Gerontological Nursing
THE CONCEPT OF COMFORT IN AN ENVIRONMENTAL FRAMEWORK

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INTRODUCTION

Comfort has been defined as the experience in which the basic human needs for ease, relief, and transcendence have been met (Kolcaba, 1991a). It is a term that has been traditionally associated with the art of nursing, as in Donahue's statement: "It is through comfort and comfort measures that nurses provide strength, hope, solace, support, encouragement, and assistance" (Donahue, 1989). And it is an important term for gerontological nursing, as demonstrated by Hamilton's qualitative study of elderly patients in a long-term setting (Hamilton, 1989).

In Hamilton's (1989) study, patients were asked what "comfort" meant to them. From her qualitative inquiry, six comfort themes emerged that were consistent with the findings of Kolcaba (1991a). However, the usefulness of the term to plan for or to assess the effectiveness of interventions was not demonstrated in either of these studies. This article will develop a framework for gerontological nursing practice that includes comfort as a multidimensional construct for planning and evaluating nursing interventions. A framework of care, if succinct and comprehensive, would be useful for organizing practice and conceptualizing successful outcomes. Moreover, a desirable framework for gerontological nursing would implement knowledge about comfort to provide holistic care.

COMFORT

The taxonomic structure of comfort developed by Kolcaba (1991a) reveals that the concept has at least 12 aspects (Figure 1). These aspects are represented in a grid in which the three senses of comfort (ease, relief, and transcendence) are juxtaposed with the four contexts in which comfort is experienced (physical, psychospiritual, psychosocial, and psychoenvironmental). The grid is useful for conceptualizing the multitude of comfort needs of clients and for assessing successful outcomes of interventions designed to meet those needs.

A comprehensive comfort assessment acknowledges more than physical sensations; Figure 1 indicates that the client's comfort includes emotional/spiritual states, social relationships (including those with caregivers), and environmental factors that promote or distract from overall comfort. A lack in any aspect of comfort signals a comfort need. Thus, a comprehensive comfort assessment suffices for multiple separate assessments of factors such as the absence

FIGURE 1

The Taxonomic Structure of the Concept of Comfort

Context	Sense: Ease	Relief	Transcendence
Physical			
Psychosocial			
Psychospiritual			
Psychoenvironmental			

of pain, social experiences, spirituality, mental health, and person-environment fit.

Comfort is important to assess because it is state specific; a client's comfort can come or go quickly, depending on the circumstances at the moment. The concept is often used informally by experienced nurses who ask clients about the state of their comfort or intuit a client's comfort needs without verbal cues. After the need is assessed, a specific comfort measure is designed to meet the need. Thus, the signs of the absence of comfort, even though they are experienced globally, are often amenable to specific nursing interventions that have historically been called comfort measures. In this way, comfort measures are aimed at specific discomforts (located on the grid), are administered with artistic skill, and often have immediate, measurable results.

OTHER SIGNIFICANT CONCEPTS

A facilitative environment is the therapeutic milieu in which a high level of gerontological care takes place. The idea of adapting the environment to fit the nursing needs of special clients was promoted by Wolanin and Phillips (1981). A facilitative environment has two dimensions: the psychological dimension addresses factors that affect the client's mental status, such as structured activities, control of noise and light, color cues, and quality of caregiving; the physiological dimension addresses factors that affect the client's physical status, such as rest and relaxation, treatment of medical conditions, level of nutrition and hydration, and elimination of wastes. A skillful nurse manager designs and implements a facilitative environment by assessing each client's comfort needs and designing specific comfort measures as necessary to meet those needs.

The concept of excess disability is widely accepted to mean a reversible deficit or symptom that is an undesirable and temporary extension of a primary disability (Kahn, 1965; Schwab, 1985). The primary disability can involve the compromise of any organ system, an injury, an infection, or other physiologic problem, such as dehydration or constipation. As is typical in the practice of gerontology, the symptoms of excess disabilities often seem unrelated to the original underlying biological pathology. An excess disability can be manifested psychologically by extreme behaviors, such as temper tantrums, crying, withdrawal, restlessness, or anxiety. An excess disability can also be manifested physically by fatigue, abnormal vital signs, or change in daily habits (Table). The client's state of comfort is an indicator of the absence of excess disabilities.

The third concept in this framework is optimum function, which refers to the highest level of physiological and psychological function that the client can achieve. It includes the ability to socialize, perform tasks, and interact positively with the environment. Indeed, if the term is conceptualized in its largest sense, it encompasses optimum function for each client in mind, body, and spirit. Optimum function is judged by comparing the highest functional level achieved to the client's baseline function (at comfort level). It is important to remember that optimum function cannot occur unless the client is first in a state of comfort.

