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Comfort Theory

A Unifying Framework to Enhance the Practice Environment

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The application of theory to practice is multi-faceted. It requires a nursing theory that is compatible with an institution's values and mission and that is easily understood and simple enough to guide practice. Comfort Theory was chosen because of its universality. The authors describe how Kolcaba's Comfort Theory was used by a not-for-profit New England hospital to provide a coherent and consistent pattern for enhancing care and promoting professional practice, as well as to serve as a unifying framework for applying for Magnet Recognition Status.

The working milieu at our hospital had matured to the point where the staff nurses and administrators felt ready to undergo the journey to achieve Magnet status. While analyzing what needed to be done to accomplish this daunting goal, the task force realized that our existing theory base was eclectic, not well defined or understood, and not practical for everyday use. Therefore, we were essentially practicing and conducting research in a piece meal, atheoretical, and inconsistent manner. We had no cohesive vision or framework that would serve as a guide in developing and achieving leadership, practice, or research goals.

Our nurses nonetheless felt empowered by our mutual decision to work toward Magnet status.

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This sense of empowerment and the challenge of Magnet status led to our decision to find one theory that fit our values and mission. Such a theory could provide real direction in further enhancing our work environment, an all-important aspect in achieving Magnet status.

Selecting a Theory

The decision to explore the adoption of a single nursing theory was initiated by staff nurses. After taking a graduate nursing theory course, 3 members of our staff suggested that the "right" theory would enhance practice by providing a consistent and thematic focus instead of our institution's current philosophy of care based on an eclectic array of concepts borrowed from several nursing theorists. The 3 students, together with our chief nursing officer (CNO), met and discussed theory requirements and how to choose one overarching theory that fits our practice culture. We decided that a good first step would be to invite a nursing theory professor from a nearby college to acquaint clinical nurses with key theoretical concepts and their application. Nursing staff were invited to attend an open forum on how theories can guide practice. This sparked a renewed interest in the application of nursing theories within the nursing department.

After several theories were researched, we decided that 2 theories met our criteria. Kolcaba's Comfort Theory[1] and Jean Watson's Theory of Caring[2] were discussed by the nursing staff at multiple sessions. The staff selected Comfort Theory (CT) by Kolcaba because it most represented our philosophy of care and values and its effects were easier to measure. Having the staff participate

actively at this early stage engaged them in the selection and implementation processes.

Dr Kolcaba was invited to New England for a 2-day interactive consultation with staff nurses, nursing leaders, and the CNO. Kolcaba was asked to focus on both the comfort of nurses, an application of the theory not as familiar to the staff, and the comfort of patients and families. Nurses as care givers often ignore their own comfort in lieu of the comfort of patients and families. Kolcaba believed that the comfort of nurses is an important factor in morale and ultimately impacts recruitment and retention.

Background of CT

Initially, CT was developed as a patient/family-centered theory. Kolcaba's initial analysis of the concept of comfort[3] revealed the strengthening aspect of comfort as being central to nursing. She defined 3 types of comfort: (a) relief—the state of having a specific comfort needs met; (b) ease—the state of calm or contentment; and (c) transcendence—the state in which one can rise above problems or pain.[1,2] Wilson and Kolcaba[4] observed that discomfort is more than a negative physical sensation or emotional distress and that other aspects of comfort/discomfort affect holistic beings. Therefore, CT was congruent with nursing values and domains such as care, symptom management, interaction, holism, healing environment, identification of needs, and homeostasis.

In addition, human experience takes place in 4 contexts: physical, psychospiritual, sociocultural, and environmental.[1,5] Physical comfort is defined as all physiological and homeostatic dimensions of an individual; psychospiritual comfort is defined as an internal awareness of self, including esteem, identity, sexuality, meaning in one's life, and one's understood relationship with a higher being; sociocultural comfort is defined as interpersonal, family, and societal relationships (finances, teaching, healthcare personnel, family traditions, rituals, and religious practices); and environmental comfort is defined as the external background of human experience (temperature, light, sound, odor, color, furniture, landscape, etc). Comfort Theory proposes that, when patients and their families are more comfortable, they engage more fully in health-seeking behaviors that include internal behaviors, external behaviors, or a peaceful death. When patients and families engage in health-seeking behaviors more fully, the institution benefits in such areas as reduced cost of care and length of stay, increased patient satisfaction, enhanced financial stability, more positive publicity, and so forth.[1,6]

