A Framework of Comfort for End of Life Care

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www.TheComfortLine.com
What do we mean by comfort?

Technical Definition (from literature in nursing, psychiatry, ergonomics, theology, psychology, etc)

- The immediate experience of being strengthened by having needs for comfort met
  - Physically
  - Psychospiritually
  - Socioculturally
  - Environmentally

Pattern for assessment of comfort needs
Holistic, simultaneous perception of total comfort, umbrella term
   - “I am NOT comfortable going there....”

Intuitive, not complicated
   - The kind of patient care we already know how and want to do

Noun (state of comfort) or adjective (comfortable)
Comfort is an Umbrella Term, a **Whole Person Term**

- **“Relief”** - unmet comfort needs
  - partial list of common discomforts in palliative care

- **“Ease”** - contentment

- **“Transcendence”** - we never give up: interventions to help patient/family cope when full relief is not possible

- Comfort is greater than relief of one or two discomforts

- Also, interventions for one “cell” affect other cells

<table>
<thead>
<tr>
<th></th>
<th>Relief</th>
<th>Ease</th>
<th>Transcendence</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physical</td>
<td><em>Pain, Nausea, Fatigue</em></td>
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<tr>
<td>Psycho-spiritual</td>
<td><em>Anxiety, Loss of Meaning</em></td>
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<tr>
<td>Socio-cultural-political</td>
<td><em>Isolation Role change</em></td>
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<tr>
<td>Environmental</td>
<td><em>Noise, odors, interrupted sleep</em></td>
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Comfort Management

- **Symptom management of patients and families** (relabeled)
  - Loss of appetite
  - Restlessness
  - Difficulty breathing
  - Others?

- **Comfort Expectations? (always changing)**
  - Desired level of alertness
  - What has worked in the past

- **Ethical decision making based on comfort needs of patient** (often different than family’s needs)
Three easy parts to a Framework of Comfort:

- **1. Comfort interventions enhance comfort**
  - Immediate outcome

- **2. Enhanced comfort facilitates & predicts successful engagement in HSBs**
  - Subsequent outcome

** = tested in real patients

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(Health Seeking Behaviors???)

[Scholtfledt R (1975 & 1981)]

- **Internal**: evidence of healing, decreased inflammation, increased T-cells or white blood cells

- **External**: improved mobility, increased functional status, increased appetite, and decreased pain
Health Seeking Behaviors (cont)

- **Peaceful Death**: a passing that ends well and is poignant for the patient, health care workers, and family; a time to say goodbye to each other and one’s mortal life, to find meaning and sum up that life
  - “Patients should die like they’re being rocked to sleep in their mother’s arms” [Dozor, R. & Addison, R. (1992)]
3. Successful engagement in HSBs is related to improved Institutional Outcomes

- Wonderful patient/family satisfaction surveys and testimonials
- Favorable cost-benefit results
- Positive marketing claims
A Framework of Comfort is:

- An interdisciplinary guide for:
  - the practice of palliative care
  - enhancing your working environment
  - team communication and care planning

- An “architectural structure” upon which you can hang all the other information in your orientation

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Framework of Comfort (Palliative Care)

Health Care Needs Patient/Family/Staff

Nursing Interventions

Intervening Variables

Patient/Staff Comfort

Health Seeking Behaviors Patient/Family/Staff

Institutional Integrity

Comfort Needs Before, During and After Admission

Specific Comfort Measures

Staffing Levels

Pt. Characteristics

Physical Psychospiritual Social/Cultural Environmental

Internal External Peaceful Death

Positive Value System Intentional Goals re. patient, family/ staff comfort, Financial Viability

Assessment before Comfort Measures

Protocols For Patient/Family/Staff

Use in Data Analysis (covariates)

Assessment After Comfort Measures

Less nausea, pain; Less absenteeism

Pt/family/staff Satis; Cost-Benefit

1. 2. 3.

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Whose comfort? (2 prongs)

- Your patients & their families

And Also:
- The staff, including managers, clerks, administrators, & interdisciplinary team
- Your families

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So a framework of comfort is also...

- a “blueprint” for:
  - your own job satisfaction, an institutional outcome
    - Other institutional outcomes?
  - Southwest Airlines business philosophy
Application of Framework:

- **Daily Patient/Family Rounds**
  - Comfort needs of patient & family?
  - Interdisciplinary care planning, evaluation
  - Pattern for bedside care (same as the definition)
    - *Physical*
    - *Psychospiritual*
    - *Sociocultural*
    - *Environmental*
Application of Framework (cont):

- **Environmental design**
  - Details to make your work easier
  - Comfort needs of staff?