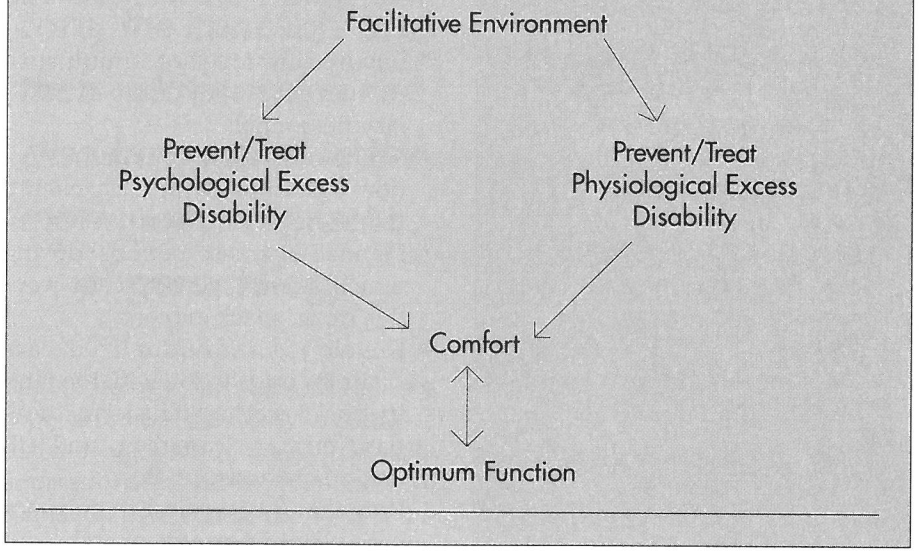
The fourth concept, comfort, provides conceptual linkages in the framework because the gestalt of the term (embodied in the three senses and four contexts) is applied during the assessment and intervention processes. As discussed above, the sense of ease is synonymous with the comfort baseline that describes each client's status when excess disabilities are not present.

Thus, comfort provides a conceptualization of baseline performance against which to measure optimum function. Indeed, the theoretical origin of the sense of ease designates it as a positive state in which one is ready to perform well (Kolcaba, 1991b).

The sense of relief is useful to conceptualize a return to comfort after the manifestation of an excess disability and an effective nursing intervention. (Either "ease" or "relief" must be apparent before tasks can be effectively tackled by the older client; "relief" becomes "ease" if the relief from discomfort is long-lasting.) The sense of transcendence is important for describing the state of the client who has been inspired, motivated, and helped to do the task well. The four contexts are important for locating the psychological or physical experience of comfort or, conversely, the origin of an excess disability.

FIGURE 2

A Framework of Care for Gerontological Nursing



Relationships Among the Concepts

The facilitative environment is named as such only if each client's comfort and optimum function are ensured. Not only do nurse managers design and implement the principles that underpin the environment, but they also are part of the environment. The manager structures the environment along general guidelines that are safe and that "feel good" to the older client (Wells, 1988). Second, the comfort needs of each client are assessed and met in an attempt to prevent excess disabilities. If an excess disability is apparent, the manager or staff determines the origin of the disability and moves promptly to relieve it, returning the client to the state of comfort. Third, tasks for optimum function are planned and implemented with the client, and, if necessary, the client is assisted to achieve them. Lastly, each client has opportunities for remaining in the relaxing state of comfort, which allows for rejuvenation, daydreaming, or rest. The framework is diagrammed in Figure 2.

IMPLEMENTING THE CLINICAL PROGRAM

The framework was implemented on a dementia unit in a Midwestern teaching nursing home. All 15 clients on this unit were women, aged 65 to 90 years, and in the second stage of dementia (ambulatory, profoundly and irreversibly confused with limited verbal skills). Men were not admitted on the unit because the women competed for the attention of men when the latter were present. The unit was also very small and it was impossible to have separate areas for men and women clients.

The clients frequently exhibited behavior problems prior to being transferred to the unit; no resident was excluded because of difficult behaviors, although these behaviors were priority nursing challenges to meet on the client's admission to the unit. The behaviors were usually mediated by the smaller and quieter environment, acceptance of the client by the other residents and staff, the client's freedom to wander, and esteem-building activities.

The best staffing pattern for the unit was a nurse manager and three nursing assistants on the day shift, a nurse and two nursing assistants on the evening shift, and a floating

TABLE

Manifestations of Excess Disabilities

Expressions of anxiety* (verbal or nonverbal)
Aggression (verbal or physical)
Agitation* (increased verbal or motor activity)
Weeping
Screaming
Paranoid declarations
Obsessive-compulsive behavior or conversation
Expressions of fear* (verbal or nonverbal)
Increased reclusive behavior*
Fatigue*
Rash
Abnormal vital signs*
Nausea/vomiting/diarrhea
Change in appetite
Change in habits

**Comparative behavior; validate against baseline.*

nurse supervisor with two nursing assistants on the night shift. Nursing assistants were selected on the basis of their communication skills, compassion, patience, and willingness to work with demented clients. They were given continuous inservice education by the nurse managers on topics such as the dementing process, communication with clients using gestures and body language, ways to facilitate clients' participation in activities of daily living, and finding the causes of and treating excess disabilities. Housekeepers and other routine visitors to the unit were also included in the educational programs.

