



CONTINUING EDUCATION

Practical Application of Comfort Theory in the Perianesthesia Setting

Linda Wilson, PhD, RN, CPAN, CAPA, BC

Katharine Kolcaba, PhD, RN, BC

Comfort management is a priority for patients in all settings. Comfort theory provides a foundational and holistic approach to comfort management. This article reviews comfort theory and presents the application of comfort theory in the perianesthesia setting.

© 2004 by American Society of PeriAnesthesia Nurses.

Objectives—Based on the content of the following article, the reader will be able to (1) define comfort; (2) identify comfort interventions; and (3) discuss the importance of a goal for enhanced comfort in patients.

HOLISTIC COMFORT IS a desirable outcome of nursing care in the perianesthesia setting. Moreover, it is an umbrella term under which the discomforts that patients experience as a result of surgery or procedures can be placed. These discomforts are many and include pain, nausea, anxiety, and hypothermia. This article provides an overview of current comfort theory and a framework for addressing the comfort needs of patients in the perianesthesia setting. A

useful tool for identifying and addressing patients' comfort needs is described, and an example of its application in the perianesthesia setting is included.

Comfort Theory

Comfort theory¹⁻³ as it relates to nursing is best understood when divided and described in 3 parts. Part 1 states that nurses assess the holistic (physical, psychospiritual, sociocultural, and environmental) comfort needs of patients in all settings. Furthermore, nurses implement a variety of interventions to meet those needs and measure or assess patients' comfort levels before and after those interventions. This part of comfort theory also describes positive and negative intervening patient variables over which the nurse has little control, but that have considerable impact on the success of comfort interventions. Examples of these variables are the patient's financial situation, cognitive status, extent of social support, and prognosis.¹⁻³

Linda Wilson, PhD, RN, CPAN, CAPA, BC, is an Assistant Professor in the College of Nursing and Health Professions at Drexel University in Philadelphia, PA and is a Past President of ASPAN; and Katharine Kolcaba, PhD, RN, BC, is an Associate Professor in the College of Nursing at the University of Akron, Akron, OH. She is the author of *Comfort Theory and Practice*.¹

Address correspondence to Linda Wilson, Drexel University College of Nursing and Health Professions, 1505 Race Street, 7th Floor, Mail Stop 501, Philadelphia, PA 19102; e-mail address: lbw25@drexel.edu.

© 2004 by American Society of PeriAnesthesia Nurses.

1089-9472/04/1903-0006\$30.00/0

doi:10.1016/j.japan.2004.03.006

Part 2 of comfort theory states that enhanced comfort strengthens patients to consciously or subconsciously engage in behaviors that move them toward a state of well-being.⁴ These behaviors are called health-seeking behaviors and provide rationale for implementing comfort interventions. For patients in the perianesthesia setting, health-seeking behaviors might include decreased blood loss, no complications, increased healing, increased mobility, and the ability to take oral fluids.¹⁻³

Health-seeking behaviors are related to what is called institutional integrity in part 3 of comfort theory. Institutional integrity is defined as the quality or state of health care organizations in terms of being complete, sound, upright, professional, and ethical providers of health care.¹⁻³ It is measured by many indicators, including cost of care; length of stay; staff turnover rate; and patient, nurse, and staff satisfaction.

Patients Define Comfort

In her seminal work of 1989, Hamilton⁵ identified 5 themes that 30 elderly hospitalized patients used to describe their experience of comfort. The first theme was the disease process, or physical comfort. According to those interviewed, physical comfort entailed both an emphasis on treatment of overt discomforts, such as pain, as well as meeting less obvious needs, such as being able to go back to bed when requested, sitting correctly in furniture, and having regular elimination.⁵

The second comfort theme was self-esteem, which encompassed both psychological and spiritual comfort.⁵ Moreover, those interviewed did not differentiate between psychological and spiritual comfort, because persons can be spiritual without a religious affiliation and vice versa. The third comfort theme, positioning, encompassed the physical and environmental aspects of comfort.⁵ Positioning was an important part of overall comfort for these patients. These findings demonstrated that the environ-

ment played a major role in the patient's perception of comfort. This is good news for nurses, because often they can easily manipulate the environment to enhance patient comfort and function. For example, perianesthesia nurses can prevent or treat shivering by offering patients a variety of warming interventions, including patient-regulated warming devices, which may both warm and increase patients' sense of control.

