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Nursing Theory–Directed Healthcare

Modifying Kolcaba's Comfort Theory as an Institution-Wide Approach

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The tradition of the nursing discipline borrowing theory from other disciplines is examined, and the idea of other healthcare disciplines borrowing nursing theory is proposed. A brief literature review of borrowed theory sets the stage to examine how a modification in the theoretical framework of Kolcaba's theory of comfort can guide the thinking and work of other healthcare disciplines. This change positions Kolcaba's theory as an acceptable blueprint to guide the activities of all health disciplines within an institution, transposing this theory from a theory for nursing to a theory for healthcare. In a healthcare climate that embraces interprofessional collaboration, a single theoretical framework has the potential to facilitate greater understanding between disciplines and greater continuity of care for healthcare recipients and their families. To clearly demonstrate this assertion, a hypothetical case example is presented. **KEY WORDS:** *comfort*, *comfort theory*, *interdisciplinary healthcare*, *Kolcaba*, *nursing shortage*, *nursing theory* *Holist Nurs Pract* 2009;23(2):75–80

The discipline of nursing is relatively new with nursing theories largely nonexistent before the 1950s.[1] Over the course of nursing theory development, concepts, for example, Kohut's self-psychology model of empathy and Murray's concepts related to human needs, have frequently been borrowed from other more established sciences.[1–4] In this article, the idea of borrowing theory will be examined, with a particular focus on what could potentially be gained by healthcare recipients if nursing theory was shared with other disciplines and implemented at the institutional level. Kolcaba's comfort theory, a nursing theory, will be proposed as an acceptable theory to direct the care provided by all healthcare disciplines within an institution. To accomplish this directional change, a modification of the theoretical structure of Kolcaba's comfort theory will be put forth for consideration. To clearly demonstrate this proposal, a hypothetical case example will be presented. But first, a brief literature review of borrowed theory is presented and the metaparadigm of nursing described.

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BORROWED THEORY

Literature review

A review of MEDLINE, CINAHL, and ProQuest databases reveals only 7 journal articles in the current healthcare literature that examine the subject of borrowed theory. Six of these articles describe how the nursing discipline has adapted theory from other disciplines, with no mention of other healthcare disciplines borrowing theory from nursing.[4–9] The seventh article did not refer to the discipline of nursing.[10]

Throughout the history of nursing, it has been common for theories to be borrowed from other disciplines, for example, from the fields of psychology and sociology.[1,4,9] This borrowing, or the practice of testing theories from another discipline for use in one's own discipline,[4] continues to occur despite the fact that over the past few decades nurse theorists have developed and tested many theories specific to nursing.[9] This brings forth the question: What could other healthcare disciplines potentially gain if nursing theory were to be borrowed?

Pros and cons of borrowing theory

It has been noted that the nursing discipline can indeed gain from borrowing and/or sharing the knowledge developed by other disciplines; however, insufficient attention has been paid to determining the appropriateness of this knowledge for nursing before borrowing it.[9] On the other hand, Latham has argued that investigating borrowed theories fit for nursing is limiting to the profession.[7] She asserts that nursing research efforts are better directed into nursing-specific conceptual frameworks rather than those that can be borrowed from other disciplines. She does, however, admit that interdisciplinary dialogue can be beneficial.

Nursing is its own discipline and unique from other disciplines.[4] Even though nurses work in partnership with other healthcare professionals, theories from other disciplines should not be blindly adopted without assessment regarding the appropriateness of these theoretical structures for nursing.[3,4,9] Nurses should not lose sight of their discipline identity. However, if theory could be shared from one discipline in healthcare to the next, in all likelihood, a deeper understanding of roles and responsibilities and a greater continuity of care for patients will emerge.

THE NURSING METAPARADIGM

The *metaparadigm* of a discipline has been defined as "a statement or group of statements identifying its relevant phenomena."[11(p84)] At the level of the metaparadigm, these statements should be global to the discipline rather than specific to particular philosophies, worldviews, conceptual models, or theories.[11,12] In order for professionals in other healthcare disciplines to determine the appropriateness of nursing theories to guide their practice, an understanding of the metaparadigm of both their own discipline and nursing is essential.

The concepts that comprise the metaparadigm of nursing have been defined as person, environment, health, and nursing.[11] *Person* is defined as "the recipient of nursing, including individuals, families, communities, and other groups."[12(p95)] *Environment* has been defined as "the person's significant others and physical surroundings, as well as . . . the setting in which nursing occurs."[12(p95)] The concept of *health* is defined as "the person's state of well-being, which can range from high-level wellness to terminal illness."[12(p95)] Lastly, *nursing* is defined as "the actions taken by nurses on behalf of or in conjunction with the person, and the goals or outcomes of nursing actions."[12(p95)] Awareness of these definitions will assist healthcare administrators in discerning similarities and differences between nursing and other health disciplines.

