BEST WISHES FROM IZMIR ...
Comfort Care
A Theory for Nursing

Sebnem CINAR YUCEL PhD, Assistant Professor
Ege University School of Nursing, Izmir, Turkey.
sebnem.cinar@ege.edu.tr
Historically, comfort is identified as one element of nursing care (Paterson & Zderad, 1988; McIlveen & Morse, 1995).

However, different perspectives of comfort also exist (Paterson & Zderad, 1988; Kolcaba, 1992a; Cameron, 1993)

and despite the colloquial use of comfort in daily life the exact meaning of the term comfort is unclear.
The position of comfort has also changed with the passage of time


From a review of the literature they suggest that comfort has moved from being the central essence of nursing to a minor strategy within nursing care.
In the early 1900s, when curing was unlikely, comfort was presented as, the central goal and moral imperative of nursing.
In the early period, comfort was essential because cures for patient ailments were largely unavailable.

The patient comfort with the help of nurses was positive and sometimes was related to an improvement in the patient’s condition.
In these early years, comfort resulted from several interventions including physical, emotional, and environmental.

Physicians often wrote orders for specific comfort measures for the nurse to carry out, including application of heat and positioning of the bed.
As medicine and society developed, *McIlveen & Morse (1995)* argue that physical comfort and pain relief became more important.

From 1960 to 1980 comfort appears as a minor strategy focused on physical comfort with an increasing emphasis on emotional comfort since the 1980s.
Comfort is identified by Orlando (1961) as central to her description of nursing.

Orlando (1961) saw the nurse’s role as focusing her attention on anything that interferes with his (the patients) mental and physical comfort.

Hall (1964, 1969) identified comfort in her model of nursing but as a part of the process of care giving.

This model entailed three interlocking concepts; the care, the core, and the cure, which she describes as three interlocking circles.


Paterson & Zderad (1988) define comfort as:
Comfort is an aim toward which persons’ conditions of being move through relationships with others by internalizing freedom from painful controlling effects of the past.

Paterson & Zderad see comfort as an umbrella term that encompasses health, growth, openness and freedom.

Roper et al. (1980) devised a model for living which identifies four groups of activities. These are daily living, preventing, comforting and seeking activities. The patient is seen to undertake or need help with these activities. Comforting activities are seen to have a physical, psychological and social basis and to support independence in relation to the activities of living.

More recent developments in relation to comfort have been made by Kolcaba


Kathy Kolcaba
According to Kolcaba’s (1994) Comfort definition;

Kathy Kolcaba travels the country, advising hospitals on making patients physically and spiritually comfortable. "Comfort can be something as simple as turning down the television or getting a warm blanket," she said.

Kolcaba likes to tell a story about the time one of her patients was depressed and refusing food.

"I decided to turn-off my beeper, close the door and find out why this patient would not eat," she said.

The patient told Kolcaba that she found the hospital’s food unappetizing, but she would like a bowl of Cream of Wheat. Kolcaba got it and hand-fed it to the patient.

The patient later wrote Kolcaba a thank-you note. She wrote that the Cream of Wheat and "your TLC (tender loving care)" were the first steps in her recovery.

Kolcaba’s theory outlines four areas of comfort: physical, psycho-spiritual, environmental and socio-cultural.

Hospitals usually provide physical comfort, but Kolcaba teaches staff to provide comfort in the other three areas. Her comfort theory can make hospitals run more efficiently, she said.

"If nurses take the time to make patients comfortable while they’re on their rounds they won’t have unhappy patients ringing the buzzer all the time," she said.

Psycho-spiritual comfort means looking after a patient’s mental and spiritual well-being.

“A patient may have anxiety about a diagnosis and they want to speak with a chaplain or they simply want someone to talk to,” she said.

Environmental comfort means making the patient’s hospital room comfortable. Socio-cultural comfort means helping patients with loneliness or depression.

Kolcaba has taught Comfort Theory at Mt. Sinai Hospital in New York. She is travelling to San Francisco this month to work with Kaiser Permanente Hospitals.