The Campaign

In preparation for Kolcaba's visit, there was an intensive campaign to promote CT. The campaign unfolded in 3 stages: increasing name recognition of the theory and its author, introducing all staff to the basic elements of the theory, and presenting clinical examples of CT. The following actions were taken: (a) disseminating the book Comfort Theory and Practice[1] to all units in the hospital; (b) using a color theme for all communications that matched the cover of the book; (c) creating bookmarks with the date of the workshop and brief excepts from the book; (d) distributing business-sized cards with a reminder of the workshop dates; (e) designing pins for staff that stated, "Ask me about Comfort"; (f) inviting faculty from area nursing schools and nursing leadership to attend a reception with the author; (g) conducting an informal survey of various personnel (healthcare and ancillary), asking how they brought comfort to patients and families; and (h) displaying each person's name, picture, and their comments from the survey on large color-coordinated posters. The campaign spanned several months and reached all levels of the healthcare organization.

Consultative Visit

At 2 identical sessions organized around breakfast and lunch, Kolcaba presented the clinical staff a brief overview of CT that focused on 2 major themes: (a) enhancing the comfort of nurses through environmental changes, which would encourage nurses and other valued employees to remain with the institution and participate in the entire culture, and (b) enhancing the comfort of patients and their families during hospital stays. Both of these themes served to enhance the practice environment.

Enhancing the Comfort of Nurses

Comfort Theory proposes that when the comfort of nurses is enhanced, nurses are more satisfied, more committed to the institution, and able to work more effectively. These nurse outcomes result in improved patient outcomes and increased organizational strength.[6] An extensive literature review by Kolcaba about what nurses want in their workplaces revealed many factors that could be organized according to the contexts of comfort as explicated in CT (physical, psychospiritual, sociocultural, and environmental [organizational structure]). The comfort factors from the review generated a great deal of interest from our audience of nurses. A list of these factors, under each context, is in Figure 1. For these presentations, "comfortable environment" was

Figure 1. *Comfort of Nurses**

Physical comfort
   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, and is complete; good salary, benefits, profit sharing, and retirement; increased routinization; day care available; noise controlled; pleasant and efficient physical layout; enough room to work; self-scheduling.
Psychospiritual comfort
   Job fits with one's own values; managerial support; decrease in nonnursing work; opportunities for advancement; timely feedback on job performance (positive also!); control over practice; freedom to make important patient-care decisions; interdepartmental cooperation; trust in management; sharing of feelings; empowerment; agreement with organization goals and culture; creativity encouraged; support for learning, growth, and development; role clarity; appropriate authority, responsibility, respect, and recognition; skills and talents utilized optimally; positive change models.
Sociocultural comfort
   Supportive social environment; opportunities to be part of major decisions; information shared by administration; strong communication; cultural and 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; good organizational fit.
Environmental comfort (organizational culture)
   Distinct and strong nursing department; flat organizational structure; professional milieu for practice; working together for high JCHO scores; none or minimal agency staffing; decreased paperwork and administrative duties; specialty units; workload adjusted for precepting new nurses and students; visionary leaders; good organizational fit; respect for professional goals; openness to new ideas with clear and channels for communication; political transparency and trustworthiness in the institution.

JCHO indicates Joint Commission on Accreditation for Healthcare Organizations.
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ASPAN Pain and Comfort Resource Manual. Available at: www.ASPAN.org.
Beaudoin L, Edgar L. Hassles: their importance to nurses' quality of work life. *Nurs Econ*. 2003;21(3):106-113.
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defined as one in which nurses and other healthcare providers feel embedded in an institution based on 4 contexts of comfort.

