APPLICATION OF KOLCABA’S THEORY OF COMFORT IN NURSING PRACTICE

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In 21st Century nursing is the bridge that holds a patient’s health care process together. The important task for nurses is to determine patients’ needs and to satisfy them in a timely manner and a good quality. The comfort of a patient is a fundamental need that determine functionality, quality of life and health care outcomes of individual. The comfort theory developed by Katharine Kolcaba provides the essential assumptions and theoretical underpinings that might be helpful dealing with clinical, educational, scientific and managerial issues.

Aim: the aim of this study was to analyze the application of Kolcaba’s Theory of Comfort for nursing research, education, practice and leadership.

Methods: a theoretical-reflective essay conducted in a dialectical process between relevant literature, theoretical framework and reflection.

Results: Kolcaba's Theory of Comfort has been successfully applied in nursing research, education, nursing practice and leadership. The majority of studies with Comfort Theory were concerned with the effects of interventions on the patient’s level of comfort.

Conclusion: Kolcaba's Theory of Comfort is totally applicable in nursing research, education, clinical nursing practice and leadership initiatives in the health care organisations. By utilising Comfort theory in health care institutions in Kazakhstan nurses can create a positive atmosphere for the comfort of each patient assuring respect for his present and past, for his life values, traditions and beliefs. The principles of theory might be integrated into undergraduate and postgraduate nursing education programs.

Keywords: Katharine Kolcaba’s theory, Nursing, Comfort, Patient.

ПРИМЕНЕНИЕ ТЕОРИИ КОМФОРТА КЭТРИН КОЛЬКАБА В СЕСТРИНСКОЙ ПРАКТИКЕ

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Сестринское дело 21 века - это мост, соединяющий воедино процесс оказания медицинской помощи пациенту. На протяжении всего пребывания пациентов медсестры неустанно работают, чтобы определить потребности человека и обеспечить их удовлетворение. Комфорт пациента является фундаментальной потребностью, определяющей функциональность, качество жизни и результаты лечения человека. Комфорт
Пациентов и его влияние на восстановление их здоровья были тщательно исследованы. Как следствие, это способствовало развитию теории, которая называется «Теория комфорта».

**Цель**: цель этого исследования состояла в том, чтобы проанализировать использование Теории комфорта Колкабы для сестринских исследований, образования, сестринской практики и лидерства.

**Методы**: теоретико-рефлексивное эссе, проводимое в диалектическом процессе между актуальной литературой, теоретической базой и рефлексией.

**Результаты**: Теория комфорта К. Колкабы успешно применялась в исследованиях, образовании, сестринской практике и лидерстве в области сестринского дела. Большинство исследований Теории комфорта касались влияния вмешательств на уровень комфорта пациента.

**Вывод**: Теория комфорта К. Колкабы полностью применима к клинической сестринской практике. Используя теорию Комфорта в учреждениях здравоохранения Казахстана, медицинские сестры могут создать позитивную атмосферу комфорта для каждого пациента, обеспечив уважение к его настоящему и прошлому, к его жизненным ценностям, традициям и убеждениям. Принципы теории могут быть интегрированы в программы бакалавриата и последипломного образования медсестер.

**Ключевые слова**: Теория Кэтрин Колкабы, комфорт, пациент.
Relevance and goal
The important task for nurses is to determine patients’ needs and to satisfy them in a timely manner and a good quality. The comfort of a patient is a fundamental need that determine functionality, quality of life and health care outcomes of individual. F. Nightingale is the first one who recognized the need to ensure patient’ comfort. According to F. Nightingale ‘it must be lost sight of what observation is for. It is not for the sake of piling up miscellaneous information or curious facts, but for the sake of saving life and increasing health and comfort’. F. Nightingale implies that the relationship between health and comfort is dependent [1].

Comfort is a holistic state that captures many of the simultaneous and interrelated aspects of positive human experience [2]. The concept of comfort theory in nursing manifests itself as psychological support, providing emotional stability. Comfort is a term that has a significant historical and contemporary association with nursing [3]. The authors of nursing models (Peplau, Orlando, Watson, Roy) knowingly integrated statements of Comfort Theory into their models and related them to nursing care. The analysis of care models in terms of comfort reveals that comfort in nursing is inseparable from a person's health, physical and psychological well-being and his / her interactions with other people: relatives and caregivers.

