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Comfort Theory

Unraveling the Complexities of Veterans' Health Care Needs

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The health care needs of veterans, especially those who have served in combat zones and their families are complicated, challenging, and interrelated. Physical limitations impact mental health, and mental health problems affect every aspect of adjustment to civilian life. Comfort theory offers a simple and holistic pattern for identifying needs, creating interventions to meet those needs, and evaluating the effects of those interventions. The aim of this article is to demonstrate how comfort theory has been applied throughout 1 Veterans Administration System to fulfill the goal of providing quality veteran-centric care. The application of comfort theory to daily patient and family care, discharge planning, and follow-up in various settings, as well as ways to enhance institutional integrity and branding are discussed. **Key words:** *comfort*, *comfort theory*, *patient/family outcome*, *theory application*, *veterans' health care*

THIS ARTICLE is focused on theory application, specifically the ways in which comfort theory[1] can be utilized by Veterans Health Systems. Two main premises will be examined. The first premise maintains that the use of the taxonomic structure (TS) of comfort will deconstruct the complex and interrelated needs of individual veterans and guide their corresponding holistic care plans. This premise will be explored in the context of a case study. The second premise states that comfort theory directs health care team members from many disciplines, and especially nurses, to design effective comforting strategies for their patient population within their medical centers, outpatient clinics, and across all settings. These successful strategies or interventions are associated with veterans' increased engagement in health-seeking behaviors (HSBs) (goals of care) and with enhanced institutional integrity. This premise will be explicated in the context of comfort initiatives at 1 Midwestern Veterans Administration (VA) Health System.

BACKGROUND

In its recently published Blueprint for Excellence, the Veterans Health Administration (VHA) has renewed its commitment to providing high-quality patient-centered care that is "personalized, proactive, and patient-driven, and engages and inspires Veterans to their highest possible level of health and well-being."[2(p26)] The VHA is progressively improving the interactions between veterans and health care providers by approaching care from a "Whole Health" perspective, encouraging veterans to set goals that are meaningful to them and relevant to their lives and priorities,[3] as well as supporting them in

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achieving measurable outcomes.[2] The nursing service at a Midwestern VA system aspired to implement a professional practice model that would reinforce and augment a holistic approach to health care. Comfort theory proved to be the perfect fit and is congruent with many of the 10 strategies that the Blueprint for Excellence outlines to achieve optimum health and well-being for our veterans.

REVIEW OF LITERATURE

Comfort theory was a good fit particularly because it encompassed comfort for the entire cadre of patients, families, health care workers, and administrators. Comfort theory evolved from Kolcaba's early concept analysis and TS of comfort as a desirable outcome of nursing care as determined by the patient.[4] She demonstrated that patient comfort could be measured through patient questionnaires[5-8] and later verbal rating scales (VRS),[9,10] and that these measurements were sensitive enough to show a significant increase in comfort over time, given an effective intervention.[5-9,11] Moreover, patient comfort was found to be predictive of which patients achieved their selected goals related to health.[11] From the outset of her work, Kolcaba conceptualized comfort as being patient-centered and a desirable outcome, supporting VHA's enduring principles. Later, her work evolved to include nurse comfort,[12,13] family comfort,[14] and employee comfort, including nonmedical personnel.[12]

CREATION OF THE TAXONOMIC STRUCTURE OF COMFORT

The TS was essential in the creation of comfort theory because it represented the entire content of patient comfort and, by extension, could pinpoint any unmet comfort needs.[2,4] (This is congruent with the Strategy 1 in the Blueprint: "Operate a health care network that anticipates and meets the unique needs of enrolled Veterans, in general, and the service disabled and most vulnerable Veterans, in particular."[2(p10)]) Since comfort is a complex concept, there were many meanings in contemporary texts available at the time. Therefore, it was useful to diagram relevant types of comfort and juxtapose those types with contexts of human experience. The diagram of comfort delineated 3 types of comfort when needs are addressed: relief, ease, and transcendence.[1,4] Moreover, the archaic meaning of comfort was *to strengthen greatly*, which was appropriated for comfort theory as a rationale for why patient comfort is significant beyond its altruistic purpose.[1] Finally, the essence of holism was explored, and 4 contexts of human experience were found, which are simultaneous and interrelated: physical, psychospiritual, sociocultural, and environmental. (This emphasis on the human experience is congruent with Strategy 2 of VHA's Blueprint for Excellence: "Deliver high quality, Veteran-centered care that compares favorably to the best of private sector in measured outcomes, value, efficiency, and patient experience."[2(p12)]) The TS is created when these 4 contexts of experience are juxtaposed with the 3 meanings of comfort. The TS of comfort was designed to operationalize comfort as a patient-centered outcome. The definitions of each type of comfort (relief, ease, and transcendence) and each context of experience (physical, psychospiritual, sociocultural, and environmental) are included in Figure1.[15] The TS has required only slight modifications since publication in 1992.[4]

