A True Story: Implementing a Comfort Based Hospital

Nurse Smith worked for approximately15 years in a single large hospital system. Because of her strong work ethic and creative ideas, she had been promoted from staff nurse to positions in upper management over the years. In addtion to her BSN, she had her MBA and was also enrolled in graduate nursing education to attain her DNP. While attending graduate school and at the age of 45, however, she developed breast cancer and was a patient in her own system. She was full of anxiety about her prognosis, treatment, and role change and spent many days in various settings including in-patient, out-patient, surgery, radiation therapy, and chemotherapy. Her treatment spanned several months in close contact with the nurses from her own organization.

To her chagrin, during this time of high comfort needs, Nurse Smith received little or no comfort from the nurses with whom she came in contact. She recalled that no personal connections were made with these nurses, who delivered their interventions mechanically, with no personalized eye contact. Nurse Smith felt lonley, scared, and in more pragmatic moments, deeply concerned for her profession.

Shortly after her recovery from intensive therapies, Nurse Smith applied for the Chief Nursing Officer (CNO) position. As part of her interview, she told the administrators who would be choosing the next CNO about her experience as a patient. She knew from her own personal episode that the “patient experience” could be greatly improved and she had an idea about how to make that happen. Her vision was for her hospital to adopt Comfort Theory for its multidisciplinary framework to undergird the patient experience. Every encounter with patients and families would be a comforting and connecting experience. There would be no need for scripting, because each encounter would be based on comforting the patient and family in some way – each encounter would be individualized, sincere, and unique to the skills of the care giver. She believed that such encounters would take the same amount of time as impersonal ones, and indeed, they would help allay anxiety almost immediately. She was hired.

CT was officially adopted by this institution, integrating the following components: commitment by administration, retelling of the CNO’s story, redefining quality care in terms of comfort for patients and families, orientation to CT for all personnel, an introduction of CT to the academic community including nursing students, small changes in the way care would be delivered, comfort rounds, comfort charting (electronic and paper based), performance review/clinical ladders, and marketing strategies – putting their commitment to comforting care “out there.” Data are being collected regarding the patient experience.