The concept of comfort is related to the nursing process, the functions of nurses, the results of nursing and the satisfaction of basic needs of individuals. Morse et al. discussed the link of comfort with sympathy and compassion in a way that ‘sympathy demonstrate acceptance of the sufferer's state and thereby provide comfort’ and that ‘the caregiver expresses compassion that strengthens and comforts the sufferer’ [4]. Different nursing activities are carried out in order to reduce patient discomfort. Discomfort occurs where comfort is depleted, so, comfort might be achieved by controlling the discomfort. In numerous clinical research settings, enhanced comfort is a desirable and meaningful outcome of patient care. In this paper, a middle-range theory of Comfort (Katharine Kolcaba) is described and reflected in relation to nursing care and quality improvement.

K. Kolcaba “Theory of Comfort”
Katharine Kolcaba (born December 28, 1944) – the nurse professor, published a concept analysis of comfort in 1991. She was keen on comfort as a theoretical construct while working with the group of patients with dementia [5]. K. Kolkaba was a head nurse and was asked to describe her work as a nurse besides of special duties. It was understandable that there is a lack of written knowledge about a comfort as an important part that affects the patient and its care [6]. Even though the concept of comfort was as aged as the nursing profession, Kolcaba's theory turned it into a measurable entity with certain supporting characteristics [7].

The K. Kolcaba's theory that was developed in 1990 is related to health care practice, education and research. In theory the comfort is defined for nursing as the satisfaction (actively, passively or co-operatively) of the basic human needs for relief, ease or transcendence arising from health care situations that are stressful [8, 9]. In this theory relief, ease and transcendence are identified as three components of comfort:

- Relief was defined as the experience of the patient when a specific need has been met. Relief is the expulsion of all symptoms. Nursing care has to evaluate symptoms, for instance, feeling cold or having sickness, and afterward give interventions to destroy them.
- Ease is a condition of calm, happiness, and satisfaction and a certain need for comfort for example reducing of anxiety.
- Transcendence is a condition of lifting oneself over the current circumstance notwithstanding the presence of discomfort and pain. In the context of caring, transcendence is to transcend signs and symptoms that can be “killed” and to bear the side effects and discover strength without misery. The point in nursing care is to help and guide the patient to suffer, discover trust, and oversee signs and any “indications” that can not be eliminated [10].

K. Kolcaba identified four contexts in which the patient experiences comfort:
• **Physical comfort** - related to bodily sensations, homeostatic mechanisms, immune function, etc.

• **Psychospiritual comfort** - referring to an inner awareness of oneself, including respect, identity, sexuality, meaning in life, and an understood relationship with a higher level or being.

• **Environment comfort** - related to the external background of the human experience (temperature, light, sound, smell, color, furniture, landscape, etc.)

• **Sociocultural comfort** - related to interpersonal, family and social relations (finance, training, medical personnel, etc.), as well as family traditions, rituals and religious practices [1,10].

Kolcaba created the Taxonomic Structure of Comfort, in which the three components of comfort (ease, relief, transcendence) and 4 contexts (physical, psychospiritual, environmental, sociocultural) form a matrix of 12 cells [10]. This structure can be used as a guideline for assessing a patient’s level of comfort while caring for him or her. Based on this taxonomic structure, Kolcaba described comfort as an immediate state of being strengthened by having the needs for ease, relief, transcendence met in four contexts of experience (physical, psychospiritual, environmental, sociocultural) [1, 2, 5].

According to Kolcaba’s (1994) comfort theory identify total comfort needs of the patients in stressful health care situations. Nurses then design interventions to meet needs of the patient that currently not being met [2]. When nursing is effective, increased comfort is achieved and relief of psychological and physical symptoms occurs [7]. Once comfort is achieved, it is desirable to maintain and improve this condition.

**The usefulness of Kolcaba's Comfort theory for nursing research and education**

Kolcaba’s Comfort theory has been tested in many research studies in the past decades. Comfort theory has been successfully applied in different clinical nursing practices and nursing research. For example, Ergin and Yucel conducted experimental study on the effect of music on the comfort and anxiety of older adults living in a nursing home in Turkey using General comfort questionnaire and found that music reduced anxiety experienced by the older adults since it improved their comfort [11]. Further Yücel et al. carried out a study to investigate the effects of hand massage and therapeutic touch on comfort and anxiety in the elderly living in nursing homes. It was concluded that therapeutic touch and hand massage decreased the anxiety and increased the comfort levels of the elderly living in the nursing home [12]. Krinsky et al. discussed the care of patients suffering from symptoms related to the discomfort from cardiac syndromes and provided the evidence for ‘quiet time’ intervention as a comfort measure that addresses Kolcaba's four contexts of comfort: physical, psychospiritual, environmental and sociocultural [13].