OVERVIEW OF KOLCABA'S COMFORT THEORY

The theoretical structure of Kolcaba's comfort theory has real potential to direct the work and thinking of all healthcare providers within one institution. To gain an understanding of the potential utility of implementing this theory within an institution, an overview of the theory and proposed modification of the theory is described.

Background

The comfort theory is a nursing theory that was first developed in the 1990s by Katharine Kolcaba, an American nursing scholar who attained a PhD in nursing and a certificate of authority as a clinical nurse specialist, among several other scholastic awards and achievements.[2] It is a theory that is current with today's healthcare environment and continues to change and evolve, with the conceptual framework having been updated as recently as November 2007.[13]

From 1900 to 1929, comfort was considered to be a goal for both nursing and medicine, as it was believed that comfort led to recovery.[14] Over the decades since then, comfort has become an increasingly minor focus, at times reserved only for those patients for whom no further medical treatment options are available.[14] Kolcaba's theory has the potential to place comfort once again in the forefront of healthcare.

Comfort as a concept

During the development of the comfort theory, Kolcaba conducted a concept analysis of comfort that examined literature from several disciplines including nursing, medicine, psychology, psychiatry, ergonomics, and English.[2,15] This review confirmed that comfort is a positive concept and is associated with activities that nurture and strengthen patients.[2]

Forms of comfort

Kolcaba described comfort as existing in 3 forms: *relief, ease, and transcendence*.[16] If specific comfort

needs of a patient are met, for example, the *relief* of postoperative pain by administering prescribed analgesia, the individual experiences comfort in the relief sense. If the patient is in a comfortable state of contentment, the person experiences comfort in the *ease* sense, for example, how one might feel after having issues that are causing anxiety addressed. Lastly, *transcendence* is described as the state of comfort in which patients are able to rise above their challenges. An example of comfort in this form is evident in the patient who is involved in a physical therapy or rehabilitation program.[15] While these types of programs are often associated with physical discomfort, Kolcaba and Kolcaba[15] asserted that they eventually lead to a state of transcendence or renewal, in which the individual has moved past the initial discomfort with the end result being increased individual strength.[15]

Contexts of comfort

Kolcaba described 4 contexts in which patient comfort can occur: *physical, psychospiritual, environmental, and sociocultural*.[16] She described the *physical* context of comfort as any comfort that pertains to the sensations of one's body. The *psychospiritual* context of comfort is "pertaining to internal awareness of self, including esteem, identity, sexuality, meaning in one's life, and one's understood relationship to a higher order or being."[16(¶2)] She described the *environmental* context of comfort as the external surroundings of the patient. Finally, the *sociocultural context* of comfort is defined as "pertaining to interpersonal, family, and societal relationships."[16(¶2)]

Assertions of Kolcaba's theory

In the comfort theory, Kolcaba asserted that when healthcare needs of a patient are appropriately assessed and proper nursing interventions carried out to address those needs, taking into account variables intervening in the situation, the outcome is enhanced patient comfort over time.[13] Once comfort is enhanced, the patient is likely to increase health-seeking behaviors. These behaviors may be internal to the patient (eg, wound healing or improved oxygenation), external to the patient (eg, active participation in rehabilitation exercises), or a peaceful death. Furthermore, Kolcaba asserted that when a patient experiences health-seeking behaviors, the integrity of the institution is subsequently increased because the increase in health-seeking behaviors will result in improved outcomes. Increased institutional integrity lends itself to the development and implementation of best practices and best policies secondary to the positive outcomes experienced by patients (Fig 1).[13]

Kolcaba's theory and the nursing metaparadigm

Kolcaba's comfort theory successfully addresses the 4 concepts comprising the metaparadigm of nursing.[2,17] She defined the metaparadigm concepts as they correspond to her theory. *Nursing* is described as the process of assessing the patient's comfort needs, developing and implementing appropriate nursing interventions, and evaluating patient comfort following nursing interventions. *Person* is described as the recipient of nursing care; the patient may be an individual, family, institution, or community. *Environment* is considered to be the external