In addition, Kolcaba and the CNO visited the nursing units in the hospital, initiating brainstorming sessions with each group of clinical staff. One purpose of these meetings was for the staff nurses to identify comfort strategies for enhancing the nursing work environment. Nurses were encouraged to write down ideas for a "wish list" of changes that would create a more comfortable work environment. "Who do we give these wish lists to?" asked one nurse. The CNO responded, "Most of these changes can be initiated on your unit without additional resources. But if a suggestion does require additional resources, you can send that suggestion to me." This statement was very empowering and consistent with the CNO's philosophy of shared leadership; it carried her authority to the change process and reflected her personal commitment to empowering nurses. Her philosophy simply stated and repeated at those meetings was that "every nurse is a leader."

Enhancing the Comfort of Patients and Their Families

A second purpose of these meetings was for the nurses to discuss comfort interventions that they were implementing or could implement with patients. Many suggestions and descriptions of comfort interventions were given, such as warmed blankets in the emergency department, flexible visiting hours and accommodations for families, and special comfort food as requested. However, such interventions were previously invisible because of existing documentation forms. Kolcaba emphasized that assessment and documentation before and after comforting interventions is essential to implementing CT. Charting adapted to this purpose is the only way to demonstrate when patients and families are more comfortable as a result of those interventions. Kolcaba's Web site provides guidelines to document and assess the comfort needs of patients and families, design interventions to meet those needs, and evaluate their comfort post-intervention for practice or research.[7]

Moving Towards a 21st Century Perspective

For the 21st century, Magyary[8] described a need for proactive assessment and care. Research conducted at the end of the 20th century demonstrated that adequate staffing was highly correlated with quality care. However, the measures that were used to prove this case were actually indicators of *poor* quality of care. For example, the patient care survey

conducted by Akien et al[9] cited effects of staffing on the following outcomes: patient and family complaints, pressure ulcers/skin breakdown, injuries to patients, medication errors, and complications secondary to the admitting diagnosis. When some researchers studied the effects of Magnet status on quality of care, as reported in *Nursing Economics*,[10] they cited rates on medication errors, patient falls, decubitus ulcers, nosocomial infection rates, inadequate discharge planning, and hospital readmission rates. In the same journal, Havens[11] reported data on complications and mortality.

A search of the Web site of The National Quality Measures Clearinghouse™ (NQMC), sponsored by the Agency for Health Care Research and Quality, reveals an extensive list of narrow single indicators such as improvement in ambulation, improvement in swallowing, improvement in obtaining strep cultures, and others.[12] This piece meal and/or negative system of quality measurement fails to (*a*) account for whole-person, proactive, and positive outcomes; (*b*) reflect what patients want and need during their hospitalization; (*c*) describe the kind of nursing that nurses and other providers want to implement and, in most cases, do implement; (*d*) obtain input from patients about how they perceive their care to be; and/or (*e*) provide a trans-disciplinary measure of quality care.

By contrast, the purpose of proactive assessment and care is to minimize the negative aspects of illness and trauma (such as pain, depression, and anxiety) and enhance the positive indicators of daily function (such as comfort, hope, and resiliency).[8] Magyary calls this positive orientation "a turn-of-the-century perspective" and calls for documenting and valuing positive outcomes of care. *Comfort* is a positive outcome that has been linked empirically to successful engagement in health-seeking behaviors and theoretically to positive institutional outcomes such as higher patient satisfaction and cost-benefit ratios.[1] In view of these relationships, and the fact that patients and families want to be comforted in stressful healthcare situations, the outcome of comfort is an important positive indicator to measure for healthcare research. Moreover, NQMC lists Kolcaba's General Comfort Questionnaire as an indicator of quality care.[12]

Advantages of CT

We found distinct advantages to using CT as a guide to enhance practice and our working environment: (*a*) its universal language and concepts are understood and used in everyday life by lay people, professionals from all disciplines, and ancillary personnel; (*b*) it articulates what is already being done by many persons in healthcare; (*c*) it provides direction for quality improvement, comfort "rounds" with patients, performance review, improvement of the work environment, patient and institutional outcomes research, and implementation and evaluation of comfort and comforting interventions; (*d*) it has guided the development of clinical practice guidelines that are essential for the implementation and dissemination of best practices[4]; (*e*) it speaks to the comfort of nurses, managers, nurse executives, and CNOs and to the Scope and Standards for Nurse Administrators[13]; (*f*) it makes the outcome of comfort for patients and families explicit, a holistic outcome that is highly valued by them during their hospital stays; (*g*) it has associated protocols to assess nurses' comfort and to make daily nursing assignments based on comfort needs of patients[7]; (*h*) it directly correlates with the initiatives of the American Association of Critical-Care Nurses[14] and the Joint Commission on Accreditation for Healthcare Organizations regarding the improvement of working environments for nurses; and (i) a continuing education course is available online for nurses to complete for credit.[15]