The research of Comfort theory can be divided into two groups: non-interventional and interventional. Researchers have conducted a number of studies evaluating the impact of various interventions for patients comfort in the hospital. Kolcaba’s middle range theory of comfort has been used as a framework in studies where comfort was measured as the main outcome variable in populations such as women undergoing radiation therapy [14, 15]. Tuncer and Yucel assessed the comfort and anxiety levels of women with breast cancer receiving radiotherapy in early stage. The results showed that it is necessary to determine the comfort and anxiety levels of each patient before planning and applying patient specific comfort by providing nursing interventions [15]. Similarly, Pehlivan and Kuzhan examined the relationship between comfort and quality of life in breast cancer patients undergoing radiation therapy. It was determined that radiation therapy does not affect the comfort and quality of life, and quality of life increase with increasing comfort while the comfort decreases with increasing symptoms [14]. Another example of the comfort theory utilization during the research process is a descriptive study of Findik, Topcu and Vatansever where the pain, comfort and anxiety levels of patients with drains were linked postoperatively. This study showed that surgeries and drains decrease the comfort level of the patients as pain level increases. Also, pain and discomfort increase the patients’ anxiety. The authors provide the recommendations for nurses to improve measures about pain and anxiety reduction to maintain the comfort of patients [16].
The effect of a warmed blanket on comfort for elderly patients was studied by Robinson and Benton. This study has demonstrated that warmed blankets may help promote the comfort of elderly patients in the cool hospital environment because adequate rest promotes healing, length of stay and patient satisfaction [17]. A similar study evaluating level of comfort with a warmed blanket has been done in acute inpatient psychiatric unit to assess the difference in the level of comfort between psychiatric inpatients who received a warmed blanket or not. The study found that warmed blankets are not routinely offered to patients in the psychiatric setting even if the use of warmed blankets may increase the comfort of anxious and uncomfortable patients [18]. Other study with psychiatric inpatients with depressive disorders describe the efficacy of a guided imagery intervention for decreasing depression, anxiety, and stress and increasing comfort in psychiatric inpatients. Study revealed that focusing the imagination in a positive way can result in a state of ease, encouragement, and mood regulation, all of which allow the patient to reestablish a state of physical and mental health [19].

Instrumentally, many researchers used various comfort questionnaires created by K. Kolcaba when conducting studies to assess the level of patient comfort. General comfort questionnaire was one of the commonly applied for investigations. It was translated and adapted in foreign languages and different cultures (Turkish, Spanish, Portuguese) and revealed a good psychometric properties [20, 21, 22, 23]. Other questionnaires to investigate comfort were: General comfort questionnaire, Comfort behaviors check list, Perianesthesia comfort questionnaire, Comfort daisies, Radiation therapy comfort questionnaire, Urinary incontinence and frequency comfort questionnaire, Psychiatric In-patients Comfort Scale, End of life planning questionnaire, Hospice comfort questionnaire and other [14, 15, 16, 18, 19, 21, 24, 25,26].

Kolcaba comfort theory demonstrates it’s relevance to nurse education at different levels. Kolcaba and Wilson discussed the theory of comfort application to the specialty of perianesthesia nursing. This framework of goals and comfort measures for each phase of perianesthesia is very much suitable during education process of nurses in this specialty. We can teach nurses and students on interventions designed to treat anxiety and to enhance comfort of the patient because this anxiety discomfort can be severe and can negatively affect physiologic function [27]. Rondinelli et. al. investigated the comfort of nurses in caring for parents and families experiencing perinatal loss. Study results showed that experience of professionals independently predicted comfort in delivering perinatal bereavement care. The authors suggest to structure and to enhance professional development programs that would improve confidence of perinatal nurses through experience sharing on how to stay comfortable with bereavement care [28]. We assume that Kolcaba comfort theory is useful when teaching students of nursing theory and nursing models of care, discussing nursing process and assessment of patient’s needs, developing skills of patient’s care plan preparation, implementation and assessment with the holistic approach to care. Students learn comfort care plans which are used to detail all of the comfort interventions they provided for particular patient and family during care process.

**Application of Kolcaba's Comfort theory for nursing practice and leadership**

The theory of Comfort was adopted to New England hospital because it most represented the philosophy of care and values of this hospital. The institution, which chose the Comfort theory, sought to improve comfort not only for patients and their relatives, but also for the nurses working in the institution. The hospital administration sought to change the nursing philosophy to emphasize physical, environmental, sociocultural, and psychospiritual comfort for both patient / families and nurses. Comfort interventions such as warmed blankets in the emergency department, flexible visiting hours and accommodations for families, and special comfort food as requested were implemented [29].

