COURSE RESERVE READING

SAMPLE PAPER TITLE: Sample Paper 2: NSG 501 – Katherine Kolcaba’s Theory of Comfort: An Analysis

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Katherine Kolcaba’s Theory of Comfort: An Analysis

In my nursing practice I frequently care for dying patients. Instead of simply providing medication to ease pain during the dying process, I wanted to learn about ways to enhance the comfort of the dying patient and possibly assist their family during a difficult time. This desire led me to undertake a concept analysis of comfort. Through my research of the concept of comfort care at end of life, I discovered Katherine Kolcaba’s theory of comfort. I found her theory to be useful in describing the concept of comfort care and decided to further analyze her theory for a more thorough understanding of its usefulness and applicability to nursing practice. That analysis is presented here.

Kolcaba first began “theorizing about the outcome of comfort” (Kolcaba, 2003, p. 2) while working on a dementia unit as a head nurse and pursuing her Master’s of Science in Nursing at Case Western Reserve University. She continued her research while pursuing her doctoral degree which she completed in 1997. Her interest was sparked by her understanding that comfort was a necessary component for optimum function in the patients she cared for on the dementia unit. With the patients being largely non-verbal, the nurses were required to interpret the patient’s actions to determine what may be causing discomfort in a
patient, thus leading to disruptive behaviors. From this
assessment it was possible to implement care plans to treat
underlying issues or enhance patient comfort leading to improved
patient care. Her work produced numerous articles and a book
describing the theory of comfort, its assumptions, the major
concepts and their relationships, techniques for measuring
comfort in a variety of environments, and discussions for the
theory's application in nursing practice. An overview of this
work will be presented. First, it is important to understand
what comfort is in Kolcaba's terms.

Historically, Nightingale spoke of comfort when she stated
that "it must never 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" (as cited in Peterson & Bredow, 2004, p.
256). Comfort is also referred to by many major nursing
theorists including Orlando, Roy, Watson, Henderson, and
Paterson and Ederad, but no one sought to understand the nature
of comfort itself. Kolcaba undertook this effort when she
performed her analysis of the concept of comfort.

In her analysis, Kolcaba described two dimensions. "The
first dimension of comfort consists of three states, called
relief, ease and transcendence" (Kolcaba, 1994, p. 1179). "The
second dimension of comfort is the contexts in which comfort can occur—which are derived from the nursing literature about holism” (Kolcaba, 1994, p. 1179). The definitions of the three states of comfort are presented next.

Kolcaba derived her three states of comfort from other nursing theorists. Orlando originally spoke of relief stating that “nursing actions should be designed to meet the physical and mental needs of patients and it focuses on how the nurse deciphers what the patient’s needs are” (as cited in Kolcaba, 1991a, p. 238). Ultimately, Kolcaba defined relief as “when the patient is capable of if comfort provides respite from the stress and anguish of disease, debilitation or injury” (1991b, p. 1305). The second state of comfort, ease, is defined as “an enduring state of...peaceful contentment” (Kolcaba, 1991b, p. 1306). Henderson originally spoke of the concept of ease when she stated that “only after a discomfort is relieved can the patient proceed to recovery” (as cited in Kolcaba, 1991a, p. 238). Finally, of renewal or transcendence, Kolcaba wrote that it “implies enhanced powers, strengthened motivation, and positive attitudes and outlooks for meeting the life challenges normal for that person” (1991b, pg. 1306) or “the state in which one rises above problems or pain” (Kolcaba, 1991a, p. 239). This was developed from Paterson and Zderad’s statement that “comfort
is the state in which the patient is free to be and become controlling and planning his own destiny” (as cited in Kolcaba, 1991, p. 239). After gaining an understanding of the three states of comfort, it is necessary to discuss the four contexts within which they can occur. The four contexts are physical, psychospiritual, environmental, and sociocultural which will be described now.

The first context comfort can occur in is physical. Kolcaba defined the physical context as “pertaining to bodily sensations” (1991a, p. 239). The psychospiritual context was defined as “pertaining to the internal awareness of self, including esteem, concept, sexuality and meaning in one’s life; it can also encompass one’s relationship to a higher order or being” (1991a, p. 230). The third context, sociocultural was defined as “pertaining to interpersonal, family and societal relationships” (1991a, p. 239). Finally, the fourth context, environmental was defined as “pertaining to the external background of human experience; encompasses light, noise, ambience, color, temperature and natural versus synthetic elements” (1991a, p. 239). While most would think of comfort as a strictly physical experience with only one possible outcome, Kolcaba believed it was important to stress that comfort encompassed a variety of states and contexts that were necessary
to consider when ensuring the best patient outcomes. To best
depict the relationship between them, she developed a grid in
her taxonomic structure of comfort that helped to further define
her ideas. A discussion of the major concepts in the theory is
presented next.

There are seven major concepts presented by Koldaba in her
theory of comfort. These concepts are health care needs, nursing
interventions, intervening variables, patient comfort, health-
seeking behaviors, institutional integrity and institutional
outcomes. She defines health care needs as "needs that arise for
patients in stressful health care situations" (Kolcaba, 2001, p.
90). Nursing interventions are presented as "commitment by
nurses and institutions to promote comfort care" (Kolcaba, 2001,
p. 90). Intervening variables are those things "that will affect
the outcomes" (Kolcaba, 2001, p. 90) and she describes patient
comfort as "the immediate state of being strengthened by having
needs met" (Kolcaba, 2001, p. 90). Health-seeking behaviors are
defined as "patient actions of which they may or may not be
aware and which may or may not be observed that are predictor or
indicators of improved health" (Kolcaba, 2001, p. 90).

