Complementary Health Practitioners in the Acute and Critical Care Setting: Nursing Considerations

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In response to the rising demand by patients and their families for complementary health approaches, hospitals are increasingly integrating complementary health approaches with their conventional medical practices to create healing environments. Results of the 2010 Complementary and Alternative Medicine Survey of Hospitals indicated that the top 6 inpatient modalities included pet therapy, massage therapy, music or art therapy, guided imagery, relaxation therapy, and Reiki and therapeutic touch. Whether complementary health approaches are provided by complementary health practitioners through hospital-based integrative medicine programs, volunteer practitioners, or bedside nurses, the regulatory, legal, ethical, and safety concerns remain constant. Previous articles in this column of *Critical Care Nurse* provided an overview of complementary health approaches that nurses may encounter in their practices, with specific attention to implications for acute and critical care nurses, as well as important legal, ethical, safety, quality, and financial implications that acute and critical care nurses should consider when integrating complementary health approaches with conventional care. This column provides the acute and critical care nurse with key information about validation of credentials, experience, and competence of nurses and volunteers providing complementary health approaches, as well as about institutional policies and scope of practice. (*Critical Care Nurse*. 2017;37[3]:60-65)

Mind and body practices, such as chiropractic or osteopathic manipulation, yoga, and massage therapy, are among the most commonly practiced forms of complementary health approaches (CHAs) among adults and children in the United States.[1] Formerly called complementary and alternative medicine, these approaches, which were developed outside of mainstream Western, or conventional, medicine, are often used for management of symptoms, such as pain and anxiety, induced or exacerbated by acute illness and injury.[2] There is growing evidence to suggest a biological basis for the reduction in pain and anxiety reported by patients receiving CHAs in acute care settings.[3,4]

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In response to the rising demand by patients and their families for CHAs, hospitals are increasingly integrating CHAs with their conventional medical practices to create healing environments, which have been defined as those "where all aspects of the patient experience—physical, emotional, spiritual, behavioral and environmental—are optimized to support and stimulate healing."[5] Of the hospitals responding to the 2010 Complementary and Alternative Medicine Survey of Hospitals, 42% reported offering one or more CHAs, with the top 6 inpatient modalities being pet therapy, massage therapy, music or art therapy, guided imagery, relaxation therapy, and Reiki and therapeutic touch.[6] A 2011 survey commissioned by The Bravewell Collaborative found that 15 of the 29 integrative medicine centers responding offered inpatient services in the hospitals with which they were affiliated.[7] The integration of CHAs in the acute care setting may include both licensed providers and volunteer practitioners. Surveys have reported personal use of CHAs by many health care providers, including acute and critical care nurses, for self-care.[8,9] CHAs are increasingly being provided by acute care nurses to support holistic care, as well.[10] An overview of CHAs that nurses may encounter in their practices, with specific attention to implications for acute and critical care nurses, as well as important legal, ethical, safety, quality, and financial implications that acute and critical care nurses should consider when integrating CHAs with conventional care, have been presented in earlier columns.[11,12] In this column, regulation of nurse-provided CHAs, as well as institutional policies and scope of practice related to provision of CHA in the acute care setting, are discussed.

Regulation of Nurse-Provided CHAs

According to the National Center for Complementary and Integrative Health, no standardized, national system for the regulation of complementary health practitioners (CHPs) exists in the United States, and credentials for CHPs vary widely among states and disciplines.[13] Nurses providing CHAs in the acute care setting should be familiar with regulatory language as well as their individual state's nurse practice act and institutional policies. In 2014, the American Holistic Nurses Association conducted a comprehensive analysis of the nurse practice act references specific to holistic nursing, complementary and alternative medicine, and/or integrative therapies in all 50 states and 6 jurisdictions licensing registered nurses; links to those references are available on the Association's website (http://www.ahna.org/Home/Resources/State-Practice-Acts).

Several of the individual state nurse practice acts delineate specific CHAs permissible for nurses to incorporate into their practice as part of routine nursing care, as well as issues such as competence and informed consent. For example, the boards of nursing in Massachusetts, Minnesota, Oregon, Texas, Utah, and Vermont have issued policies or position statements acknowledging that performance of certain CHAs (eg, hypnosis, therapeutic touch, Reiki, and reflexology) in any practice setting is within the registered nurse's scope of practice, provided that the nurse acquires, documents, and maintains the requisite knowledge, skills, and ability and is acting within legal, ethical, and institutional standards and policies.