Hardwiring CT

After Kolcaba's visit, several organizational and unit-based initiatives took place to integrate the essence of CT into nursing core values and operational structures. The nursing philosophy was modified to emphasize physical, environmental, sociocultural, and psychospiritual comfort for both patient/families and nurses. Several new objectives in the nursing strategic plan were specifically devoted to increasing the comfort of nurses through promoting a healthier, more comfortable work environment.

Orientation for new staff members was modified to incorporate CT as a thread throughout the curriculum. Comfort Theory and its implication for practice were presented to all new clinical staff. Core orientation competencies were developed based on assessment, intervention, and evaluation of patients' comfort. The newly developed clinical progression program (we call it "Reach-Up") was revised to include CT in the mission and vision statements. This program now focuses on promoting a comfortable and a participative work environment where professional models of care, evidence-based practice, and research are encouraged. Comfort Theory was also integrated within the performance evaluation criteria for the clinical nurse as a practice component.

Staffing matrixes and assignments were critically reviewed and modified within patient care units to

assure that a comfortable and safe work environment was maintained. Several units were renovated, with a focus on providing a structurally comfortable work environment for all age ranges of staff. Comfort was considered as one of the evaluation criteria for equipment selection. Because of the comfortable working environment, staffing was maximized and more consistent for the benefit of patient care.

The nursing leadership team believes that the adoption of CT significantly contributed to promoting excellence in our professional practice environment. The nursing turnover and vacancy rates continue to decline and are significantly below state benchmarks. Our nurse satisfaction scores are increasing. We just produced a small, 63-page booklet for internal use called *Nurses Tell Their Stories*. This is a compilation of exemplars of comfort that nurses in our clinical progression program submitted. We selected stories that promoted comfort through communication.

To jump-start creative ideas among staff, a quick and easy comfort intervention introducing hand massage and guided relaxation was given to the staff by way of a "tool kit," which was distributed to all nursing units. The tool kit was a mechanism to introduce our staff to quick, practical comfort interventions for both patients and each other. The tool kit contained a mini-relaxation exercise, a protocol for hand massage,[16] research supporting these interventions, a visual analog scale to measure pre- and post-intervention comfort, and hand lotion. In addition, a list of suggested methods for incorporating comfort into their particular practice setting was distributed to the unit-based practice committees to stimulate creativity in the implementation process.

Further objectives were directed toward enhancing patient and family comfort. Multidisciplinary comfort rounds were instituted to enhance communication among team members, family members, and patients. These were conducted in a conference room or in patients' room as appropriate. A team leader used a form developed by Kolcaba to document areas of discomfort in any of the 4 contexts (Figure 2).

The pain resource committee's Pain Guide, a teaching resource for all clinical staff, was expanded to include both pain and discomfort assessments. A discomfort scale was adopted to measure and identify detractors from comfort. Unit-based practice committees also developed specific scripts for staff to consistently address patient and family comfort needs.

Satisfaction surveys demonstrated that patients and their families value timely responses to con-

Figure 2. *Comfort Rounds[1]*

What are the comfort needs of your patients?

Physical comfort
  Homeostasis (fluids, electrolytes, respiratory, elimination, circulation, metabolic, nutrition, etc)
  Medical diagnosis–related issues
  Pain/comfort management (now, future goals)
  Other physical discomforts (perceived or potential)
  Sensory deprivation (hearing aids, glasses, speaking slowly, time for processing)
Psychospiritual comfort
  Spiritual needs (chaplain, parish nurse, own clergy)
  Anxiety, fear
  Prayer with nurse or other provider
  Meaning of illness
  Life review
  Sources of strength
Sociocultural comfort
  Finances
  Discharge planning
  Traditions (of comfort in hospital)
  Teaching/information needs
  Important relationships (conflicts to be healed)
  Visiting preferences
  Continuity of care: social worker, nursing assignments, nursing assistants, team work
Environmental comfort
  Private room
  Lounge chair for family rest
  Meal preferences (for family and patient)
  Odors, noise, light
  Clutter
  Furniture, environmental aides (cane, walker, crutches, foot stools, bedside commode, etc)