According to Hamilton, the fourth comfort theme, approach and attitudes of staff, was dependent on the nursing staff.⁵ For example, empathetic and reliable nurses contributed to comfort, whereas inaccessible nurses and those who lacked caring attributes detracted from comfort. In addition, patients wanted choices and to be allowed to do things themselves, even if it took longer. Hamilton's fifth comfort theme, hospital life, encompassed physical, social, psychospiritual, and environmental aspects of comfort.⁵ Patients described comfort in terms of its complexity and importance to their well-being. Their hospital life had an overall impact on their total comfort experience.

During Hamilton's study, the patients who were interviewed agreed that the 5 themes were equally central to comfort.⁵ They also described individual preferences for the ways nurses could contribute to comfort such as personal recognition and respect, working with a positive attitude, and attention to their individual needs. Hamilton concluded that comfort is multidimensional and means different things to different people, emphasizing the importance of individualizing attention to patients' needs.⁵

Nurses Define Comfort

A convenience sample of 220 nurses who attended the 2001 ASPAN national conference were surveyed to better understand their perceptions of pain and comfort.⁶ The study sample consisted of perianesthesia nurses from different settings including Pre-Admission Testing (PAT), PREP/Holding, Remote Anesthesia, and

all phases of the PACU. Findings showed that during the preoperative phase, nurses identified patients' desired outcome levels of pain and comfort at frequencies of 21% and 20%, respectively. These findings validated the importance of further education on pain and comfort for perianesthesia nurses.

In a survey conducted in 2003, nurses attending annual conferences for ASPAN and the Association of PeriOperative Registered Nurses (AORN) were asked about their perceptions of patient comfort (unpublished data). A total of 722 nurses completed the survey, which asked, "What are the top 3 comfort concerns of patients?" Warmth was cited most often (33.3%) as the top comfort concern, followed by pain management (18.3%), position (12.2%), and all others (36.2%). Those who participated in the survey were also asked how often cold is a comfort issue for their patients. The majority (71%) responded that cold is often a comfort issue, 25% reported sometimes, and just 4% responded that cold is rarely a comfort issue. These results underscored the need for aggressive warming interventions not simply in the clinical context of maintaining normothermia, but also as a means of increasing overall patient comfort in the perianesthesia setting.

Interviews of 27 critical care nurses were conducted to provide further insight into nurses' perceptions of patient comfort. In this unpublished data, the nurses described trusting their own intuition and the family's intuition about a loved one's comfort. In addition, they assessed vital signs, gestures, and grimaces to determine the presence of pain.

Theoretical Framework for Practice

Kolcaba provides a definition of comfort that appreciates the holistic nature of human beings—that individuals have mental, spiritual, and emotional lives, which are intimately connected with their physical bodies.^{1,7,8} Kolcaba defines comfort as the immediate state of being

strengthened by having the human needs for relief, ease, and transcendence (types of comfort) addressed physically, psychospiritually, socioculturally, and environmentally (contexts in which comfort is experienced).^{1,9} This definition emphasizes that although nurses may not be able to fully meet all of their patients' needs for comfort, they can continue to address them in a proactive fashion throughout the continuum of care.

Kolcaba identifies 3 types of comfort. The first type, relief, is the state of having a specific discomfort relieved.^{1,9} In the perianesthesia setting, some of the common discomforts to which this relates are pain, nausea, cold, or anxiety. The second type of comfort is ease and refers to a state of contentment for the patient.^{1,9} This can refer to comfort needs arising from a patient's previous experience with a particular need or by virtue of the patient's diagnosis or prognosis. For example, patients with uncertainty regarding their diagnosis may need emotional support to achieve comfort in this area. Nurses can prevent or minimize these needs, often without patients realizing that they are doing so, thus keeping patients in a state of ease. The third type of comfort is transcendence, which encompasses the need for inspiration, strengthening, and motivation.^{1,9} Nurses often focus on meeting the needs of transcendence when they are unable to fully meet the other types of comfort needs for their patients. For example, they may assist patients in the use of distraction and relaxation breathing when nausea persists despite treatment with antiemetics.

Table 1 provides a description of Kolcaba's 3 types of comfort in the 4 contexts in which patients experience them: physical, psychospiritual, environment, and sociocultural.^{1,9} The 12-cell grid in Table 2 provides a useful tool for categorizing comfort needs in ways that will allow nurses to individualize treatment plans for their patients. Each cell represents an attribute of comfort. It is important to note that the cells

Table 1. Types and Context of Comfort

Type of comfort
Relief: having a particular comfort need met.
Ease: being calm or content.
Transcendence: a feeling that one can rise above problems or pain.
Context in which comfort occurs
Physical: involving bodily sensations and homeostasis.
Psychospiritual: items such as self esteem, self concept, sexuality, meaning in life, and spirituality, which contribute to internal awareness.
Environmental: includes temperature, light, sound, odor, color, furniture, landscape, and other factors in the background of the human experience.
Sociocultural: involving interpersonal, family, and societal relationships such as finances, teaching, health care personnel, etc. May also refer to family traditions, rituals, and religious practices.