The American Society of PeriAnesthesia Nurses (ASPN) tried to adapt this theory into practice as well. ASPAN is the first professional nursing organization which to published a standard of perianesthesia nursing practice that includes comfort as a criterion for initial and ongoing
assessment and management of patients until transfer or discharge. ASPAN Research Committee tried to develop a pain and comfort clinical guideline. The aim of this research was to evaluate the ASPAN Pain and Comfort Clinical Guideline for clarity, usability, and feasibility during all perianesthesia settings. The results of this study showed that the ASPAN Pain and Comfort Clinical Guideline has practical utility for perianesthesia nurses in all settings and positively impact patients comfort in perianesthesia in perianesthesia settings [30]. These are only a couple of good practice example how to base clinical practice on theoretical background.

The Comfort theory was introduced in different clinical settings such as surgery, oncology, cardiology and other. As an example, comfort theory was suggested for pediatric care to comfort each child by all possible proactive means of holistic care and not only by pain relief interventions [31]. The authors suggest that application of the theory is strengthening and satisfying for pediatric patients/families and nurses. Moreover, the theory benefits institutions where a culture of comfort is valued. Such understanding of theory utilization open the leadership path by which nurse managers can improve the quality of care in their organisations, to create more positive work environment and to develop so called ‘a Comfort Care Institution’.

Discussion and conclusion

Each individual is not isolated from his environment and its factors, and the balance between comfort and discomfort, even in the presence of an adaptive zone, is very fragile. It turns out that in nursing, and in life in general, comfort rarely occurs on its own. On the contrary, the creation and maintenance of patient’s comfort in clinical practice requires the targeted efforts of the patient, his relatives, and health professionals. Enhanced comfort contributes to the well-being of patients during hospitalization and also improves health-seeking behavior after their discharge. Subsequently, better adherence to clinical treatment and physical checkups might be expected.

In the nursing profession, theories and conceptual models are gradually introduced into practice, which contributes to the professional growth of nurses. We were able to provide the evidence on Kolcaba's Comfort theory utility for nursing research, education, clinical practice and leadership. The Comfort theory takes on a traditional perspective on nursing in which the patient's needs are prior and the care is around the patient. Knowledge on this theory help nursing students to develop patient-centered comfort care plans for their patients.

Kolcaba stated that if patients feel comfort, they will consequently experience satisfaction with care provided, and nurses as the entire organisation will take an advantage of that [17, 18, 25]. Being in comfort work environment, nurses also feel less work-related stress and higher satisfaction with their practice. All things considered, it is exactly what the main message of the Kolcaba’s theory stands for.

With the rapid development of technology, everyone needs to live and work in comfort. Middle-range theories, based on scientific approach and evidence-based practice, present the nurse as an equal partner of the doctor who makes independent nursing decisions, plans and delivers evidence-based nursing care, reflected in nursing records. Unfortunately, for many years, nurses in Kazakhstan and in other post-soviet countries were unable to make independent decisions about patient care and care outcomes. That was caused by vocational level of nursing education with the focus on nurses as servants of the doctor, very much medicalized education programs, poor role and position of nurses in health care team, lack of professional autonomy. However, with the development of nursing in Kazakhstan through new education programs, clinical standards and research initiatives nurses are becoming more independent and autonomous in their activities. The development of nursing depends on like-minded people who want to raise nursing education, science and practice to a new level. In addition, the support of state and local healthcare institutions, in the consequence, provides benefit for the country and health care as a whole.

By utilising Comfort theory in health care institutions in Kazakhstan nurses can create a positive atmosphere for the comfort of each patient assuring respect for his present and past, for his life values, traditions and beliefs. Under such care conditions patient will receive bio-psycho-spiritual and social
comfort, thereby achieving the result of the highest comfort. Comfort is especially important for older patients and those in need of short or long-term care, as the patient’s feeling of helplessness and immobility creates a huge psychoemotional strain, an inability to reconcile with the effectiveness of medical interventions, and possibly a refusal of treatment and care [11-14].

To conclude, Katharina Kolcaba middle-range theory of Comfort has demonstrated a holistic approach to patient and care. Many researchers have shown that the comfort of the patient or his family during treatment is one of the most important goals. However, it can only be achieved through collaboration between healthcare professionals and the patient. We believe that it would be important to explore how the application of Comfort theory in Kazakhstan in various fields of nursing will efect patients’ outcomes.

References:


