# Comfort care: A framework for hospice nursing

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## Abstract

*Provision of comfort is paramount to the practice of hospice nurses. However, the approach to meeting needs holistically is often intuitive or based on multidisciplinary rather than nursing models. A review of the nursing literature identified only one article describing the application of a nursing framework to hospice nursing practice. The purpose of this article is to describe a theory of comfort care that offers definitions and a grid for the art of comfort care that are relevant to hospice nursing practice. Using Kolcaba's framework of holistic comfort, nurses can be comprehensive and consistent in assessing comfort and in designing interventions to enhance the comfort of patients and families. The content domain of holistic comfort is conceptualized as interrelated parts (types and contexts) as they are experienced simultaneously. The framework of comfort care, which includes the content domain and the theory of comfort, is explained and applied through the presentation of a hospice case study. Potential application of the framework to hospice research is proposed.*

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## Introduction

Principles for practicing hospice care have been described in the literature as intuitive or as based on medical principles of palliative care. Palliative care is defined by the World Health Organization as the active total care of patients whose disease is not responsive to curative treatment.[1] Palliative care affirms life and regards dying as a normal process. The goal of palliative care is achievement of the best possible quality of life for patients and their families. It neither hastens nor postpones death and it offers a support system to help the family cope during the patient's illness and throughout its bereavement process.[1]

Patients select hospice with the understanding that cure is improbable, but comfort is possible. Generally, they strive to come to terms with death. They want to make peace with their god and family and to somehow transcend physical and/or mental pain. Regardless of the setting, the nurses are the principal support to patients and their families as they manage symptoms, offer support, and provide encouragement around the clock.[2] Despite nursing's integral role on the interdisciplinary hospice care team, only one article could be identified that specifically describes the application of a nursing framework to hospice nursing.[3]

The purpose of this article is to introduce a framework for the practice of hospice nursing that is based on proactive principles of comfort care.[4] A consistent theoretical approach would be useful for hospice nurses, because theory provides cohesion and rationality for each aspect of care. The framework serves as a guide for providing individualized, holistic and consistent comfort care to dying patients and their families.

## The concept of comfort in hospice nursing

Although provision of comfort has been associated with hospice since its inception, an adequate operational definition for application and study of this phenomena has been limited. In nursing literature comfort has been:

- contrasted with discomfort and

viewed as a state of physical or mental well-being[5] or by degrees on a discomfort-comfort continuum.[6]

- linked with meeting patients' needs[7-8] and described as a variable that affects internal and external environments.[9]

Recently Kolcaba presented a theoretical definition of comfort that includes two dimensions: the first encompassing internal/external patient needs and the second relating to intensity.[10]

Kolcaba's theory also develops comfort as a holistic, positive outcome of nursing care[11] and has been applied in the critical care context as an advance directive.[4]

Kolcaba's theory of comfort includes three important elements that are relevant to the care of dying patients.[11] First, the term comfort is derived from the Latin word *comfortare,* meaning to strengthen greatly.[4] The strengthening quality provides the primary rationale for nurses to enhance comfort.[4] Second, the process of comforting involves active participation by the patient and family to enhance the patient's comfort. Thus, for recipients (patients/families), comfort care implies a continued active involvement that is facilitated by coaching from the hospice team. This definition describes comfort as the immediate experience of being strengthened by having the needs for relief, ease, or transcendence (types of comfort) met in four contexts of human experience (physical, psychospiritual, environmental, social).[4,11] The concept is depicted in a grid (Figure 1). Using the grid, patients' and families' needs are identified, interventions are designed, and the interventions' effectiveness is assessed. Third, comfort care consists of the process of comforting and the outcome

**Figure 1. Comfort grid**

| | Relief | Ease | Transcendence |
|---|---|---|---|
| Physical | | | |
| Psychospiritual | | | |
| Environmental | | | |
| Social | | | |

**Type of comfort**

*Relief:* The state of a patient who has had a specific need met.
*Ease:* The state of calm or contentment.
*Transcendence:* The state in which one rises above one's problems or pain.