The TS of comfort serves several functions that facilitate the nursing process and effectiveness research. First, the TS is a roadmap for the identification of patients' and/or complex families' comfort needs. Second, it guides the design of interventions to address those needs that are unmet and are often chronic and interrelated. Third, it provides methods for evaluation of interventions to discover best practices and policies. Fourth, it is a guide for the creation of Comfort Questionnaires or modification of existing comfort questionnaires for specific research questions and target populations.

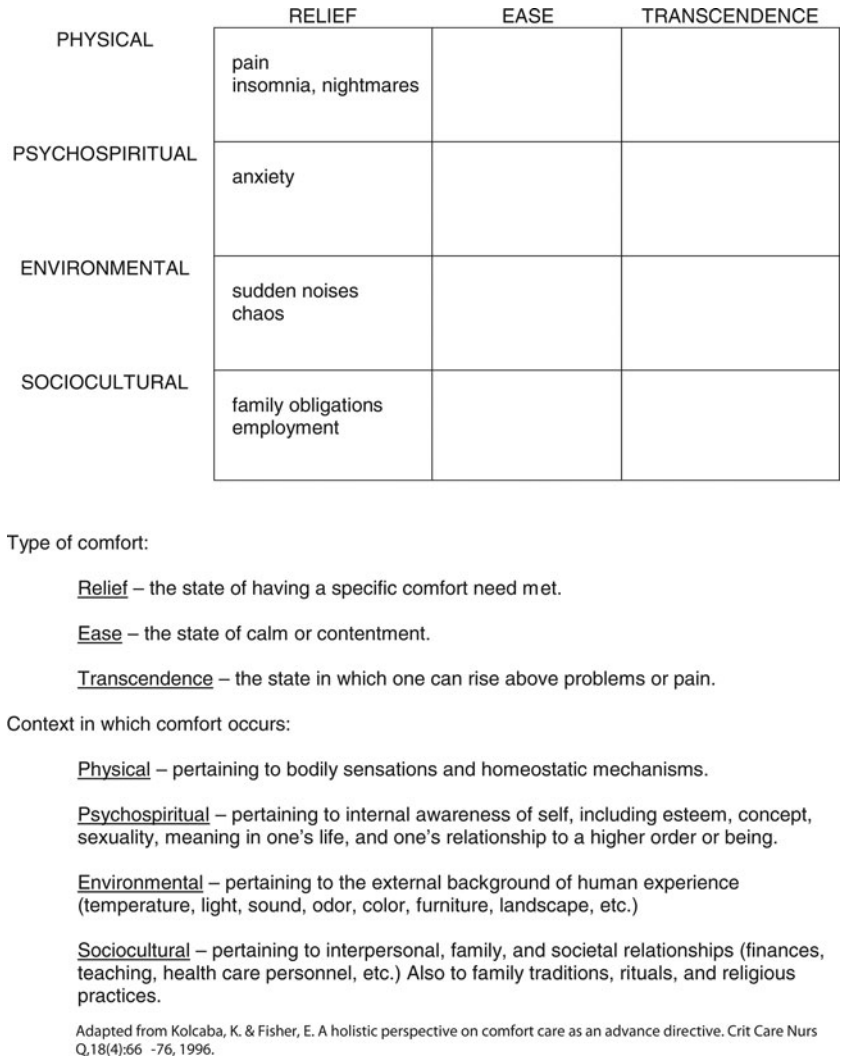

Figure 1. Taxonomic structure of comfort. Adapted with permission from Kolcaba and Fisher.[15]

