

**P-45** THERE IS MORE TO GARDENING THAN MEETS THE EYE!

<sup>1,2</sup>Karen Leckie, <sup>3</sup>Lisi Pilgrim. <sup>1</sup>University of Cumbria; <sup>2</sup>St Catherine's Hospice; <sup>3</sup>Phyllis Tuckwell Hospice Care

10.1136/bmjspcare-2016-001245.69

There is much literature supporting the use of social and therapeutic horticulture (STH) within health and social care settings (King's Fund, 2016). Benefits such as quality of life, well-being, restoration, adjustment and normalisation, affirmation of life and preparation for death through meaningful and valuable activity are deemed as some of the positive elements (Cimprich, 1993; Hartig *et al.*, 2014; King's Fund 2016; Kaplan, 1995).

However, despite these reported benefits, and some limited research relating to gardening in end-of-life care (Unruh, 2000), there remains a dearth of specific research regarding the therapeutic use of gardens and gardening within this field (Cooper Marcus and Sachs, 2014). This may lead to the underutilisation of gardening as a therapeutic occupation.

STH aligns well with providing holistic, person-centred practice, which is key to palliative care (WHO, 2013). Outcomes and evaluation indicate immediate improvement to wellbeing.

Funding for interventions met by voluntary/hospice contributions.

Nature-based and gardening activities, including accessible indoor table-top gardening, have the potential to address complex and multifaceted issues that impact clients affected by life-shortening illness (Haller and Kramer, 2006).

This subject is timely, as gardening/nature-based interventions are re-gaining popularity within hospice care (e-hospice, 2016).

We aim to:

1. debate both opportunities and challenges of gardening as an occupation for people with life-shortening illness;
2. share some practical examples of STH utilised with clients within palliative care settings;
3. share and discuss development of the STH Model (Pilgrim and Sempik, 2015).

In conclusion, we aim to promote the value of STH as an intervention to be utilised by multi-disciplinary team members (Adevi and Sempik, 2013) to enhance hospice rehabilitative care, which currently has a national profile; 'Enabling people to live fully until they die' (Tiberini and Richardson, 2015).

**P-46** "SOW AND GROW", NATURE THAT NURTURES: HORTICULTURAL THERAPY AS PART OF END-OF-LIFE CARE

Janet Wallis, Rachael Lenon. *Martlets Hospice, Hove, UK*

10.1136/bmjspcare-2016-001245.70

**Introduction** Our hospice has provided a horticultural therapy group which is open to in- and out- patients since February 2016. Gardening and being outdoors have well-documented benefits for mental health and general well-being. This group is an example of 'People' within the conference, extending our experience of our patients and volunteers.

**Aims** The group was formed to help patients spend time with plants and nature. We believe we can reach patients who do not use other services, and provide a relaxed, non-medicalised

environment in which patients can support each other. It is patient-led, giving people control of their situation. It is also a setting for emotional support, minor symptom control advice, and identifying patients who need other services or medical follow up.

**Methods** We hold a weekly two- hour group at the hospice. It is facilitated by a nurse, a horticultural therapist and a volunteer.

We do low-impact activities such as seed sowing and caring for two large raised beds. Patients take plants or produce home or to their bedside. There is time for quiet contemplation, to enjoy the birds, fresh air and the feel of warm soil on their hands.

**Results** Through patients' reports and observation, we have noticed the benefits of support, advice and sense of well-being. A dying patient who had previously sown cress smelt it and smiled as we held it under her nose. One patient who used to have a garden but now lives in a flat loves being outside again. We have observed peer support and patients taking ownership of the raised beds. Symptom control advice has been given and patients have been referred to our Clinical Nurse Specialists.

**Conclusion** We plan to review progress at six months.

**P-47** ANIMAL ASSISTED THERAPY PROGRAM: A CO-THERAPY FOR PALLIATIVE CARE

<sup>1</sup>Silvia Carlini. <sup>1</sup>Maith, Ottiglio, Italy; <sup>2</sup>Vidas, Milan, Italy; <sup>3</sup>Palliative Care Federation, Abbiategrosso, Italy

10.1136/bmjspcare-2016-001245.71

In the area of therapy animals, practice is far outpacing research. People think it works and like the idea of it, so they do it.

One challenge as the practice has become more widespread has been explaining how exactly it works. "Positive changes from animal-assisted intervention are varied and there is no single pathway that has yet been identified".

There are a number of theories as to why it works, however.

One is the biophilia hypothesis – essentially that humans have an innate propensity to connect with other living things, another is the social support theory – the idea that therapy animals provide a form of non-judgemental support.

Starting from these statements in 2015, Maith Association has devised a monitoring pattern for hospices together with the hospice staff.

First of all, together with the vet we chose the most ideal animals; while any breed or mutt can be a therapy dog, a certain kind of personality is required. "Visiting unfamiliar people in unfamiliar settings requires a well-trained, healthy dog, with a positive temperament and good manners".

We set goals, mainly recreational and emotional/affectional support:

- fostering patients' mental and physical wellness (for physical wellness we mean try to soothe pain perception)
- emotional support: animals are "emotional intermediary" and further their outing through the non-verbal channel of communication (posture, facial mimicking, body language...)

For a six month period we went to the hospice twice a week and we had access both to atrium and to private bedrooms.

Each therapy session lasted two hours with a break of ten minutes.

At the end of every single session the animal handler had to fill in three evaluation sheets:

- one for patients
- one for their relatives (if present)
- one for healthcare professionals.

**P-48 "SINGING IN THE CHOIR WOULDN'T DO US ANY HARM": EXPLORING A UNIQUE PARTNERSHIP BETWEEN A FREELANCE MUSIC THERAPIST, A LEADING NATIONAL LUNG CHARITY AND AN ADULT HOSPICE**

<sup>1,2,3,4</sup>Anna Ludwig. <sup>1</sup>Harperhall Music Therapy, Biggar, UK; <sup>2</sup>Kilbryde Hospice, East Kilbride; <sup>3</sup>Team Jak Foundation, Livingston; <sup>4</sup>Lady Home Hospital, Douglas

10.1136/bmjspcare-2016-001245.72

In 2015 a national lung charity funded a 12-week pilot project in 10 UK locations called "Singing for Lung Health". Giving a brief introduction to music therapy in an adult hospice setting, this paper will then explore how the music therapist worked in collaboration with the lung charity and the hospice to develop and run the choir after the initial 12 weeks of funding and will include what the potential benefits of singing in a choir can be.

**Aims of the choir**

- To evaluate and monitor changes in breathing, confidence and general health and well-being using questionnaires provided initially by the lung charity and now in development with the hospice and the music therapist
- To use and develop vocal and breathing techniques, originally geared towards those with lung conditions, for use with a wider client group including those with life-limiting conditions
- To maintain and develop the choir to include hospice patients, carers, staff, volunteers and members of the public

**This work in progress is**

- Bringing people together at the hospice from all walks of life, with or without a life-limiting condition
- A **partnership** with the choir, the hospice and the music therapist which includes writing and performing a song together to promote the work of the hospice (this will be shared during the presentation)
- Highlighting the **potential** health and well-being benefits of singing in a choir (including physical, mental, emotional and social benefits)
- Promoting the work of the hospice to the wider community

To conclude, the author aims to share this creative work in progress in order to highlight the benefits of singing in a choir, the unique collaboration between the music therapist, hospice and lung charity and thoughts around how this work may be evaluated in the future to ensure its success and continuation.

**P-49 POPPIES**

Nicci Williamson, Karen McPhail, Stuart Cartledge. *Douglas Macmillan Hospice, Stoke-on-Trent, UK*

10.1136/bmjspcare-2016-001245.73

Diversional therapy is a tool used to help patients express emotions in a different way. Activities are devised with a worthwhile outcome and all patients, of all abilities, can participate. It

encourages communication, expression, comradeship and reminiscence thus giving purpose and meaning for patients in our care.

One such project was to create our own 'Tower of London' display of poppies, but on a smaller scale. Poppies were to be made out of plastic bottle bottoms, painted by hand in red and black.

As the idea took hold, so the project grew. Patients formed their own 'industrial line' with some cutting, others painting and the rest assembling. The goal was for 3500 poppies. The design was drawn by an ex-draughtsman patient using his professional skills. It involved an 8 foot cross covered in poppies with a cascade of flowers to two giant poppies on the ground. The whole display measured approximately 50 metres in length and five metres in width and ran from the Spiritual Space to the Day Therapy Unit.

Patients, carers, visitors, staff and local schools 'worked' to create poppies. A growth chart recorded the number of poppies made with the target being 3500.

Local radio and newspapers appealed for bottles and the project took on a life of its own. It culminated in a service of Remembrance on the 11 November 2015 at the hospice. The service was attended by patients, carers, visitors, staff, local schools, dignitaries from the local community and British Legion. An ex-serviceman patient read the 'Ode of Remembrance'. A young schoolboy played the bugle 'Last Post' to finish.

Patients participated with enthusiasm and motivation, staff felt the strength of working as a team. Collaborative working took the hospice into the local community. The Hospice profile was raised in the media. Conversation and laughter flowed and continues to this day.

**P-50 ROYAL TRINITY HOSPICE 'WELCOMES' THE WELLBEING PROGRAMME WITH SUCCESS**

<sup>1</sup>Moira O'Connell, <sup>1,2</sup>Sian Evans. <sup>1</sup>Royal Trinity Hospice, London, UK; <sup>2</sup>Macmillan Cancer Support

10.1136/bmjspcare-2016-001245.74

**Background** Prior to the launch of the Wellbeing Programme an outpatient service evaluation was completed in 2014, with the following needs identified:

- Peer support for patients, carers and families
- Earlier intervention for patients/carers and the wider health economy for people with palliative care conditions
- A model for day/outpatient services, based on a therapeutic approach to rehabilitation and critically, self-management.

**Aim**

- To widen the breadth of support and care we provide to our patients to include Wellbeing Programmes through the introduction of peer and carer support sessions
- Ensure patients, families and carers feel supported in relation to their anxieties and practical matters about their palliative journey
- To start the new programme within six months of posts being in place
- To build partnerships with other organisations collaborating and practicing seamless communication links to ensure patient needs are addressed in a timely manner
- To further embed Royal Trinity Hospice as a provider of specialist palliative care services within its community.