SAMPLE PAPER TITLE: Sample Paper 1: NSG 501 – Comfort Care: A Concept Analysis of End-of-Life Care in Nursing

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Comfort Care: A Concept Analysis of End-of-Life Care in Nursing

Introduction

A broad definition of comfort care for nursing provided by Kolcaba (2003) states it is a "philosophy of health care that focuses on addressing physical, psychospiritual, sociocultural, and environmental comfort needs of patients" (p. 252). With regard to end-of-life care, the National Cancer Institute defines comfort care as care given to improve the quality of life of patients who have a serious or life-threatening disease. Practicing in the area of adult neurosciences I am often faced with caring for patients at the end of life. It is best stated by Seery (2004) that "we have the privilege of not only participating in the deeply personal experience of someone's death, but also in helping them to truly live until the final moment" (p. 57). I believe the best way to assist a patient with truly living until their death is to fully understand what comfort care is and to incorporate that understanding into my own practice.

The Basics of Comfort Care

According to Kolcaba, there are three types of comfort; relief, ease and transcendence. These types were derived through her research while developing her concept analysis of comfort. The first, relief, is defined as "the experience of a
patient who has had a specific comfort need addressed" (as cited in Peterson & Bredow, 2004, p. 258). Ease is defined as "a state of calm or contentment" (as cited in Peterson & Bredow, 2004, p. 258). Finally, transcendence is defined as "the state in which one rises above problems or pain" (as cited in Peterson & Bredow, 2004, p. 258).

While developing a taxonomic structure, Kolcaba defined comfort as existing within four contexts. The contexts are "physical needs, or bodily sensations; psychospiritual, a dimension that includes awareness of self and a sense of meaning in life; environment, the context in which a person lives, including light, noise, odor, temperature; social, referring to relationships" (Olson, 2001, p. 58). According to Olson (2001) "meeting basic human needs for comfort in the dying patient may include care within any of these four areas or any combination of them" (p. 58).

Derivation of Comfort Care

"Ergonomics and psychology were interested in enhancing productivity, efficiency, and performance..." (Kolcaba, 2003, p. 7) but "comfort has been called a distinguishing characteristic of nursing" (Kolcaba, 1994, p. 1182). The origins of comfort can be traced back to the work of Nightingale who defined comfort as a primary outcome for nursing when she stated that
"observation is for...the sake of saving life and increasing health and comfort" (Kolcaba, 1991, p. 1303). Kolcaba spent many years performing research to create the Theory of Comfort which is based in nursing practice. She developed this theory from other nursing frameworks and theories such as Murray’s Theory of Human Press and "The Patient’s Comfort", a chapter in The Technic of Nursing written by Goodnow in 1935 and links comfort with both physical and mental needs of patients.

Differentiation of Comfort Care

Many nursing theories discuss comfort. Roy’s theory of adaptation centers on the nurse helping patients by providing comfort to allow for adaptation. Orlando developed the deliberative nursing process in which nurses are supposed to correctly assess a patient’s comfort to determine the effectiveness of the intervention. Watson developed a theory of human caring, which uses comfort to alter the internal and external environments of a patient. While these classic theories speak of comfort as a component required for successful patient outcomes, none seek to fully define or analyze the concept of comfort in and of itself, leaving comfort to be defined on a situational basis by the patient and/or nurse.

Quantifying Comfort Care

To quantify comfort care at end of life, a study was done
to examine the effectiveness of a Likert scale questionnaire called the Hospice Comfort Questionnaire (HCQ). With the HCQ, patients are asked to rate their experience of comfort at end of life within the four contexts defined by Kolcaba. The study determined that the questionnaire had a high level of reliability and that it provided "the ability to assess and document ongoing efforts at providing comfort at the end of life for patients" (Novak, Kolcaba, Steiner, & Dowd, 2001, p. 178).

Antecedents and Consequences of Comfort Care

In the physical context, patients may experience pain, nausea, constipation, respiratory distress, insomnia, or a dry mouth or skin. Medications and basic nursing care can ameliorate these symptoms. The consequence of comfort care in this context is the relief from physical discomfort.