Technical definition of comfort

The technical and holistic definition of comfort, derived from the TS, is "the immediate experience of being strengthened by having three types of comfort needs addressed in four contexts of experience."[1(p251)] The 4 contexts of experience provide the primary pattern for individual and holistic care as demonstrated later in this article. Total comfort theoretically is attained when all comfort needs represented by the TS are met, but the more likely outcome achieved in stressful health care situations is an enhanced comfort level above a baseline measure.

OVERVIEW OF COMFORT THEORY

Comfort theory utilizes the TS and the technical definition of holistic comfort and places this concept of comfort into relationships with 6 other health-related concepts. The mid-range theory derived from these relationships is notable for its simplicity and for facilitating intuitive care planning, projects,

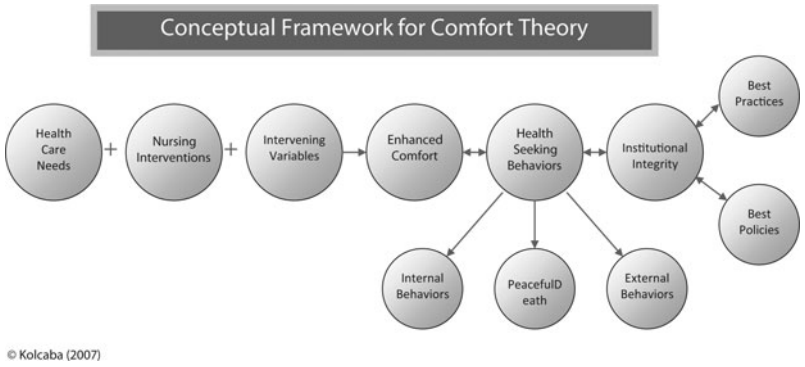

Figure 2. Theory-based empirical research (use this model to design comfort studies). Reprinted with permission from Kolcaba (2007).[16]

research, and dissemination. The conceptual framework of comfort theory is depicted in Figure 2[16] and then stated as propositions.

Propositions of comfort theory[1]

1. The health care team uses the TS of comfort to identify patients' and/or families' comfort needs that have not been met by existing support systems.
2. The health care team designs interventions to address those needs.
3. Intervening variables are those factors that providers cannot easily change, such as extent of social support, financial resources, and extent of traumatic experiences and related injuries. These factors are taken into account in designing the interventions and determining if those interventions have probability for success.
4. If the intervention is effective and delivered in a caring manner, the immediate outcome of enhanced comfort is attained, and the intervention can be called a comfort measure. *Comfort Care* entails all of these components. We can compare baseline and postintervention comfort levels by asking clients to rate their comfort from 0 to 10, with 10 being the highest level of comfort, as it has been done successfully in previous studies.[6]
5. Patients and their families and the health care team agree upon desirable and realistic goals called HSBs.
6. If enhanced comfort is achieved, patients are strengthened to engage in HSBs, which further enhances comfort.
7. When patients and their families engage in HSBs as the result of being strengthened by comfort care, nurses and patients are more satisfied with health care and demonstrate better health-related (goal-specific) outcomes. (Congruent With Strategy 4: "Grow an organizational culture, rooted in VA's core values and mission, that prioritizes the Veteran first; engaging and inspiring employees to their highest possible level of performance and conduct."[2p20])
8. A satisfying working environment produces better patient and institutional outcomes. (Congruent With Strategy 6 of the Blueprint for Excellence: "Advance health care that is personalized, proactive, and patient-driven, and engages and inspires Veterans to their highest possible level of health and well-being."[2p26]) When patients and families are satisfied with health care in a specific institution, public acknowledgment about the institution's dedication to health will contribute to

its remaining viable and flourishing Institutional Integrity.