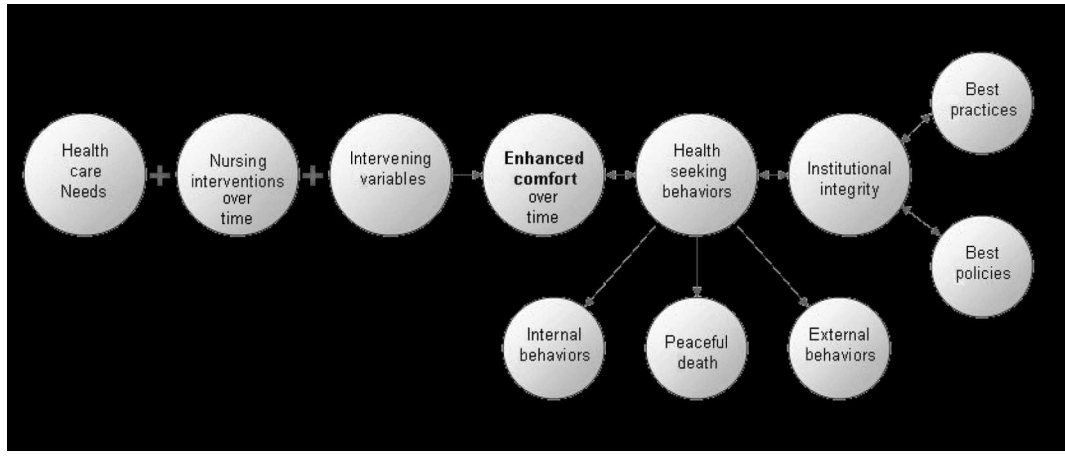

FIGURE 1. Conceptual framework for comfort theory.[13]

surroundings of the patient and can be manipulated to increase patient comfort. Finally, *health* is viewed as the optimum functioning of the patient as they define it.

Adapting Kolcaba's theoretical framework

According to Kolcaba, the concept of comfort appears to be universally present in all cultures.[17] Because of the universal nature of the concept of comfort, it can be speculated that the achievement of optimal comfort is an appropriate universal goal for healthcare. Kolcaba positions comfort theory within the domain of nursing; however, she posits that in an institution committed to meeting the healthcare needs of patients, comfort theory could potentially work as an institution-wide approach (K. Kolcaba, e-mail communication, November 27, 2007).

To implement Kolcaba's comfort theory at an institution-wide level, a change to the theoretical framework is necessary. At the present time, Kolcaba's comfort theory (Fig 1) describes the application of "nursing interventions," thus limiting the implementation of interventions leading to enhanced comfort as a function of only those healthcare providers who specialize in nursing.[13] A simple change of this term, however, to the term *comfort interventions*, broadens the potential application of this theory to any healthcare practitioner choosing to adopt this theoretical structure for practice.

Potential benefits

Because this adaptation of Kolcaba's theory is yet to be tested, the potential benefits can only be speculated. It could be hypothesized that if Kolcaba's comfort theory is indeed adapted to include all healthcare providers and implemented as an institution-wide framework for practice, that comfort for patients would be enhanced even further. The intervention strategies emerging from the consistent application of comfort theory across disciplines is likely to result in quality outcomes for the patient. In other words, comfort practices can be expected and experienced and not merely visualized. This enhanced practice could subsequently lead to an increase in patient health-seeking behaviors including but not limited to increased compliance with prescribed postoperative exercise regimes, increased compliance with prescribed diets for diabetic patients, and more peaceful deaths when palliative care is the appropriate goal.[13] In addition, the asserted link between enhanced comfort and health-seeking behaviors has been supported in the healthcare literature.[18]

Kolcaba's theoretical framework dictates that if patients' health-seeking behaviors are increased, institutional integrity will result.[13] It can be proposed, then, that if all healthcare practitioners within an institution delivered care guided by the comfort theory, that institutional integrity would be enhanced even more greatly than if the theory were used to guide nursing only. Increasing institutional integrity in such a manner could potentially aid in strategies for recruitment and retention of healthcare staff.[17] In addition, it can be hypothesized that structuring a healthcare institution around the concepts of the comfort theory would improve societal acceptance and appreciation of the institution, as well as increase patient satisfaction, due to the aforementioned positive connotations of the concept.[2]

Using the adapted framework

The following is a fictional account of a cardiac surgery patient, Mr S. This case is designed to demonstrate how certain aspects of the care of this patient may be carried out if all healthcare professionals were working collaboratively within Kolcaba's theoretical structure, and the suggested adaptation is in place.[13] Throughout the case, patient comfort will be a paramount consideration, showing how Kolcaba's comfort theory can be applied even in an environment as seemingly uncomfortable as an intensive care unit (ICU).[17]

Case example

Mr S. is a 45-year-old Canadian man who has just been admitted to the ICU postoperative cardiac surgery. He has had an uneventful coronary artery bypass graft with no complications in the operating room. He is intubated and placed on complete mechanical ventilation. His vital signs are: blood pressure (BP) 150/90 mm Hg, heart rate 86 beats per minute, respiratory rate 12 breaths per minute, and temperature 35.3°C.