Institutional integrity is defined as "the quality or state of
health care organizations" (Kolcaba, 2003, p. 255). Finally, she
described institutional outcomes as "decreased lengths of stay,
successful discharges, and improved public relations when patients and families are happy with their health care” (Kolcaba, 2001, p. 91), which for hospital administrators is the ultimate goal when comfort is a key nursing consideration. With the key concepts identified and defined, their relationship to one another needs to be understood. This relationship is presented next.

Kolcaba (2001) clearly described the relationship between her major concepts when she stated her propositions in theory of comfort:

1. Nurses identify patients’ comfort needs that have not been met by existing support systems.
2. Nurses design interventions to address those needs.
3. Intervening variables are taken into account in designing interventions and mutually agreeing on reasonable immediate and/or subsequent health-seeking behavior outcomes.
4. If enhanced comfort is achieved, patients are strengthened to engage in health-seeking behaviors.
5. When patients engage in health-seeking behaviors as a result of being strengthened by comforting actions, nurses and patients are more satisfied with their health care.
6. When patients are satisfied with their health care in a specific situation, that institution retains its integrity. (p. 90)

The last relationship, not defined explicitly by Kolcaba, is that institutional outcomes are a direct result of understanding and addressing a patient's comfort needs.

Finally, before an analysis of the theory of comfort can be completed, it is necessary to understand the major assumptions made by Kolcaba when developing her theory. According to Kolcaba (2001), those assumptions underpinning her theory of comfort are as follows:

1. Human beings have holistic responses to complex stimuli.
2. Comfort is a desirable holistic outcome that is germane to the discipline of nursing.
3. Human beings strive to meet, or to have met, their basic comfort needs; it is an active endeavor.
4. Institutional integrity has a normative and descriptive component that is based on a patient-oriented value system. (p. 90)

The theory of comfort is referred to as a middle range theory. Whall compares middle range theories with grand theories and states that middle range theories "contain fewer concepts and relationships, are adaptable to a wide range of practice and
experience, can be built from many sources, and are concrete enough to be tested” (as cited in Kolecaba, 2001, p. 86). Given this description, the theory of comfort can be readily identified as a middle range theory.

With regard to the concepts presented by Kolecaba, they are clearly defined and the relationships between them are easily understood. The concepts are generalizable and measurable through the development of numerous measurement tools designed for specific environments. The theory itself has been applied in a number of different environments including hospice, peri-operative, radiation therapy and general care areas. Questionnaires to test the theory of comfort have been developed for each of these areas and successfully tested and employed. The scope of the theory is narrow and stands at a low level of abstraction.

Most importantly, the theory is readily applicable to the nursing discipline and provides a clear framework relevant to meeting patient’s needs during stressful life events. It allows the nurse to define, with input from the patient, what their needs are within the four contexts, to address those needs with nursing interventions, to evaluate the success or failure of those interventions and to continue in a cyclic manner until the patient achieves a state of comfort. In essence, the
framework provides a process model for nursing that is specific to comfort. It is easy for a nurse to use and understand and can be applied in many environments.

In evaluating and analyzing the theory of comfort, numerous research possibilities come to mind. Given my specific interest in end of life care, it is important to understand that the nurse is focused not only on the comfort of the patient but also on that of the families and caregivers of the dying patient. While one would think of health-seeking behaviors to be focused on cure or rehabilitation, they can also be used to aid in a more peaceful or comfortable death. Therefore, a study that evaluated the level of comfort experienced by the patient and family members with and without direct care provided by the family members could be undertaken. The study would seek to determine whether less medical intervention is required to ensure patient comfort during the dying process if there is increased family involvement in care. This nurse would hypothesize that, in measuring patient comfort, less medical intervention would be required to maintain an acceptable level of comfort in death if family members have greater involvement in providing care. Conversely, another possible study could involve family member comfort and ask if family members have an increased level of comfort with greater involvement in patient
care during the period preceding death. The sample population for both studies would be dying patients and their family members. To measure family member comfort, data could be collected utilizing a likert-scale questionnaire. To measure patient comfort, a questionnaire could be developed for those patients that are able to verbalize or the nurse could be given a list of objective signs and symptoms of comfort to evaluate in order to determine patient comfort.

Kolcaba’s work has led to a universal theory applicable to all areas of nursing. She has captured the quintessential essence of nursing in a simple and structured framework. Use of her framework in practice can lead to improved patient experiences in one of the most important outcomes of nursing practice, patient comfort.


Hi Sue and Pam,

My availability for March for Task Force meetings:

March 7th Fri till 3:00
March 12th Wed open
March 13th Thur. open except 3:30-4:30
March 17th Mon after 2:30
March 18th Tues open
March 19th Wed. open
March 25th Tues open
March 28th Wed. till 12 and after 3:30
March 28th Friday open after 11:30
March 31 Monday open

Thanks so much,

Judi