There are many 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). 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 lifeshortening 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 (Haller and Kramer, 2006).
2. share some practical examples of STH utilised with clients within palliative care settings;
3. share and discuss development of the STH Model (Pilgrem 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).

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.

“SOW AND GROW”, NATURE THAT NURTURES: HORTICULTURAL THERAPY AS PART OF END-OF-LIFE CARE

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

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