INTRODUCTION OF COMFORT THEORY TO OUR MIDWEST VHA SYSTEM

After a careful search, the nursing service selected comfort theory as a framework for nursing practice. Dr Kolcaba was invited to present her theory to nursing leadership, including unit and quality managers, supervisors, and educators. She explained how the theory could be helpful in their environments of care and solicited suggestions from the audience about site-specific comfort applications. Kolcaba used illustrative case studies and anecdotal data to bring comfort theory to life in a nonthreatening way. An example of such a case study follows.

Case study

This case study is a fictional composite of a typical veteran's health care needs and illustrates how to use the TS pattern to focus care. Jake is a 32-year-old army veteran who was honorably discharged a few months ago after his second deployment to Iraq. While in Iraq, he sustained injuries due to an improvised explosive device, which also resulted in the death of 2 of his comrades. Jake underwent an above-knee amputation of the right leg and is now at a VA facility for physical therapy and rehabilitation. The facility is about 40 minutes away from his home, where his wife of 10 years, Lauren, and his 6-year-old daughter, Jessica, reside. Lauren visits Jake daily, but has to go back to work in a week.

Jake has been experiencing phantom pain and itching. He is being fitted for a prosthesis, but he shows no interest or enthusiasm about the prospect of "standing up on his own two feet again," as his wife puts it. He has been withdrawn and short-tempered and seems tired or depressed throughout the day. He has been having nightmares that make it harder for him to rest and get a good night's sleep. Medications to help with pain, anxiety, and insomnia have also been making him irritable and sleepy during the day. His projected discharge date is in 3 weeks, with home-based primary care and outpatient follow-up visits to be scheduled.

Care planning

Assessment of Jake's comfort needs follows the pattern outlined in the 4 contexts of comfort needs:

Physical comfort needs: Phantom pain, itching, motor relearning, balance relearning, wound/stump care, adjustment to prosthesis, insomnia/nightmares, possible side effects of medications.

Psychospiritual comfort needs: Spiritual distress, threat to self-image, anxiety about going home and uncertain future, posttraumatic stress disorder (PTSD) manifested as nightmares, irritability, depression.

Sociocultural comfort needs: Threat to role as breadwinner, adjustment to employment demands and fit with possible job opportunities, threats to marriage and parenthood, financial strains from unemployment.

Environmental comfort needs: Home adaptation for wheelchair access and/or crutches, transportation to VA facility, being alone during the day.

All of these needs are interrelated and complex, and they are not yet prioritized. The TS enables care providers to deconstruct Jake's entire picture using this systematic and individualized pattern (physical, psychospiritual, sociocultural, and environmental). Most of Jake's needs, when they are not yet resolved, are examples of the type of comfort called Relief. Jake needs *relief* from these discomforts. When a comfort need is relieved, the patient is in *ease* relative to that need, and the plan of care is to keep that need managed so that it does not slide back into a need for relief when small amounts of stress or mishap occur. Finally, there is Jake's need for Transcendence. Some of his identified needs may never be totally resolved, and the job of the

health care team and family is to help Jake "rise above" those persistent comfort needs. Transcendence is important for motivation and inspiration to achieve a new and stable normal relative to any particular need or set of needs. Transcendence is the type of comfort that signals to Jake and the health care team to "never give up" on meeting his many needs for comfort.

Because all of the cells of the TS are part of the whole gestalt of comfort, they are interrelated, and some contribute more to total comfort than others. For example, relief of pain at the surgical site might be of primary concern in the earlier stages of healing. This is a high priority and is addressed vigorously until Jake's pain levels become tolerable. Then anxiety and/or PTSD symptoms might come to the forefront as a major contributor to pain, irritability, and depression. Psychotherapy, complementary therapies, and medications are prescribed to address insomnia and anxiety, in the hopes that these interventions will also decrease his other symptoms. The comfort that is achieved is related theoretically to subsequent HSBs, such as decreased depression, ambulation goals, job attainment, and peaceful sleep. These goals are measureable, and data can show relationships between enhanced comfort from the interventions and achievement of specific goals. Goals or HSBs are established by collaborating with Jake and his wife to define their priorities and help them achieve their most important goals first. Such a care plan has empirical variables at every step so that a database can be established to create evidence for best practices.