Visit Kolcaba’s Web site for a detailed patient comfort questionnaire and a video. Contact her at the site, thecomfortline.com
Comfort is defined for nursing as the satisfaction (actively, passively, or co-operatively) of the basic human needs for relief, ease or transcendence arising from health care situations that are stressful.
From the time of their birth, human beings yearn for comfort.
A newborn quiets down when held and rocked,
A child stops crying when his hurt knee is kissed,
A sick elderly man/woman seems at peace when his hand is gently stroked and calming words are quietly spoken to him.
Comfort remains a substantive need throughout life and, as such, should be considered an indispensable constituent of holistic nursing care.
Kolcaba and Wykle (1997) proposed that comfortable patients heal faster, cope better, become rehabilitated more thoroughly, and die more peacefully than do the uncomfortable.

I. *Comfort*: a theory for care

A. Advantages of theory-based caring:

- organized pattern for **efficient** care
- individualized to each patient
- satisfying to patients, families, and care givers
- this particular framework is intuitive, easy to learn

- We are all familiar with the idea of comfort!
  - *What makes you comfortable?*
A. Dictionary Definitions: *Comfort* (Webster)

1. To soothe in distress or sorrow (*relief*).
2. *Relief* from distress (absence of previous discomfort) (*negative sense*)
3. A person or thing that comforts (*you!*)
4. A state of *ease* and quiet enjoyment, free from worry (*neutral sense*)
5. Anything that makes life easy (*transcendence*)
Relief, the experience of having had a specific need met or mediated.
Relief

I need help because I’m lonely.
Relief from needs is necessary for return to former function or a peaceful death.
Ease, the state of calm and contentment.
Ease

I feel totally peaceful.
Ease is the state of comfort that is a necessary condition for efficient performance.
Transcendence is defined as the state in which ordinary powers are enhanced.
Transcendence, the state in which one rises above problems or pain.
Transcendence

I did it!
(with the help of my coach...)
B. Technical definition of Comfort

Holistic: comfort is physical, emotional, spiritual, environmental, social, cultural
It is the state of being strengthened when needs for *relief, ease, and transcendence* are met in four contexts of experience: *physical, psychospiritual, sociocultural, and environmental*.

The first context is **physical**, pertaining to bodily sensations.
The second context is psychospiritual, pertaining to the internal awareness of self, including esteem, sexuality, meaning in one's life, and relationship to a higher order or being.
The third context is social, pertaining to interpersonal, family and cultural relationships, including financial.
The fourth context in which comfort is experienced is **environmental**, pertaining to light, noise, ambience, color, temperature and natural versus synthetic elements.
### C. Content Map of Comfort

<table>
<thead>
<tr>
<th>Context in which comfort occurs</th>
<th>Type of Comfort</th>
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<tbody>
<tr>
<td></td>
<td>Relief</td>
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<tr>
<td>Physical</td>
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<td>Psycho-Spiritual</td>
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<td>Socio-Cultural</td>
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<td>Environmental</td>
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D. There is no medication for holistic comfort.

- The nurse is the magic bullet.
- Therapeutic use of self enhances patient comfort.
- Think: comfort is more than pain relief.
II. Outcomes of Comfort

- Comfort encompasses relief (of pain and other symptoms), ease, and transcendence.

- Because comfort is strengthening it protects and empowers patients for all phases of their treatment/recovery!

- Also empowers patients and families for a peaceful death, if that is most realistic.
III. Comfort in institutional settings (Hamilton, 1989)

Research questions:

What is the patient’s (also known as resident, client, or child) definition of comfort?
What contributes to the residents’ comfort?
What detracts from the residents’ comfort?
How can patients be more comfortable?