It was not possible to furnish this unit with therapeutic colors, special furniture, or carpeting; however, principles of dementia care provided nursing guidelines for the unit (Clendaniel, 1989; Dawson, 1986; Richter, 1989). The nurse managers:

- Ensured low levels of stimuli, such as noise, light, and flow of auxiliary personnel;
- Structured tasks for optimum function consistent with each client's remaining strengths and interests;
- Planned for rest periods during which clients were free to wander, doze, snack, or chat;
- Developed individualized care plans in consultation with the family, social worker, physician, dietitian, primary caregiver, and client, where appropriate;
- Provided for physical exercise for each client in groups or individually;
- Promoted principles of therapeutic relationships between staff and clients that added to the clients' self-esteem, confidence, and quality of life (Wolanin, 1981);
- Used principles of effective conflict resolution between staff members, because the clients imitated the staff when reacting to each other;
- Used psychotropic medications only to enhance social behavior, and only when psychosocial nursing was insufficient for preventing psychological excess disabilities (Kolcaba, 1989);
- Used communication methods with each client that relied less on verbal skills and more on the visual and imitative capacities that the clients retained;
- Encouraged each client to participate in activities of daily living and in making simple choices.

When these principles were used consistently, the environment facilitated comfort and quality of life for the clients, regardless of the furnishings.

The clients enjoyed planned group activities such as art projects; reminiscence groups; sing-alongs; storytelling and reading; walking groups outdoors; "Ladies' Day" (the clients received manicures, makeup, and hair styles by auxiliary staff off the unit); cooking and preparing lunches, including setting and clearing the tables; fashion shows; reading the newspaper and discussing articles; going on picnics; going to the library to pick out paintings and books for loan to the unit; and attending parties. For clients to enjoy these activities, it was essential that they were well-rested and free from physical illness. Care was taken not to plan too many activities in one day.

While sharing the nurse manager position on the unit, this author conducted participant-observer qualitative research that focused on the clients' subjective signs of comfort and how comfort related to other concepts in the framework. The framework was discussed frequently with the staff, who offered input about the characteristics of

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each client's comfort baseline. It was important to include these subjective characteristics of comfort on each care plan because clients with dementia could not state whether they were comfortable. The information was necessary to identify deviations from the norm, and optimum function could be ascertained by comparing a client's performance with the known baseline. The information was also important to ensure continuity of care when an unfamiliar caregiver was assigned to the unit.

Prompt "detective work" was initiated by any staff member who noticed a client deviating from the established comfort baseline. The staff member tried to determine the source of the excess disability by considering possible comfort needs. An intuitive diagnosis was often correct and a client could be returned to comfort by a simple adjustment, such as in the environmental or social context (exemplifying the sense of relief). In cases where the excess disability was caused by a physical problem (such as a urinary tract infection), return to the comfort baseline occurred more slowly. Each nursing intervention was specific to a comfort need; the effectiveness of the intervention was assessed by determining the degree to which the client returned to baseline comfort (the state of ease). Staff also encouraged and empowered each client to participate in her care and activities (the sense of transcendence).

NURSING IMPLICATIONS

Although this framework was applied to dementia care, the concepts and their relationships can also be applied to the more general practice of gerontology. For example, the concept of excess disability signifies a diffuse reaction to many possible sources of discomfort. As is true with dementia care, many cognitively intact older clients in health-care settings feel they have lost control in an alien environment, or they lack an understanding of the decisions being made. The feelings of dependence, loss, or fear can cause extreme emotional or physical reactions. Likewise, the importance of environmental adaptations and optimum function that were demonstrated on the dementia unit have been discussed frequently in the general gerontological literature (Matteson, 1988; Miller, 1990).

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Comfort is an extremely important concept in caring for older adults because it denotes attention to individual needs. Successful outcomes mean that comfort needs have been met by appropriate comfort measures. Because of its significance to older adults, the term is also used as a legal standard of quality care (Department of Health, 1974; Lind, 1983). These references acknowledge that comfort entails many significant aspects for the quality of life of older adults.

CONCLUSION

A framework of care is an aid for organizing existing knowledge as represented by concepts. Each concept entails a wealth of information, but each is static by itself. Only when concepts are set into relationships with other concepts is there a relevant working model for describing specialized nursing care. The framework presented here is dynamic because, in addition to describing the essential phenomena in strong gerontological nursing care, it explains what to observe and what to do based on those observations. The framework also predicts successful outcomes of effective care. Because comfort is a central concept in the framework, by definition the model also advocates for a gerontological nursing approach that is warm, skillful, and holistic.

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COMFORT KEYPOINTS

Kolcaba KY. **Gerontological Nursing: The Concept of Comfort in an Environmental Framework.** *Journal of Gerontological Nursing.* 1992; 18(6):33-38.

1. The Facilitative Environment Framework organizes a holistic gerontological practice.
2. Comfort describes the state of patients when their excess physiological and psychological needs have been met.
3. Patients must be in a state of comfort before they can perform the tasks of optimum function.
4. The Facilitative Environment Framework was applied to a dementia setting, but it is suitable for other gerontological settings as well.

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