Data from Kolcaba and Fisher.¹²

are not mutually exclusive; they are “fluid,” and there is considerable overlap in the attributes of comfort. In other words, most discomforts that patients experience in the perianesthesia setting, such as pain, hypothermia, and nausea, may have physiological, psychological, environmental, and sociocultural components.

The holistic, interrelated, and individualized nature of comfort needs is better understood when nurses mentally place their patients’ needs within the cells on the grid. This approach makes it easier for nurses to identify and implement comfort interventions targeted to meet those needs. Table 2 provides an example of a hypothetical patient and how the grid can be used to tailor the treatment plan.

Table 2 demonstrates that a wide variety of comfort needs of patients in perianesthesia settings can be placed somewhere on the grid, including individualized needs for spiritual guidance, emotional support and reassurance, environmental adjustments, and physical needs. Also note that essential to comfort is the maintenance of homeostatic mechanisms such as oxygenation, circulation, fluid and electrolyte balance, normothermia, digestion, mobility, and elimination. Many of the patient’s homeostatic needs can be gleaned from a review of the patient’s history and current medical problems. A key point to remember is that all of these comfort needs interact and produce more discomfort together than can be accounted for by considering each comfort need separately.

Comfort Detractors and Contributors

After assessment of comfort needs, nurses address the sources of discomfort (Table 1).¹ Nurses can implement a number of interventions that will contribute to comfort by minimizing or negating the detractors of comfort. Several interventions can be delivered simultaneously in a seamless interaction with patients and can influence the patient’s overall perception of comfort. For example, pain is a major detractor from physical comfort. Patients often describe “waiting for pain medication” (a contributing detractor) as a significant pain intensifier.¹ Nurses can intervene to minimize this detractor by promptly administering analgesics. Other detractors are homeostatic imbalance, poor positioning, breathing difficulties, itching, feeling too hot or too cold, nausea, and discomfort from invasive tubes or lines.

Anxiety related to surgery and the aftermath of care is a major detractor from psychospiritual comfort. Other detractors in this context are confusing, incomplete, or negative information;

Table 2. Taxonomic Structure of Comfort Needs Applied

Context	Relief	Ease	Transcendence
Physical	Pain Nausea	Comfortable bed, homeostasis	Patient thinking "How can I tolerate pain when I wake up?"
Psychospiritual	Anxiety	Uncertainty about prognosis	Need for spiritual support
Environmental	Noisy PACU; bright lights; cold	Lack of privacy	Need for calm, familiar environmental elements
Sociocultural	Absence of traditions and culturally sensitive care	Family not present; language barriers	Need for support from family or significant other; need for information, consultation

NOTE. Patient is a 45-year-old Hispanic male with colon cancer admitted to the PACU immediately following sigmoid colon resection.

questionable or threatening diagnoses; fear; and the prospect of a change in routine or health status. Detractors from sociocultural comfort include isolation from family, disregard for cultural traditions, uncaring or anxious nursing behaviors, fragmented care, lack of nursing care when desired, poor social support, and limited resources for ongoing care at home after discharge.

Factors in the environment that detract from patients' comfort are cold, noise, chaos, endless bright lights, bad odors, lack of privacy, and uncomfortable stretchers, chairs, and beds. Unmet safety needs can detract from comfort and include a lack of properly functioning equipment, security problems, security hazards, inaccurate care, poor aseptic/sterile technique resulting in nosocomial infections, and medication or treatment errors. Freeing patients from restraints and restrictive devices such as intravenous lines, invasive monitors, and sensors as soon as possible is a goal to which nurses can strive to achieve by obtaining orders for intermittent saline locks, noninvasive monitors, and intermittent, rather than continuous, monitoring when appropriate.