cerns or complaints, recognition of emotional needs, sensitivity to inconveniences, and participation in treatment plans. To that end, the hospital expanded its service recovery program and launched several points-of-care surveys, each showing that our patient satisfaction scores are rising. Other care initiatives included the use of focus groups and consumer participation in a variety of committees. The patient/family admission booklet was revised to address comfort by making it user friendly, using principles of health literacy and cultural sensitivity. CT influenced the design and content of a new surgical patient education pamphlet. We implemented the Caring Bridges program to enable family and friends to stay in touch during significant life events, thereby enhancing their comfort.[17]

Safety was enhanced by a surge of changes. Patients and families were encouraged to articulate their comfort needs, and families were encouraged to participate in the care of the patient. Communication improved by the use of communication boards in patient rooms, enhanced discharge planning efforts, and newly revised discharge instructions. CT was introduced at a time of physical plant

expansion, and improved environmental comfort was considered in the newly renovated emergency department, cardiac services department, waiting areas, and other renovation projects. Most rooms were converted to single-patient rooms while accommodating overnight stays by family members.

A nurse researcher was hired to enhance the comfort of nurses in undertaking various studies to gather evidence for best practices. The postanesthesia care unit conducted research on the measurement of core body temperature in postsurgical patients using comfort as their conceptual framework, and a research proposal was written to measure the effects of comfort interventions on delirium. In addition, clinical practice guidelines that integrated elements of CT were developed and/or revised.

Branding the Institution

Presently, hospital leaders are fully dedicated to supporting a *comfort place* for all staff, patients, and family members. Once the commitment is made by the hospital administration, the CNO, and staff to implement and maintain the changes described above, it is natural and advantageous for us to integrate the principals of the CT into organizational marketing initiatives designed to reach both internal and external audiences. The concept of comfort is a familiar one to lay and professional people, and knowing that a particular hospital focuses on the comfort of patients and families supports the decision to become a patient or third-party payer of that hospital.

We continue to examine how we can incorporate CT in all dimensions of practice. Additional goals for the future include (*a*) expanding comfort scripting to all areas and evaluating the impact on patient satisfaction; (*b*) integrating comfort in all patient and family education material; (*c*) improving patient and family access to healthcare information; (*d*) developing future unit-based research studies within a comfort framework using comfort questionnaires; (*d*) revising performance criteria for individuals in a formalized leadership role to focus on enhancing comfort for their staff in the work environment; (*f*) implementing a patient-directed model of shared decision making; (*g*) introducing the comfort interventions of pet therapy and a therapeutic garden; (*h*) using nurse navigators within specialty areas to facilitate movement of patients and families through our healthcare system; and (*i*) expanding the discharge by appointment program.

Conclusion

Our shared leadership approach provided the natural environment for the adoption of CT to articulate a cohesive framework for leadership and care in this not-for-profit New England hospital. Because the theory could be applied to all facets of healthcare and management, it served as a unifying framework for the challenge of achieving Magnet status. In addition, it provided a holistic focus for institutional interventions, directing administrators to ask an important and ongoing question, "How will *this* intervention contribute to the comfort of patients and staff?"

When CT was adopted to guide the Magnet journey, the institution's commitment to achieving a higher level of care for patients/families and improving the organizational culture became aligned around the focus of comfort. CT served as a catalyst during this journey for nurses at all levels to partner in creating positive practice and environmental changes. Comfort was invaluable as our common denominator not only because it is a recognized measure of quality and caring across disciplines and cultures, but also because comfort is a fundamental need that all individuals understand and desire to have met. Working toward this common denominator was our solution to our previous disparate vision, goals, and strategies for enhancing patient care and the working environment. Thus, the implementation of CT has had a far greater impact on our organizational climate than we originally thought possible. We have just completed our Magnet site visit, and the integration of CT within our organization was identified as an exemplar.

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