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Just as the practice of nursing is regulated at the individual state level, so too are the various CHAs, and there is great diversity among the states regarding the determination of competence to perform CHAs. For example, the nurse practice acts in Minnesota and Oregon include specific language regarding adherence to standards for regulated practices such as massage therapy.[14,15] The Oregon Administrative Rules regarding licensing of massage therapists contain a detailed description of competence and continuing education.[16] On the other hand, massage therapy is not currently regulated at the state level in Minnesota; although the Office of Unlicensed Complementary and Alternative Health Care Practice within the Minnesota Department of Health addresses concerns about unlicensed CHAs,

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including massage therapy, and contains language specific to CHAs provided by licensed nurses, it does not delineate competent practice.[17,18]

The World Health Organization has compiled a summary of the legal regulations and education and training of CHPs in 123 countries.[19] The World Health Organization notes that the United States regulates the practice of CHAs in 6 related areas of law: licensing, scope of practice, malpractice, professional discipline, third-party reimbursement, and access to treatment. Registered nurses who have become certified or licensed in various CHAs, or who practice forms of CHAs not typically regulated (eg, Reiki and reflexology) and who integrate those practices in the normal course of nursing care in the acute care setting, must be mindful of those legal regulations.[20] It is within the scope of practice for the registered nurse to perform comprehensive and focused nursing assessments, make nursing diagnostic statements, and develop a nursing plan of care; diagnosis and treatment of a disease or condition in the course of providing CHAs within the acute care setting is not within the scope of nursing practice and should be avoided. The nurse in this setting must be identified to the patient and family as a registered nurse, not as a CHP, to avoid role confusion, blurring of professional boundaries, and potentially illegal practice.

Nurses who are also licensed to practice typically regulated CHAs, such as massage therapy, should carefully consider scope of practice and licensure. The Oregon State Board of Nursing Policy on Complementary and Alternative Modalities and Nursing Practice includes a question-and-answer section to guide overlap in scope of practice.[15] For example, massage provided by a nurse to a patient in the context of the nursing care plan may be within the nurse's scope of practice, but the nurse cannot set up an independent practice and advertise for massage unless the nurse is also a licensed massage therapist. Nurses who are also licensed massage therapists cannot promote their independent massage practice while caring for patients within the acute care setting. Additionally, the Minnesota Office of Unlicensed Complementary and Alternative Health Care Practice provides examples of actions that may result in complaints against licensed nurses who also practice CHAs, such as explicitly identifying oneself as a licensed registered nurse to clients receiving massage.[18] In such circumstances, clients might reasonably expect care at the level of a registered nurse, which may extend beyond that of a licensed massage therapist.

Acute and critical care nurses who practice CHA in the acute care setting must be mindful of scope of practice, role clarity, and professional boundaries.

Nurse-Provided CHAs

Nurses performing CHAs in acute and critical care settings should refer to their individual state boards of nursing for questions regarding specific practices. Nurses integrating CHA with usual care need to maintain clear boundaries and standards of safe, ethical practice, including informed consent. Any deviation from nursing scope of practice and standards of care may result in liability for malpractice. A registered nurse who practices unregulated CHAs such as Reiki, or who is licensed to provide a regulated practice such as massage therapy, must first check with the local state board of nursing policy before integrating the therapy with nursing care for patients with acute or critical illness or injury. If the practice is permitted, the nurse should avoid diagnosing a specific condition (such as a musculoskeletal disorder not previously identified by a medical provider in a trauma patient) for which the practice may be beneficial.

A patient or family may become aware that the registered nurse is also a trained provider of CHAs and request specific practices for alleviation of unpleasant symptoms such as discomfort or anxiety. If the registered nurse fulfills such a request, the CHAs should be rendered with no stated guarantee of efficacy or outcome, and care provided would be documented according to institutional guidelines. If CHAs are being provided by the nurse in addition to or outside usual care, the nurse must be identified as a CHP, and responsibility for provision of nursing care rests with the assigned bedside nurse. Best practices include clear communication among the patient, family, and health care team, as well as documented verbal or written informed consent according to institutional policy.

Volunteer CHPs in the Acute Care Setting

It has been suggested that CHAs such as music therapy, relaxation, massage, and therapeutic touch, many of which are unregulated and may be integrated with nursing practice, may help "humanize" acute and critical care practice.[21] An increasing number of hospitals are providing services through the use of volunteers, including animal-assisted therapy and Reiki.[22] Reiki is a noninvasive,

☐ Annual Competency
☐ Initial Training

Reiki Program

VOLUNTEER COMPETENCY/EVALUATION CHECKLIST

_____ Understands and is competent to fulfill Volunteer Service Description

_____ Understands and maintains HIPAA and Patient Confidentiality and shredding practices

_____ Pager instructions (optional)

_____ Patient Book

_____ Sign in and out procedures, where to put jacket and personal things, way finding and meal allowance

_____ Understands Precautions and proper hand washing

_____ Understands Reiki forms (purple for nurse & chart, pink for volunteer office)

_____ Volunteer adheres to hospital procedures as they are observed performing Reiki on a precaution patient and a non-precaution patient

☐ **non-precaution patient**
- Proper check-in at nurse's station.
- Proper placement of forms and carrying case while in a patient's room.
- Hand wash with gel or soap and water before entering room.
- Proper introduction to patient or if patient unavailable leave a card.
- Check ID to verify correct patient.
- Permission to do a Reiki session.
- If this is his/her first Reiki session, explain Reiki and hand placement, offer brochure.
- Ask patient permission to move things in the room to do Reiki more easily and to raise or lower bed with nursing consent.
- When complete, return room, items and bed to original placement.
- Wish the patient a good day.
- Wash hands on way out with gel or soap and water.
- Fill out Reiki forms (purple-nurse, pink-volunteer office, white-request book)

☐ **precaution patient (optional)**
Same as above, except
- Wash hands with soap and water before you gown and glove.
- Gown and glove before entering patient's room.
- Remove gown and gloves before leaving patient's room.
- Wash hands with soap and water after leaving patient's room.