Detractors can be plotted on the comfort grid (Table 2). Note that their placement on the grid illustrates the overlap and interrelatedness of

comfort needs. In other words, most comfort needs can be placed in more than 1 cell, because they have multiple origins. All detractors from comfort interact to produce a simultaneous perception of total comfort, which the patient can rate, using a 0 to 10 visual rating scale, as being from no comfort (0) to highest possible comfort (10).¹

Comfort Care Interventions

Comfort care entails at least 3 types of comfort interventions that can be implemented to achieve the goal of enhancing patients' total comfort (Table 3). The first are standard comfort interventions that are designed to maintain homeostasis such as monitoring vital signs and laboratory results, and responding to changes in patient assessment findings that indicate homeostatic compromise.¹ Standard comfort interventions also include attention to pain, hypothermia, administration of appropriate medications, and repositioning. These comfort interventions are designed to help the patient maintain or regain physical function and comfort and prevent complications.¹

The second type of comfort interventions is generally referred to as "coaching."¹ Coaching helps to relieve anxiety, provide reassurance and information, and instill hope. It involves listening and offering an optimistic plan for

Table 3. Comfort Care Actions/Interventions

Type of Comfort Care Intervention	Example
Standard comfort interventions	Vital signs Lab results Patient assessment Medications and treatments
Coaching	Emotional support Reassurance Education Listening
Comfort food for the soul	Therapeutic touch Music therapy Spending time Personal connections

recovery in a culturally sensitive way. Effectiveness of these interventions depends on their implementation at a time when the patient is ready to accept new or more positive thoughts.^{1,10}

The last group of comfort interventions is described as “comfort food for the soul.”¹ Patients do not expect this type of intervention but are usually very pleased when it is offered. Examples of interventions that provide comfort food for the soul are massage, adapting the environment to enhance warmth, music therapy, touch, and hand holding. Like comfort food that we eat, these comfort interventions make patients feel strengthened in intangible, personalized ways. Comfort food for the soul targets the need for transcendence through memorable connections between the nurse and patient or family.¹ These connections help to fortify patients for the difficult tasks associated with healing, rehabilitation, and return to what they consider a “normal” lifestyle.

Holistic comfort interventions can be used to target many comfort needs at one time. For example, providing medications and using non-pharmacologic and integrative interventions (guided imagery, massage, music) can address a

patient’s needs across the 4 contexts of comfort (Table 2). To illustrate this, a patient receiving music therapy can have the needs for ease, relief, and transcendence met simultaneously. Ease is addressed by the contentment the patient feels while listening to a favorite type of music. The music addresses relief by calming the patient and thereby reducing the discomfort of anxiety. Transcendence is addressed when the music allows the patient to think positively or spiritually.

Therapeutic use of (the nurse’s) self is often the most important comfort intervention for meeting patients’ social and psychospiritual comfort needs.¹ For example, assuring patients that their nausea can be treated successfully with both pharmacologic and nonpharmacologic methods may be more effective than simply administering an antiemetic without reassurance.

As mentioned earlier, there may be times in which little improvement in comfort is achieved despite applying the recommendations outlined in this article. Under these circumstances, nurses can look at intervening variables to help explain why comfort care is not working. Variables such as an abusive home environment, lack of financial resources, devastating diagnoses, or cognitive impairment may render ineffective the most appropriate interventions and comforting actions. However, the nurse should not give up and through repetitive administration of comfort care can still try to help patients transcend such difficult circumstances. It is important to remember that transcendence is a type of comfort!

Conclusion

The comfort care model presented in this article includes definitions, comforting actions or interventions, and the goal of enhanced comfort. It is proactive, energized, intentional, and longed for by patients and families in all settings.^{3,5,6,11}

Proactive care seeks to not only minimize negative aspects of surgery and illness such as pain, nausea, and anxiety, but to enhance positive indicators of daily function, such as comfort, mobility, and healing. Comfort is a

positive outcome that has been linked to successful engagement in health seeking behaviors¹ and is an important indicator to measure for perianesthesia care and research.

References

1. Kolcaba K: *Comfort Theory and Practice: A Vision for Holistic Health Care and Research*. New York, Springer Publishing Co, 2003
2. Kolcaba K: Evolution of the mid range theory of comfort for outcomes research. *Nurs Outlook* 49:86-92, 2001
3. Kolcaba K, Wilson L: The framework of comfort care for perianesthesia nursing. *J Perianesth Nurs* 17:102-114, 2002
4. Schlotfeldt R: The need for a conceptual framework, in Verhonic P (ed): *Nursing Research*. Boston, Little & Brown, 1975, pp 3-25
5. Hamilton J: Comfort and the hospitalized chronically ill. *J Gerontol Nurs* 15:28-33, 1989
6. Krenzischek D, Wilson L: An introduction to the ASPAN pain and comfort clinical guideline. *J Perianesth Nurs* 18:228-231, 2003
7. Kolcaba R: The primary holisms in nursing. *J Adv Nurs* 25:290-296, 1997
8. Kolcaba KY: The art of comfort care. *J Nurs Scholarsp* 27:287-289, 1995
9. Kolcaba KY: A taxonomic structure for the concept of comfort. *J Nurs Scholars* 23:237-240, 1991
10. Benner P: *From Novice to Expert*. Upper Saddle River, Prentice Hall, 1984
11. Puntillo K, Stannard D, Miaskowski C, et al: Use of a pain assessment and intervention notation (P.A.I.N.) tool in critical care nursing practice: Nurses' evaluations. *Heart Lung* 31:303-314, 2002
12. Kolcaba KY, Fisher EM: A holistic perspective on comfort care as an advance directive. *Crit Care Nurs Q* 18:66-76, 1996