- **Workplace culture**
  - Mission statement
  - How to utilize and enhance team work
  - Governance, support, scheduling, assignments (based on comfort needs of patients/families?)
  - Meals, breaks, continuing education
○ Are there any questions?

○ What are your “gut” reactions to using a framework to structure all the care you give? (including goals, methods, desired outcomes, etc.) of your new unit?

○ Do you think a Framework of Comfort is appropriate? Useable? Will make life easier?
**Staff Comfort:**

Definition: totality of embeddedness in an organization based on physical, psychospiritual, sociocultural, and environmental attributes of an institution or agency

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Physical Comfort of Nurses:

Clean, safe environment; attractive, convenient, and clean lounge; restful breaks; good coffee, tea, etc; flexible scheduling; off duty on time; no rotating shifts; continuity of patient care; adequate staffing; resources allocated consistently and fairly; control over resources; equipment that works, is available, is complete, is ergonomic; good salary, benefits, profit sharing, retirement; increased routinization; day care available; noise controlled; pleasant and efficient physical layout; enough room to work; self-scheduling;

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Psychospiritual Comfort of Nurses:

Job fits with one’s own values; managerial support; decrease in non-nursing work; opportunities for advancement; timely feedback on job performance (positive also!); control over practice; freedom to make important patient-care decisions; inter-departmental cooperation; trust in management; sharing of feelings; empowerment; agreement with organization goals & culture; creativity encouraged; support for learning, growth, & development; role clarity; appropriate authority, responsibility, respect, & recognition; skills and talents utilized optimally; positive change models;

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Sociocultural Comfort of Nurses:

Supportive social environment; opportunities to be part of major decisions; information shared by administration; strong communication; cultural & ethnic diversity of patients, families, and staff; mentorship; nurse-physician collaboration; PhD in nursing research on staff; enough time to discuss patient-care problems with other nurses; education provided; teamwork valued; nurse managers strong leaders and advocates for staff;

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Organizational (Environmental) Comfort of Nurses:

Distinct and strong nursing department; flat organizational structure; professional milieu for practice; working together for high JCAHO ratings; none or minimal agency staffing; decreased paperwork and administrative duties; specialty units; workload adjusted for precepting new nurses & students; visionary leaders; good organizational fit; respect for professional goals

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Wouldn’t YOU like to work in a place with these qualities?
What’s in it for the Institution?

- Local (public) recognition (word of mouth, media)
- Third party payer recognition
- National recognition
And….

- It is recommended that one guiding conceptual framework be utilized to coordinate such a work place.

- This really makes theory come to life!
  - applied to change in the values of health care units
  - applied to transformational changes in nurses’ environment
  - consistent with desired and positive patient outcomes
Permit me to digress… on positive patient outcomes!

Hospital outcomes have focused on negative outcomes:

- Nosocomial infections, UTIs, bedsores, falls, complications, errors
- Failure to rescue!
- Mortality
Don’t our patients hope for care that is good?

How can we measure quality of care positively?

Examples of positive outcomes are: comfort (holistic), early and successful discharge, healing, sustained functional status, etc.

Positive outcomes are consistent with a transformed environment of care.
Data show that poor work environments for nurses were associated with poor quality of care and adverse patient outcomes.

- 8 developed countries with differently organized and financed health systems
- Different levels of resources
If employees aren’t happy and well-cared for, patients and families won’t be either.

Transformational effect due to striving for and achieving a holistic and positive environment for health care.
Suggestions for Co-Creating a Comfort Place.....

- Rethinking of symptom management (of patients/families) as comfort management
- Comfort Competencies, Pre & Post-tests
- Documentation of comfort management
- Creative standards of care
- Environmental factors
- Organizational structure
- Transformation of nursing practice
- Embeddedness vs. retention
- Comfort as an interdisciplinary concept
  - unifies patient care
  - everyone can contribute
  - communication enhanced

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Deliverables guided by the Comfort Framework

- Sections about:
  - positive patient outcomes
  - documentation
  - nurses comfort and “productivity”
  - changing one’s practice from the bottom up
    - Perianesthesia nursing
    - Clinical practice guidelines
  - performance review
  - patient care assignments
  - scheduling

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Thank you for listening!

- Are there any questions?
- What are your “gut” reactions?
- This framework is evolving constantly
- Suggestions important!
- Follow up sessions planned

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