**Context in which comfort occurs**

*Physical:* Pertaining to bodily sensations.
*Psychospiritual:* Pertaining to the internal awareness of self, including esteem, concept, sexuality, and meaning in one's life; one's relationship to a higher order or being.
*Environmental:* Pertaining to the external background of human experience.
*Social:* Pertaining to interpersonal, family, and societal relationships.[4]

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of enhanced comfort. The process is meaningful only if it results in the desired outcome.[4] These three elements formulate an expanded sense of comfort care that constitutes a positive, active, moral and humane framework for discussion and action. The comfort grid provides an organizing structure for giving thorough and efficient care to dying patients and their families.

Comfort needs are identified by gathering subjective and objective data *and* utilizing whatever sources are available to achieve an accurate assessment. Plans for comfort care are then formulated to meet the needs of each unique situation, considering the known intervening variables. In each of the four contexts of comfort, the type of comfort needed/desired is addressed. The dynamics of comfort are interactive. Thus, when one comfort need is met, other needs are positively affected and total comfort is enhanced.[4]

Ideally, the patient/family are involved in decision-making throughout the comfort care process. Their input should be obtained prior to the implementation of comfort measures and their continuous feedback is essential in assessing the measures' effectiveness. Examining all the comfort care framework components, this feedback is used to determine if other actions could further enhance total comfort or whether previously utilized comfort measures should be repeated. In this way, the comfort grid is used to meet current and evolving comfort needs in each unique situation. Note that in most health care situations it is rare for patients to experience total comfort. Rather, interventions are designed to enhance comfort compared to a previous baseline assessment. Finally, verbal and written communication, using the comfort grid as a framework for interdisciplinary discussion, can promote continuity, consistency and efficiency in the management of emerging comfort needs.[4]

The following case study demonstrates the application of the comfort care framework.

***The authors believe that research is necessary to establish the effectiveness of holistic comfort measures in hospice care...***

## Case study

Mr. L was 82-years-old, Jewish, and dying of heart failure. He had run a successful family business from which he was retired. He had two sons and a spouse of 52 years.

He and his family chose that he live his final weeks in a residential hospice facility. Mr. L enjoyed his quality of life during the day, when he usually had family visitors. Nights, however, were difficult, as his family was unable to stay. Subsequently, he would call for a nurse or other staff member to spend time with him, because he was afraid of dying in his sleep. Despite medication to induce relaxation and sleep or to relieve shortness of breath when needed, he was unable to get adequate rest, which added to his fatigue.

Noticing a violin case in the corner of his room, one of his nurses asked if he played it. He replied he was too weak to play lately, but that he'd been a member of a community chamber orchestra, and that music was an important part of his life. This same nurse observed that his daughter-in-law would play guitar for him, which he seemed to enjoy. After his family left one evening, Mr. L. turned on his call light, stating he was having trouble getting to sleep again. The nurse asked if she might hold his hand and sing him a song to help him relax. He responded that she could try. The nurse queried what style of music he liked and whether he had any favorites she might know. They decided on a few show tunes, starting with some upbeat, optimistic songs to which Mr. L. clapped along. He then requested some ballads during which the nurse held his hand and established eye contact while singing to him. He visibly relaxed and eventually fell asleep. Whenever this nurse worked the night shift, sharing music became their ritual. The family was asked to bring in tape recordings of some of Mr. L's favorite music to assist him through his anxiety.

Music also served as means of opening communication to difficult topics between family members. For example, one day the patient invited the nurse to sing for the family. She asked if they liked the musical "Fiddler on the Roof" (which embraces their Jewish heritage), to which Mrs. L. replied, "Do we like it? We live it!" She then began singing the song from the musical "Do I love you?"—which is a conversation about life and love between long-married spouses. Mr. L responded with the next line of the song. They sang the lines back and forth to each other, a poignant moment for all in the room. This then led to the couple spending some private time together, saying that of any losses, they would miss their relationship most of all.