The surgeon caring for Mr S. is familiar with Kolcaba's comfort theory and structures the orders accordingly. The target systolic BP for Mr S. is less than 130 mm Hg and the surgeon's postoperative orders include BP medications and intravenous morphine sulfate for pain. In addition, the surgeon prescribes an nonsteroidal anti-inflammatory drug,

ketorolac, to be administered to the patient once it has been determined that they are not bleeding excessively and have acceptable renal function. This close attention to treatment of pain represents a comfort intervention instituted by the surgeon that not only addresses a particular healthcare need of the patient but also recognizes the importance the surgeon has placed on of the relief form of comfort. There is a standing order in place for warming patients postoperative coronary artery bypass graft.

The ICU where Mr S. is admitted has a respiratory therapist (RT) on staff. This RT is aware that mechanical ventilation is very uncomfortable for patients.[19] There is a standing order in the ICU that heart surgery patients may be weaned from the ventilator as tolerated and extubated when stable. Using Kolcaba's theory, the RT decides to wean and extubate Mr S. as soon as possible postoperatively.

The nurse caring for Mr S. also structures patient care using Kolcaba's theory. When Mr S. is beginning to arouse from the anesthesia, he is grimacing and his BP is rising above the target level. Had the nurse not been familiar with comfort theory, she may have chosen to simply treat Mr S.'s BP with medications designed to target only BP. Because this nurse is accustomed to assessing comfort needs, she recognizes that this patient response is suggestive of increasing pain and administers morphine sulfate as ordered. In addition, Mr S. is given a warming blanket to increase his body temperature. Both of these interventions represent the nurse helping Mr S. to achieve comfort in the relief sense.[16]

The next morning, Mr S. is seen by the ICU physiotherapist, who has also been educated in comfort theory. When assessing Mr S.'s comfort needs, the physiotherapist recognizes that he is anxious about moving and exercising so soon after surgery. With this in mind, the physiotherapist carefully explains her plan of care to Mr S. in a calm and unhurried manner. This allows Mr S. to relax, what Kolcaba has referred to as the ease sense of comfort.[16] He becomes willing and able to work with the physiotherapist in his postoperative exercise routine, thus exhibiting what Kolcaba refers to as health-seeking behaviors, or comfort in the transcendence sense.[13,16]

The healthcare team worked collaboratively to enhance the patient's comfort during the immediate postoperative period. This, in turn, led to Mr S. having a successful recovery period with no significant complications.

Because this hospital follows Kolcaba's comfort theory when caring for all of their patients, institutional integrity is enhanced by an overall increase in positive patient outcomes, a decreased hospital length of stay, and continued community hospital support.[13]

CONCLUSIONS

Throughout nursing's history, it has been common for theories to be borrowed from other disciplines, yet in a review of the literature it was found that this has not been reciprocated.[1,4,9] Sharing knowledge between disciplines can be beneficial, although at times, the appropriateness of borrowing theories from one discipline to another has been called into question.[3,7,9] Before theories are shared between disciplines, they should be assessed for appropriateness of fit within the discipline's metaparadigm.

Kolcaba's comfort theory has been examined in relation to the nursing metaparadigm and determined appropriate for this discipline.[2,17] A change in the conceptual framework, replacing Kolcaba's "nursing interventions" with the term *comfort interventions*, has been proposed, and it has been hypothesized that this could enable other healthcare professions to practice using comfort theory.[13] In addition, it has been speculated that this type of interdisciplinary approach to theory implementation could allow for greater understanding and collaboration between healthcare team members.

In light of the current nursing shortage, the pertinence of a team-based approach to healthcare is evident.[20] The case example demonstrated continuity of comfort care across healthcare disciplines. When healthcare providers have the same goal, client needs are satisfactorily met and health-seeking behaviors and institutional integrity are enhanced. In today's chaotic healthcare environment, adopting and testing this theory has a variety of potential benefits with no known risks. The potential of this modified version of Kolcaba's theory to improve recruitment and retention of skilled healthcare professionals may be of particular interest to institutional administrators.

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