This approach follows the New Pain Management Guidelines to include Integrative/Complementary Care[17] when treating persistent pain. These guidelines urge that nonpharmacologic approaches (eg, acupuncture, chiropractic, massage, relaxation) be offered equally along with opioids and other pharmaceuticals, the latter being presented with new warning signs. The TS provides a holistic guide to enhancing comfort because complementary therapies target many of the cells in the TS simultaneously and needs are interrelated. Thus, they deliver more overall comfort than anticipated because the whole is greater than the sum of its parts. Using this method of systematically targeting cells in the TS, a holistic and comprehensive care plan for acute and/or rehabilitative care can be developed. Similarly, comfort theory provides theoretical support to palliative care, where nurses intuitively administer holistic interventions to enhance comfort.[18] Using the grid enhances the interventions by targeting all comfort needs within the TS. In addition, they would be able to measure comfort outcomes and relate them to subsequent goals, such as a peaceful death.[18]

Systemwide implementation

Following the theorist's initial visit, the theory was introduced facility-wide to nurses across all settings and geographical areas through scheduled training sessions that introduced the theory and provided real practice examples. Dr Kolcaba returned a few months later to meet with staff at their points of care to discuss theory applications in their practice settings. Nurses described what they were currently doing to promote veterans' and each other's comfort so that comfort interventions could be provided more intentionally and mindfully.

Comfort theory was subsequently included in new employee orientation, as well as presented to nursing students who completed their clinical rotation at the facility. Nursing staff was encouraged to think about future projects to enhance their patients' and their own comfort, as well as to determine how their current projects impacted patient or staff comfort. Grant applications for comfort projects were submitted and awarded, and data are being collected. Nurses in outpatient clinics were able to complete a project that enhanced patient's environmental comfort by making examination rooms look livelier and more inviting. Moreover, funding for healing touch training, a complementary energy modality, was secured to promote patients' physical and psychospiritual comfort. Healing Touch was initially provided

to inpatient veterans on an individual basis, following a referral from their health care provider or nurse. Currently, it is also offered to all palliative care patients as one of the nursing interventions to promote comfort.

A Comfort Center was established to address patients' chronic pain and other comfort needs in a holistic manner. The dimensions of comfort were discussed with patients, with emphasis on the fact that this is a *comfort* center, not a *pain* center. Patients' overall comfort scores were rated on a 0 to 10 scale, as well as their pain and anxiety levels, and these scores were incorporated in the progress note template used for documentation in patients' electronic health records. Other *comfort therapies* were subsequently introduced, such as auricular acupuncture, aromatherapy, and M-technique, a structured touch therapy that was designed to promote comfort and relaxation. Veterans were also introduced to mindfulness techniques that provided them with tools to enhance their psychospiritual comfort and overall well-being.

Recently, clinics for Comfort Therapies were established that offer a different holistic therapy each day of the week in a group setting by trained nurses, physical therapy staff, recreational therapists, and social workers. The clinics offer Tai Chi, healing touch, auricular acupuncture, aromatherapy, M-technique, mindfulness, and relaxation. Veterans' overall comfort, pain, and anxiety levels were measured on a 0 to 10 scale and entered in each patient's electronic health records. The electronic progress notes were built to allow for tracking of each patient's outcomes as well as comparing multiple patients' outcomes following comfort interventions. Most patients were found to experience increased comfort and a decrease in pain and anxiety of at least 1 point postintervention. Few patients who did not experience a decrease in pain intensity have expressed a change in the quality of pain (pain became dull instead of sharp) or a deeper sense of calm and relaxation, which is reflected in their increased comfort scores, providing evidence for the holistic nature of comfort. Almost all patients report increased relaxation, and most report increased satisfaction with the options and modalities offered. As the initiatives described above mature, and more data are compiled, formal research and data analysis will be conducted to determine empirical effectiveness of particular interventions in enhancing patient comfort.