**Figure 2. Completed comfort grid**

| | Relief | Ease | Transcendence |
|---|---|---|---|
| **Physical**<br>Shortness of breath<br>Fatigue<br>Weakness<br>Complaints of r/t immobility | Diuretics, morphine, nasal oxygen were prescribed, as were stool softeners to prevent constipation.<br>At times music helped promote rest.<br>The spouse went home to sleep to prevent undue fatigue. Back and foot massages with warm lotion and position changes helped relieve discomfort. | At times music resulted in well-being. The relief of anxiety seemed to relieve shortness of breath and reduced subjective complaints of discomfort. | Despite intervening variables of terminal illness and its accompanying fatigue, music was able to help transport the patient beyond the discomfort for periods of time. |
| **Psychospiritual**<br>Fear of dying<br>Anticipatory grief of both spouses<br>Belief in finality of death, *i.e.*, no afterlife | Music facilitated discussion of fears and feelings of patients and family members and brought complex needs to light, such as the need to resolve some old family conflicts, especially between the siblings and the patient. | Music brought solace; temporarily displaced or relieved fears to allow rest; promoted family reminiscences; and revealed need for further family support services such as referrals to chaplain and psychiatric CNS. | When able, the patient actually sang or actively listened, contributing to a sense of rising above his fears; he spoke of the nurse as being his angel; demeanor would change from great anxiety to one of calm or happiness. |
| **Environmental**<br>Homelike setting valued | Lighting was adjusted to the patient's liking. Familiar belongings such as a violin, music, pictures, flowers and a pillow from home promoted a sense of familiarity.<br>When desired by the patient, doors to the outside were opened, and if he felt strong enough, the patient was taken outside amongst the forest-like setting. | Addressing sights, sounds, and smells that are calming to the patient and the family can promote an environment that is restful and healing to the body, mind and spirit. This is most important when the hospice concept is being provided in a residential facility rather than the patient's own home; an institutional environment is avoided when possible. | A peaceful, soothing environment helps the patient relax, meditate and perhaps find meaning in the illness experience. |
| **Social**<br>Patient needs<br>Family needs | Daily visits from the family are essential; volunteers and staff supported those times when the family needed to be away. | Ongoing support of CNS, chaplain, and volunteers is helpful to the family in doing griefwork and resolving issues throughout the hospice experience. | Loved and trusted companions (including the nurse) can help the patient and/or family find the courage to go on. |

The hospice chaplain was consulted. She listened, shared prayers and sang traditional Yiddish songs, which the family found consoling. The psychiatric CNS also was consulted to offer ongoing support in dealing with their struggles through the grief process. These relationships were sustained through their bereavement as well.

See Figure 2, which demonstrates application of the comfort care map. The grid demonstrates the identification of patient/family needs and levels of comfort met by various interven-

tions. Assessment of the effectiveness of comfort measures (comforting actions) is an ongoing process. At any given time, the interventions are modified according to the needs being identified and the feedback obtained from the family and patient.

Moreover, the grid can be used by nurses to communicate ways that have been successful in achieving comfort for each patient/family. Unlike generic plans of care, the grid can promote continuity of care, yet demonstrate the ongoing uniqueness of each patient's experience of comfort.

## Additional applications

Hospice nurses often feel satisfied that their interventions are successful in enhancing comfort. Nursing journals are rife with descriptive articles to that effect. However, hospice nurses might want to demonstrate empirically that their interventions, as described above, really work. Hospice journals do not generally contain data-based nursing research; first because the specialty is young in terms of its development and second because research is thought to be intrusive during the dying process.

The authors believe that research is necessary to establish the effectiveness of holistic comfort measures in hospice care to enhance explicitly the value of nursing in the current outcome-oriented health care environment. Nurses can and should conduct intervention research in a sensitive, theory-driven, scientific manner. They can do this by using the theory of comfort as a guide to identify comfort needs holistically and to design holistic interventions to meet the interrelated needs. Intervening variables are recognized prior to implementing the intervention to increase the nurse's understanding of the context in which the comforting actions are being applied. If comfort is enhanced after the action, as compared to the previous baseline, the intervention can be deemed a scientific comfort measure.

While nurses perform many of the steps above in administering care, the quantitative evaluation of comfort is the additional step that must be taken in order to conduct empirical research in a hospice setting. Comfort can be assessed through questionnaires read to the patient, or self-administered if the patient is strong/lucid enough. Comfort also can be assessed by using a nursing checklist of patient/family behaviors, facial expressions, muscle tension, and statements (if any).

A quantitative application might consist of the following: A need to relieve pain is assessed. Examining the contexts in which comfort occurs and what intervening variables exist, the nurse determines what interventions are most likely to result in pain relief. One of the well-tested pain analogue scales[12] could be used to quantitatively measure the effectiveness of the interventions.