In the psychospiritual context, patients at end of life are confronted with exploring their thoughts on death, satisfaction with their life, or the need for a spiritual connection. The nurse should aid the patient by exploring these issues when the patient chooses and then assist them in obtaining the appropriate support. The ultimate consequence is to help the patient deal with these issues to allow them to feel at ease.

In the environmental context, patients may be affected by the temperature, smell, color, and noise level of the room. The
nurse should modify the physical environment as much as possible. The consequence of comfort care in this context is the removal of any noxious stimuli negatively impacting the patient.

In the social context, patients may have problems with family members or close relations. The nurse should explore these issues as the patient is ready and provide the appropriate assistance. The consequence of comfort care in this context is to help the patient find peace in their social connections.

Exemplars

The first case is that of a patient with a long history of breast cancer that is brought to the emergency room experiencing mental status changes after a fall at home. By computed axial tomography (CT) scan it is determined that she has a subarachnoid hemorrhage. She is also found to have extensive brain metastases. Shortly after admission, the patient becomes comatose. The family, being well aware of the patient’s wishes, asks that comfort measures only be provided. The patient is placed on a morphine drip, fluids and feedings are stopped, and the patient passes away quietly within two days having suffered no apparent distress.

This case exemplifies model comfort care at end of life. The patient’s wishes were known and were enacted by a loving
family. The patient's physical comfort was provided for, there
was no distress noted, and her life was not sustained
unnecessarily or against her wishes.

In the second case a patient is admitted from the emergency
room under orders for comfort measures only after suffering a
significant right middle cerebral artery (MCA) stroke. The
patient is to be placed on a morphine drip between two and
twenty milligrams per hour and titrated for patient comfort. A
new nurse starts the drip at a rate of two milligrams per hour
and the patient's respiratory rate is elevated. The oncoming,
more experienced nurse incrementally increases the morphine rate
to eighteen milligrams per hour appropriately dropping the
respiratory rate to ten. The patient dies a few hours into the
next shift with no apparent distress.

This is an example of marginal comfort care. The new nurse
does everything in accordance with good comfort care, except
does not completely address the issue of respiratory distress
due to fear of overdosing the patient. The experienced nurse
was able to realize that the morphine rate needed to increase
significantly to provide proper comfort for this dying patient.

In the third case the patient is admitted suffering with
right-sided weakness and expressive aphasia after suffering a
left MCA stroke. The patient is able to state that he desires
no heroic interventions, including fluid and nutrition, to sustain his life. Shortly after admission, the patient loses consciousness. The wife, as health care proxy, with support from her children, insists on having a feeding tube placed and fluids started. The patient never regains consciousness and is transferred to a hospice facility where he passes away after three months of care. His pain is well controlled throughout through the use of morphine and ativan.

This case is a borderline example of comfort care at end of life. The patient passes away comfortably with no apparent distress, but his wishes with regard to fluid and nutrition is not respected. It is important to address all contexts of comfort for the care to be considered appropriate.

In the final case a patient is admitted from the emergency room after being found to have a severe MCA stroke. The family is informed that the patient will not regain consciousness and the recommendation is made that the patient be provided comfort measures only. The wife, as health care proxy, insists that the patient receive fluids and a feeding tube despite being told that this will not enhance his comfort. She also refuses the use of morphine to provide for his comfort because she is afraid he will become addicted. The patient’s children are aware that there is a living will that states the patient wishes to have no
fluid or nutrition and would want to be medicated for comfort as he is afraid to suffer with respiratory distress at the time of his death. The patient passes away with a high respiratory rate and low oxygen saturation, suffering with apparent respiratory distress.

This is an illegitimate case of comfort care. The patient is in obvious physical distress, the family is unable to agree on the care to be provided, and the patient’s wishes with regard to end of life are not properly fulfilled.

Comfort Care in Practice

Comfort care is not simply proper sedation of the terminal patient to provide for physical comfort. Instead, it is attending to the whole person and ensuring their social, spiritual, cultural and environmental needs are met, in addition to just their physical comfort. To assist a patient to live their life as fully as possible until the moment of death, it is important to be aware of all aspects of comfort care a patient may require. Incorporating the use of the HCO into daily practice when caring for hospice or terminal patients would begin to raise awareness of the inadequacy of addressing only the physical needs of the dying patient.
References