Found five recurring themes.
1. **Comfort Theme of Disease process**

**Contributing factors:**
- Pain relief
- Regular bowel function

**Detracting factors:**
- Physical disabilities
- Medical problems
  - Neuropathy, eye pain, etc.
- Being in pain most of the time
  [80% have chronic pain]

(NurseWeek, 2001)

**Proposed factors for more comfort:**
- **Better pain management**
  (in US, pain is now assessed as the 5th vital sign)
- **Better diagnostics**
2. Comfort theme of self-esteem

**Contributing factors:**
- Faith in God
- Being independent
- Feeling relaxed
- Feeling useful

**Detracting factors:**
- Adjusting to change
- Being afraid

**Proposed factors for more comfort:**
- Being informed
- Welcoming contributions
- e.g. grandma holding baby

**Contributing factors:**
- Individually adjusted seating
- Sitting correctly
- Independent movement in chair
- Returning to bed upon request

**Detracting factors:**
- Unsuitable wheelchairs
- Sitting too long
- Sliding down in chair or bed
- Being unfavorably positioned in chair
4. Comfort theme of approach and attitudes of staff

Contributing factors:
- Friendly, kind people
- Empathetic nurses
- Reliable nurses

Detracting factors:
- A lack of caring and understanding
- Inaccessible nurses
- Fragmented care

Proposed factors for more comfort:
- Caring, understanding nurses
- Encouraging residents to help themselves
- Continuity of staff
5. Comfort theme of hospital life.

**Contributing factors:**
- Homelike surroundings
- Social and family contacts
- Structured leisure activities
- Informal pastimes

**Detracting factors:**
- Tolerating the system
- Boredom with activities
- Lack of privacy
- Unpleasant mealtime atmosphere
IV. Three types of comfort measures:

1. Technical interventions, for relief and ease
   - Internal physical needs to maintain *comfort*
   - Pain management

2. Coaching for ease

3. Comfort food for the soul (transcendence)
Comfort Measures:

- Music as desired, guided imagery
- Massage – foot, back, hand
- “Being with” “Therapeutic use of self”
- Environmental beauty (nature)
- Family, friends if comforting
- Spiritual support
- Reassurance, especially related to specific anxieties
- Legacy Book – reminiscence
Total comfort is affected by fear and anxiety

Anxiety impacts negatively on:

- perception of pain
- ability to relate to others
- ability to pray, prepare
- ability to let go, relax, accept

- Trust....that we, the caregivers, will do the right thing.
Although there is evidence that nurses undervalue the importance of comfort, several researchers have demonstrated the value of comfort as a patient outcome.
Bottorf (1991) examined the lived experience of being comforted by a nurse and identified comfort in such contexts as community, presence of others, language, touch, and home.
Similar to Kolcaba’s (1991) technical sense of comfort, Bottorf (1991) frequently referred to comfort as a state of ease.
Morse (1992) described comfort as an outcome of nursing care, where the effectiveness of this care is identified by the patient’s comfort level.
Gropper (1992) recognized comfort not only as a basic human need but as an important nursing and patient objective.
Walters (1994) analyzed comfort in the critical care setting and found that comfort was described in relation to providing support to the patient, relief from pain, relief from anxiety, communicating, using touch, facing death, and comforting family and friends.
Ferrell & Ferrell (1990) indicated that all nursing care should be based on comfort and studied comfort as an outcome resulting from active approaches by both the nurse and the patient.
Cameron (1993) studied the nature of comfort in relation to hospitalized patients in a medical surgical unit, and addressed the current state of comfort care within nursing practice and the patient’s view of comfort.
Similar to studies conducted before and after, Cameron found that comfort was a complex and dynamic concept.