Reiki Volunteer Name: _____
Reiki Volunteer Signature: _____ Date: _____
Reiki Volunteer Trainer/Reviewer Signature: _____ Date: _____

Figure Checklist used to evaluate competency of volunteers in the Reiki program.

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energy-based CHA that promotes relaxation and supports the body's own healing ability.[23] The author's institution implemented a volunteer Reiki program over 10 years ago to meet the growing demand for the service.

Patient safety is of utmost importance in the acute and critical care setting. Volunteer CHPs must maintain infection control and patient privacy and security. Volunteer Reiki and animal-assisted therapy providers at the author's institution must complete a rigorous process of orientation and training, including instruction on infection control, environmental safety, informed consent, privacy and confidentiality, and accurate documentation. New volunteers must spend time shadowing an experienced volunteer. Evidence of training and certification is verified by the director of volunteer services before hospital identification and access are granted, and initial and ongoing competence must be validated through skills demonstration at least annually (see Figure). Novice CHPs and new volunteers are not permitted to practice in specialty areas, such as critical care units. These standards are consistent with those described by other hospital-based volunteer programs.[24,25]

According to the American Association of Critical-Care Nurses Synergy Model,[26] acute and critical care nurses must act as patient advocates while promoting comfort and healing. If CHAs are requested of or offered

Table Complementary health approaches (CHAs) in acute and critical care settings

CHA		Practitioner/credentials	Patient population, potential benefits
Manipulative and body-based therapies	Osteopathic manipulative medicine	Doctors of osteopathic medicine who are licensed to practice medicine by licensing boards in each state Requirements vary by state	Severe exacerbation of chronic obstructive pulmonary disease: improved exercise capacity, pulmonary function[27] Hospitalized pneumonia patients: shorter stay, decreased rates of respiratory failure and death[28] Neonatal intensive care unit: physiological stability, shorter stay[29]
	Massage	Massage therapists: most states regulate massage therapists by requiring a license, registration, or certification; training standards and requirements for massage therapists vary by state and locality, but most states require a minimum of 500 hours of training	Acute pain in hospitalized children: pain and anxiety reduction[30] Acute coronary syndrome: pain and anxiety reduction[31] Perioperative vascular access device patients: pain and anxiety reduction[32]
Energy therapies	Reiki	Not a regulated practice; training typically provided by a Reiki master or teacher, but format and length of training vary	Acute coronary syndrome: relaxation and stress reduction, decreased autonomic dysfunction[8,33]
	Acupuncture	Most states require the examination or certification by the National Certification Commission for Acupuncture and Oriental Medicine; each state regulatory board has unique requirements for licensure	Acute pain in adults and children: pain reduction[34] Patients receiving mechanical ventilation: improved gastric emptying[35]

by volunteer practitioners, the nurse must ensure adherence to all safety measures. Patients in acute and critical care settings may be more challenging for the volunteer because of limited space, presence of biomedical equipment and monitoring devices, frequent interventions, and often-changing physiological status. A therapeutic environment can be maintained through close collaboration and communication between the nurse and volunteer. The nurse should brief the volunteer on any restrictions concerning hand placement and pressure applied, patient positioning and movement, manipulation of equipment, use of any music or aromas, and signs that the CHA should be terminated. The patient should continue to be closely monitored throughout provision of CHAs for any physiological and psychological status changes, and patient response to the CHA should be documented.

Implications for Acute and Critical Care Nurses

Examples of medical professional- or therapist-delivered CHAs typically encountered in the acute and critical care setting are summarized in the Table. Whether those CHAs are provided by hospital-based practitioners, volunteers, or the bedside nurse, legal and ethical considerations are paramount to maintaining safety and trust with the patient and family. The author hopes that this series of articles about complementary and alternative medicine and CHAs in the acute and critical setting has provided nurses with the tools to confidently address the challenges that may be presented by patient and family requests for CHAs. Awareness of scope of practice, institutional policies, and legal boundaries can facilitate partnerships among acute and critical care nurses, patients and families, and other members of the health care team to ensure safe, high-quality, holistic care. Resources provided by the National Center for Complementary and Integrative Health (https://nccih.nih.gov), the American Holistic Nurses Association (http://www.ahna.org), the Bravewell Collaborative (http://www.bravewell.org/bravewell_collaborative), the Academic Consortium for Integrative Medicine and Health (https://www.imconsortium.org/index.cfm), and the Cochrane Complementary Medicine (http://cam.cochrane.org/about-us-1) can further assist acute and critical nurses to safely and

confidently incorporate patient and family requests for CHA into the plan of care. CCN

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None reported.

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See also

To learn more about complementary therapies, read "Strategies for Acute and Critical Care Nurses Implementing Complementary Therapies Requested by Patients and Their Families" by Kramlich in *Critical Care Nurse,* December 2016;36:52-58. Available at **www.ccnonline.org**.

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