Similarly, staff comfort has been emphasized throughout the training, as well as through a comfort open house during Nurses' Week, where nurses were treated to a variety of comfort therapies in a relaxing environment. The event was well received, and feedback was extremely positive that the Comfort Open House became a fixture during Nurses' Week. Comfort therapies were also extended to all staff members with *Comfort Booths* at almost every health fair and event at the facility. Weekly "Comfort for the Staff" sessions offer auricular acupuncture to enhance staff comfort, with positive feedback and attendance from the staff. Monthly comfort sessions are being pilot-tested on one unit and recently expanded to another. The sessions offer techniques and interventions to promote staff physical and psychospiritual comfort, as well as foster a healing work environment and supportive relationships.

ENHANCING INTEGRATION OF COMFORT THEORY

Because of the broad geographic territories that many VA systems cover and the variety of roles assumed by nurses and other providers, excellent communication and support are essential for integrating any new framework. Therefore, the concepts from comfort theory should be integrated fully into electronic patient records to provide a picture of a unique patient's situation. To enhance the culture of health care systems, comfort theory can be introduced to interviewees, made a part of mentorship programs, and included in performance reviews.[11]

Similarly, feasible ideas for enhancing the comfort of populations of patients can be

piloted. Successful comfort projects can be 1 criterion for advancement. Attending to comfort among staff members can be a priority, promoting a *Comfort Zone* where team members encourage and support their colleagues based on the known comfort needs of their coworkers.

Nurses recognize the importance of accurate and timely methods for change of shift in acute care settings. One way to accomplish this is through the use of Comfort Rounds. Using the basic pattern provided by the 4 contexts of experience, forms are created with the 4 contexts of experience listed: *Physical* (issues related to medical diagnoses and activities of daily living); *Psychospiritual* (symptoms of PTSD, spirituality or meaning, self-confidence); *Sociocultural* (extent of family and financial support); and *Environmental* (assessment of modifications needed at home prior to discharge). As staff visits each patient's room, patients and family members can be asked about comfort needs in all 4 contexts. Any comfort needs that haven't been relieved are readdressed by the oncoming shift, perhaps with changes in care planning and further evaluation.

Branding a health care system with symbols of the guiding principles often brings clarity about what to expect from providers and consumers. When integrating comfort theory into a system, Kolcaba suggested that staff create a logo that represents one of the facility's unique features, such as its geographical location. The inspiration for our logo came from a nearby lighthouse, which represents light and guidance to comfort and safety to everyone around. The VA's core values were incorporated into that basic design. These values were derived from the institution's mission statement, its philosophy of care, its chosen professional practice model (comfort theory), and its method of care delivery (patient centered). These sources for core values were examined for congruency and impact. Posters may be designed for prominent patient care areas in which the core values are restated. During Nurses' Week, posters consisting of personal statements from nurses about how they, within their job description, routinely enhanced the comfort of patients or family members graced the walls of the celebration venue. We liked the idea from one institution, which also included photographs of employees along with their statements.[12]

APPLICATION OF COMFORT THEORY FOR RESEARCH OR GROUP INTERVENTIONS

For group interventions, tracking outcomes is especially desirable because of the larger population of veterans participating in the same group work at any one time. Often goals for such group work are established for all participants, so the extent to which those goals are met is important to determine. In such groups, a formal study can be conducted using the General Comfort Questionnaire as a guide along with VRS. In 2003, the complete instrument was registered as a multidisciplinary outcome indicator by the National Quality Measures Clearinghouse.[19] The actual instrument and instructions for modification for specific patient populations or problems are available in print[1] and online.[16] If desired, a 10-point VRS can also be utilized along with the comfort questionnaire to establish further reliability and concurrent validity between the 2 comfort instruments.[9,11] Likewise, these scores can be correlated with patient satisfaction scores at the end of that time frame, as an indicator of Institutional Integrity. Also, providers can compare comfort scores across different interventions or combination of interventions, using a control group receiving "traditional care" only to determine relative effectiveness.

CONCLUSION

As a patient outcome, comfort is a *value-added indicator* because it represents what patients and families want and need during their health care experiences. Comfort is

also what team members want to provide to patients and their families, because this kind of holistic care enhances the team's own satisfaction and morale. As a concept, comfort describes the important and complex mission of health care professionals when caring for our very special veteran population. Comfort theory, in turn, facilitates a holistic approach to helping veterans and their families adjust to a new normal in civilian life and for collecting data to underpin best practices.

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