A finding of the study was that comfort was not a passive process; rather, patients took a very active part increasing personal levels of comfort.
According to the authors, achieving comfort is based on the patients’ needs to not be dominated by their bodies through illness or injury.
In the study that Kolcaba et al (2006) examined the effect of hand massage on comfort in elderly patients staying in nursing home, they found that hand massage was significantly effective in first weeks in the experiment group but not significant in the following weeks*

Kolcaba (2004) in another study detected that hand massage increased the comfort of nursing home patients**

Efficacy of Hand Massage for Enhancing the Comfort of Hospice Patients

Katharine Kolcaba, PhD, RN, C; Therese Dowd, PhD, RN; Richard Steiner, PhD, MPH; Annette Mitzel, MSN, RN, LMT

There is a need to develop and test interventions for patients near end of life that are comforting, easy to learn and administer, and require little effort on the part of recipients. This experimental study tested the efficacy of bilateral hand massage for enhancing hospice patients' holistic comfort as measured with the Hospice Comfort Questionnaire (HCO). We hypothesized that, over 3 time points, patients who received hand massage would have higher comfort and less symptom distress than a comparison group. Participants were randomized into treatment (received the intervention twice weekly for 3 weeks) or comparison groups (received the intervention once at the study's end). Findings indicated that patients receiving hand massage had increased comfort over time, while symptom distress remained flat in both groups. However, findings were insignificant. Ethical and practical issues experienced in this study are discussed.

KEY WORDS

comfort
hand massage
hospice comfort questionnaire
end-of-life care
palliative care
hospice

Katharine Kolcaba, PhD, RN, C, Associate Professor, The University of Akron, College of Nursing, Akron, OH.

Therese Dowd, PhD, RN, Associate Professor, The University of Akron, College of Nursing, Akron, OH.

Richard Steiner, PhD, MPH, Associate Professor, The University of Akron, Dept of Statistics, Akron, OH.

Annette Mitzel, MSN, RN, LMT, Instructor, The University of Akron, College of Nursing, Akron, OH.

Address correspondence to Katharine Kolcaba, PhD, RN, C, Associate Professor, The University of Akron, College of Nursing, 209 Carroll St, Akron, OH 44325-3701 (e-mail: klcaba@uakron.edu).
Tsay et al (2005) determined a statistically significant healing in comfort level, dyspnoea, anxiety, and physiological indicators of dyspnoea in patients who were applied acupressure with chronic obstructive pulmonary disease (COPD) in the support of mechanical ventilation.

Music therapy as a nursing intervention within the context of comfort, pain, and anxiety of mechanically ventilated patients was investigated by Besel (2006).

She found that comfort, anxiety, and pain scores before and after the intervention and control also did demonstrate significance.
V. Comfort Theory states that:

1. Nurses identify unmet comfort needs

2. Nurses design comfort measures (interventions) to address those needs.
V. Comfort Theory states that:

3. **Intervening variables are considered when designing**

(1) comfort measures and

(2) mutually agreed upon immediate outcome (enhanced comfort) and/or

(3) subsequent (health seeking behaviors) outcomes.
Comfort theory (cont’d)

4. If comfort is enhanced, patients are strengthened to engage in health seeking behaviors (internal, external, or peaceful death).
Comfort theory (cont’d)

5. When residents engage in health seeking behaviors, families and nurses have more satisfaction and financial costs to the facility are less (theoretical – needs to be tested).
## Comfort Care Plan

**Names:** Patient ______________ Medical Diagnosis ______________ Student ______________

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<tr>
<th>Alpha Press</th>
<th>Beta Press</th>
<th>Unitary Trend</th>
<th>Institutional Outcomes</th>
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<tbody>
<tr>
<td><strong>Comfort Needs</strong></td>
<td><strong>Interventions</strong></td>
<td><strong>Intervening Variables</strong></td>
<td><strong>Perception of Comfort</strong></td>
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<tr>
<td><strong>Physical</strong></td>
<td>The nurse...</td>
<td>Objective</td>
<td>The patient will...</td>
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<td><strong>Psychospiritual</strong></td>
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<td><strong>Socialcultural</strong></td>
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Kathy Kolcaba
VI. Conclusion

- Patients and families want to be comforted by their nurses.

- **Memorable nurses** are those that attend to comfort needs of patients and families – in any setting!
The Comfort Line is at:

www.thecomfortline.com

Available at:
- [www.uakron.edu/comfort](http://www.uakron.edu/comfort)
- [www.Amazon.com](http://www.Amazon.com)
THANK YOU FOR YOUR INTEREST