A Comfort Unit: Outcomes Associated with Addressing Holistic Comfort Needs of Hospitalized Patients

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OUTLINE FOR PROPOSAL

I. Basic Research Design

A. After a 1-2 year implementation of Comfort Unit (CU) principles, outcomes on experimental unit are compared to a similar, but usual care, unit at Your Favorite Hospital (YFH).

B. Random assignment of incoming patients, who meet inclusion criteria, to Comfort Unit or comparison unit.

C.Independent data collectors (funded by study).

D.Staff on CU not aware of which patients are being surveyed on selected outcomes.

E.All patients on CU receive Comfort-focused Care.

F.Basic CU Components

a. Principles of Comfort-focused Care shared with all staff on selected unit and implemented with all patients (next two pages)

G. Model of care delivery: Primary nursing

H.CNS (hired by grant) conducts interdisciplinary team conferences every day (medicine, nursing, pharmacy, nutrition, OT, PT); team makes recommendations for care on each patient on unit.

1. interdisciplinary comfort care plan – light green color- put in patients' charts

I. CNS conducts after care visits as necessary

J. Optimum staffing on all shifts, as determined by staff nurses (additional staff funded by study)

K. Some environmental modifications (funded by YFH to demonstrate support?)

L. Medical director "on board"

M. Frequent in-service programs about Comfort-focused Care to all staff on selected unit

**Most costs covered by Federal Funding. If selected unit houses predominately adults 65 yrs. or older, application could be made to NIH's Institute on Aging.

WAYS TO ADDRESS PATIENTS' COMFORT NEEDS ON COMFORT-FOCUSED UNIT

Pt's Comfort Needs	Modifications to Unit/Approach to Care
Physical Comfort Needs	
Homestasis	Daily team conferences conferring on lab values, functional status, vital signs, recovery as expected, expected difficulties when discharged
Mobility	Remove tethers ASAP, lower bed rails except for one top one top rail for patient leverage; keep beds in low positions; Hand rails in halls, non slippery floors; walking aids including correct shoes
Elimination	Remove catheters ASAP, bedside commodes, PT every day; change door knobs to door handles; toilet q 2 hrs. Adequate fiber and fluid.
Pain Management	PCA pumps when possible; meds for breakthrough pain; pain mgt. consultant; implementation of **intentional comfort measures**; Coaching;
Sensory	Glasses, hearing aids, dentures in place – procedures for not losing them;
Medications	Responses/side effects to old and new meds, monitoring of therapeutic levels appropriate to age
Nutrition	Assessment caloric and fluid intake, implementation of nutrition recommendations
Hygiene	Oral care, bed bath

Rest/sleep	Adequate pain medication; anxiety addressed
Position	In and out of bed upon request; independence from tethers; comfortable wheelchairs, lounge chairs, chairs for eating Correct position in bed; correct turning techniques

Psychospiritual Comfort Needs

Anxiety	Assessment & discussion of i**ntentional comfort measures;** complementary therapies
Depression/dementia	Depression screen; determine baseline for cognitive function (pre-hospitalization);
Spiritual	Visits of clergy as indicated; spiritual assessment/care from all staff members;
Expectation	Assessment of patient's/family's expectation for recovery;
Loss of control	Choice, consultation with patient

Sociocultural Comfort Needs

Home issues	Hardships/concerns at home
Family support	Family visits (pets?) around the clock, favorite foods brought in or prepared;
Loneliness/fear	Therapeutic use of self; empathy; unhurried interactions; whole-person interactions; Pet Therapy
Financial	Financial paper work assistance; medication costs
Educational	Teaching about meds, rehab and nutritional guidelines; Information about condition, diagnostic tests, options
Discharge Planning	Discharge planning begins first day of admission; implementation of OT recommendations; home care as necessary;
After care	Phone calls, visits by CNS as necessary
Cultural sensitivity	Interpreters available; traditions facilitated whenever possible; consultation with spiritual/cultural leaders; **Intentional comfort measures** as indicated by family

Environmental Comfort Needs

Relocation	Environmental cues, personal belongings
Furniture	Comfortable furniture (especially for overnight situations) in room for patient and family;
Safety	Call light easy to use;
Ambience	No intercom noise; light, TV as desired; clutter removed;
Privacy	Curtains, draping, signs on BR doors
Function	Aids nearby; bed alarm instead of restraints; distances measured and marked in hall, implementation of PT recommendations
Meaningful Activities	OT prescribes therapeutic activities to do in unit

Nurses' Comfort Needs

Ergonomic Safer Designs (equipment, furniture, syringes, gloves, etc.)

Improved career ladders, opportunities to advance into management

Increased autonomy for practice decisions

Flexible (self) scheduling

Increased recognition

Breaks, lunch, leaving on time

Less paper work, less non-nursing work

Managerial support at unit level

EXAMPLES OF INTENTIONAL COMFORT MEASURES

Hand massage	Staff nurses (after CE program)
Foot massage	Staff nurses (after CE program)
Back massage	Staff nurses (after CE program)
Full body massage	Massotherapist (funded by study)
Guided imagery	Staff nurses (after CE program)
Music/art therapy	Certified therapists (funded by study)
Healing touch	Staff nurses (after CE program)

EXAMPLES OF OUTCOMES TO BE MEASURED

Comfort	General Comfort Questionnaire, Comfort Behaviors Checklist
Pain	Comfort and Pain Visual Analog Scales
Functional Status	
Peaceful Death	(When most appropriate and agreed-upon outcome)
Adverse Events	Med errors/toxic effects; new incontinence, nosocomial infections, falls, new decubiti, etc.
Decrease in analgesia, Anti-anxiety, HS sedation	Chart Review
Length of Stay	Records
Hospital readmission	Records
Patient/Family Satisfaction	Survey
Cost/Benefit Analysis	
YFH priority outcomes?	