Identification of psychospiritual factors (such as anxiety) or social variables (lack of social support, family conflict) that can impact the pain experience would also require planning of interventions to elicit relief or ease or transcendence. The effectiveness of these interventions could be assessed in a similar manner, using preexisting instruments with demonstrated levels of validity and reliability, such as the State-Trait Anxiety Inventory (STAI)[13] or the General Comfort Questionnaire (GCQ),[14] adapted for hospice care. Questionnaires for pain or anxiety are not holistic. Therefore, an adapted comfort questionnaire may be more congruent with holistic interventions and the comfort care framework. For further information on comfort questionnaires, see Kolcaba's Web site: www.uakron.edu/nursing/faculty/kolcaba/comfort.htm.

## Summary

Hospice nurses are angels of mercy in times of acute discomfort. They rely on traditional nursing methods for their observations and interventions rather than on high tech approaches. Although few data-based articles provide empirical evidence of their efficacy, hospice nurses are highly valued by their clients. The framework for comfort care offers a theory-based foundation upon which to build patterned, individualized methods for the practice of comforting, the essence of hospice nursing. It recognizes that the contexts and intervening variables in which comfort occurs are interrelated and constantly changing. It also acknowledges that interventions are and need to be designed continually with these contexts and the desired comfort outcomes in mind.

Although total relief is not always possible, ease or transcendence may be attained. When a cause of discomfort is primarily physical, physiology-based interventions are in order. However, when the physical discomfort has multiple psychospiritual, social, or environmental components, these also must be addressed. The framework reflects this reality of the effective practice of comforting. The framework also provides congruent approaches to conducting research that can objectively validate hospice nurses contributions to comfort outcomes. Many hospice nurses believe hospice is their calling and find their satisfaction in being able to make a difference in the lives of the dying and

their families. Comfort care research has the potential to augment this satisfaction by increasing their professional knowledge base, visibility, and value in the hospice setting as well.

## References


1. World Health Organization (1990). Cancer Pain Relief and Palliative Care. Technical Report Series 804. Geneva: World Health Organization.

2. Gentile M, Fello M: Hospice care for the 1990s: a concept coming of age. *Journal of Home Care Practice*. 1990; 3(1): 1-15.

3. Laferriere R: Orem's theory in practice: hospice nursing care. *Home Healthcare Nurse*. 1995; 13(5): 50-54.

4. Kolcaba, Fisher E: A holistic perspective on comfort care as an advance directive. *Critical Care Nursing Quarterly*. 1996; 18(4): 66-76.

5. Flaherty GG, Fitzpatrick JJ: Relaxation techniques to increase comfort level of postoperative patients: A preliminary study. *Nursing Research*. 1978; 27: 352-355.

6. Patterson JG, Zderad LT: *Humanistic Nursing*. John Wiley, New York, 1976.

7. Orlando I: *The Dynamic Nurse-Patient Relationship*. Function, Process, and Principles. Putnam, New York, 1961.

8. Roy C, Roberts S: *Theory Construction in Nursing: An Adaptation Model*. Prentice Hall, Englewood Cliffs, New Jersey, 1981.

9. Watson J: *Nursing: The Philosophy and Science of Caring*. Little Brown, Boston, 1979.

10. Morse JM, Bottorff JL, Hutchinson S: The phenomenology of comfort. *Journal of Advanced Nursing*. 1994; 20: 189-195.

11. Kolcaba K: A theory of holistic comfort for nursing. *Journal of Advanced Nursing*. 1994; 19(1): 1178-1184.

12. Acute Pain Management Guideline Panel: Acute Pain Management: Operative or Medical Procedures and Trauma. Clinical Practice Guideline. AHCPR Publication No. 92-0032. Rockville, Maryland, Agency for Health Care Policy and Research, Public Health Service, US Department of Health and Human Services, 1992.

13. Spielberger C: (1993) *Manual for the State-Trait Anxiety Inventory*. Palo Alto, California: Consulting Psychologists Press Inc.

14. Kolcaba K: Holistic comfort: Operationalizing the construct as a nurse-sensitive outcome. *Advances in Nursing Science*. 1992; 15(1): 1-10.



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