Practical Application of Comfort Theory in the Perianesthesia Setting

1.0 Contact Hour

Directions: The multiple-choice examination below is designed to test your understanding of the Practical Application of Comfort Theory in the Perianesthesia Setting according to the objectives listed. To earn contact hours from the American Society of PeriAnesthesia Nurses (ASPAN) Continuing Education Provider Program: (1) read the article; (2) complete the posttest by indicating the answers in the test grid provided; (3) tear out the page (or photocopy) and submit postmarked before June 30, 2006, with check payable to ASPAN (ASPAN member, \$12.00 per test; nonmember, \$14.00 per test); and return to ASPAN, 10 Melrose Ave, Suite 110, Cherry Hill, NJ 08003-3696. Notification of contact hours awarded will be sent to you in 4 to 6 weeks.

Posttest Questions

1. Comfort is most accurately defined as
 - a. pain relief.
 - b. relief of discomfort.
 - c. having human needs for relief, ease, and transcendence addressed.
 - d. satisfaction.
2. The contexts in which comfort can occur are
 - a. environmental and physical.
 - b. psychospiritual.
 - c. sociocultural.
 - d. all of the above.
3. Cold detracts from the desired patient state of comfort and must be addressed to achieve the goal of patient comfort.
 - a. True
 - b. False
4. Which of the following are pain intensifiers?
 - a. anxiety
 - b. nausea
 - c. poor positioning
 - d. all of the above
5. Which of the following is a physical detractor from comfort?
 - a. shivering
 - b. fear
 - c. loneliness
 - d. disregard for cultural traditions
6. Which of the following is an environmental detractor from comfort?
 - a. fear
 - b. anxiety
 - c. noise
 - d. hunger
7. Which of the following is a psychospiritual detractor from comfort?
 - a. bright lights
 - b. anxiety
 - c. visitors
 - d. dry mouth

8. Which of the following is a sociocultural detractor from comfort?
 - a. isolation from family
 - b. anxiety
 - c. nausea
 - d. shivering
9. Possible priorities for future perianesthesia research include
 - a. comfort outcomes.
 - b. comfort interventions.
 - c. patient/nurse knowledge of comfort.
 - d. all of the above.
10. Current research shows that all patients have adequate pain and comfort management.
 - a. True
 - b. False

ANSWERS

System W010606. Please circle the correct answer

- | | | | | | | | | | |
|----|----|----|----|----|----|----|----|-----|----|
| 1. | a. | 2. | a. | 3. | a. | 4. | a. | 5. | a. |
| | b. | | b. | | b. | | b. | | b. |
| | c. | | c. | | | | c. | | c. |
| | d. | | d. | | | | d. | | d. |
| 6. | a. | 7. | a. | 8. | a. | 9. | a. | 10. | a. |
| | b. | | b. | | b. | | b. | | b. |
| | c. | | c. | | c. | | c. | | |
| | d. | | d. | | d. | | d. | | |

Please Print

Name _____ Nursing License No/State _____

Address _____

City _____ State _____ Zip _____

ASPAN Member # _____

EVALUATION: Practical Application of Comfort Theory in the Perianesthesia Setting

(SD, strongly disagree; D, disagree; ?, uncertain; A, agree; SA, strongly agree)	SD	D	?	A	SA
1. To what degree did the content meet the objectives?	1	2	3	4	5
a. Objective #1 was met.	1	2	3	4	5
b. Objective #2 was met.	1	2	3	4	5
c. Objective #3 was met.	1	2	3	4	5
2. The program content was pertinent, comprehensive, and useful to me.	1	2	3	4	5
3. The program content was relevant to my nursing practice.	1	2	3	4	5
4. Self-study/home study was an appropriate format for the content.	1	2	3	4	5
5. Identify the amount of time required to read the article and take the test. 25 min 50 min 75 min 100 min 125 min					

Test answers must be submitted before June 30, 2006, to receive contact hours.