia.manson@rcn.org.uk)

### **RCN Accreditation Unit**

Tel: 020 7647 3647  
Email: [accreditation@rcn.org.uk](mailto:accreditation@rcn.org.uk)

### **International Federation of Professional Aromatherapists**

82 Ashby Road  
Hinckley  
Leicestershire LE10 1SN  
Tel: 01455 637987  
Email: [admin@IFPAroma.org](mailto:admin@IFPAroma.org)  
Contact:  
[http://ifparoma.org/html/contact\\_the\\_ifpa.html](http://ifparoma.org/html/contact_the_ifpa.html)

### **Nursing and Midwifery Council**

23 Portland Place  
London W1B 1PZ  
Tel: 020 7637 7181  
Website: [www.nmc-uk.org](http://www.nmc-uk.org)

### **Complementary Therapies in Nursing and Midwifery Journal**

and **International Journal of Aromatherapy**  
Churchill Livingstone  
Elsevier Science Ltd  
Website: [www.elsevier.com](http://www.elsevier.com)



Royal College  
of Nursing

**October 2003**

Published by the  
Royal College of Nursing  
20 Cavendish Square  
London  
W1G 0RN

020 7409 3333

**RCNONLINE**  
[www.rcn.org.uk](http://www.rcn.org.uk)

**RCNDIRECT**  
[www.rcn.org.uk/direct](http://www.rcn.org.uk/direct)  
**0845 772 6100**

The RCN represents nurses and nursing,  
promotes excellence in practice and shapes  
health policies.

Publication code 002 204

