Utilizing Comfort Theory in the Care of a Critically Ill Mother

Introduction

According to the Cambridge English Dictionary, comfort is “the pleasant and satisfying feeling of being physically or mentally free from pain and suffering, or something that provides this feeling” (Comfort, 2019). When one thinks about nursing care and the duty of a nurse, this word “comfort” is likely to come to mind, as helping patients to be comfortable is one of the main goals of a nurse. Katherine Kolcaba, one of many nurse theorists, recognized comfort as being a basic human need, essential to health and well-being (McEwen & Wills, 2014). To share her beliefs about comfort and how it relates to the nursing profession, Katherine Kolcaba published the Theory of Comfort in 1994 (McEwen & Wills, 2014).

Overview of the Theory of Comfort

The Theory of Comfort, also known as Comfort Theory, was developed by Katherine Kolcaba (2003) to place an emphasis on the importance of the basic human need for comfort. Within Comfort Theory, there are three main concepts that comprise the theory and explain Kolcaba’s beliefs about comfort and its effects. Each of the three main concepts of Comfort Theory are discussed below.

Meeting a Patient’s Comfort Needs

The first component of Comfort Theory is a nurse’s holistic assessment of a patient’s needs and the nurse’s interventions to meet that patient’s comfort needs (Kolcaba, 2003). According to Kolcaba (2003), interventions are intended to achieve three types of comfort: relief, ease, or transcendence. Relief comfort results from having a certain need met, ease comfort is experienced as being calm or content, and transcendence comfort is comfort that results from rising above challenges or problems (Smith & Parker, 2015).

Within the Comfort Theory, Kolcaba (2003) states that these three types of comfort can be experienced within four different contexts: physical, psychospiritual, sociocultural, or environmental. The physical context is related to physical symptoms a patient may experience, while the psychospiritual context is related to understanding, coping, and emotions; the sociocultural context is related to social support, relationships, and culture (Kolcaba, 2003; Smith & Parker, 2015). The environmental context of comfort relates to a person’s surroundings (Kolcaba, 2003). Any combination of type and context of comfort can be paired to specifically describe the comfort that a patient experiences.

Health-Seeking Behaviors

The second component of Comfort Theory is Kolcaba’s belief that when a patient is able to experience true comfort, he or she will participate in health-seeking behaviors (Kolcaba, 2003). Health-seeking behaviors can be internal, such as an immune response within the body to

improve its own health (Kolcaba, 2003). Health-seeking behaviors can also be external, which are behaviors that a person purposefully engages in to improve his or her own health (Kolcaba, 2003).

Institutional Outcomes

The third component of Comfort Theory is that once a patient is comfortable and therefore participates in positive health-seeking behaviors, health care institutional outcomes will improve (Kolcaba, 2003). Some of these institutional outcomes include patient satisfaction and rates of morbidity and mortality (Kolcaba, 2003). Institutional outcomes influenced by health-seeking behaviors, according to Comfort Theory also include those such as staff satisfaction, institutional rankings, and institutional reputation (Kolcaba, 2019).

Exemplar: Being Kelli’s Primary Nurse

Kelli was admitted to the surgical intensive care unit one Saturday evening after a life-threatening hemorrhage caused by HELLP syndrome, which is a condition affecting pregnant women that causes hemolysis, elevated liver enzymes, and a low platelet count. Earlier that day, Kelli was at her baby shower and suddenly experienced a tearing pain across her abdomen. With Kelli going in and out of consciousness, her family quickly called 911, and she was taken to the nearest local hospital. A quick CT scan revealed that Kelli’s hepatic artery was hemorrhaging, and she was taken to surgery immediately to stop the bleeding and to emergently deliver not one, but two, baby girls! After the babies had been delivered, Kelli’s abdomen was packed full of sponges and combat gauze, and she was flown to the nearest trauma center about 60 miles away. She underwent another emergency procedure to repair her hepatic artery, and afterwards, Kelli was transferred from the operating room to my unit.

When I entered Kelli’s room, I saw a beautiful, young woman that was sedated, on a ventilator, with many IV medications and fluids hanging on multiple IV poles, blood products infusing, a handful of drains, and a large, open abdomen. At Kelli’s bedside, I saw a nervous, frightened man: her husband. Only twelve hours prior, he and his wife had been excitedly celebrating and prepping for the arrival of their twins, and now, Kelli lay critically ill in a hospital bed with their premature baby girls 60 miles away at another facility.

On the first night that she was admitted to my unit, I opted to be Kelli’s primary care nurse for the duration of her stay in the surgical intensive care unit. I remember thinking that I could not imagine what Kelli’s family was going through, and I wanted to make sure that they felt supported in what was possibly the scariest time of their lives. The intensive care unit can be a very intimidating environment to those who are unfamiliar with the many monitoring devices and pieces of equipment that we use, along with all of their chimes, beeps, and dings. Very early on, I made sure that I explained to Kelli’s family everything that we were monitoring on her and what the numbers on the monitors meant. I also explained the ventilator, the medications, the IV lines, the drains, and anything else that they had questions about.

A few days later, after Kelli had stabilized hemodynamically, it was time for her to be weaned off of the sedation, wake up, and begin to breathe on her own. During this time period of weaning sedation, it is a challenging process and a balancing act. The goal is to slowly let the patient wake up and being to breathe as normally as possible without being too uncomfortable, gagging

on the endotracheal tube, or being dangerously agitated. Once the patient is able to tolerate extremely minimal settings on the ventilator and maintain an adequate oxygen saturation, the endotracheal tube can finally be removed. In Kelli's case, it took about half a day between beginning to wean her sedation and removing her endotracheal tube. As Kelli was waking up, she had no recollection of where she was, why she was in the hospital, what happened to her babies, or anything else that was going on. She required very frequent orientation by myself and her family in order to keep her from panicking.

Once Kelli had been extubated and was finally fully awake and alert, her husband explained to Kelli everything that had happened over the previous several days. When she could finally comprehend everything, Kelli was on an emotional roller coaster. She was so thankful to be alive and have her family to support her, but she was also worried about the health of her premature twin girls that she had not even had the chance to meet. Kelli's husband had pictures of the babies that myself and the other nurses posted on the walls, and we made sure that Kelli had some uninterrupted time during her days to video chat with family members that were visiting the twins.

After "Baby A" and "Baby B," as they were called because they still did not have real names yet, were stabilized and healthy enough for transfer, they were eventually transported from the local hospital to the trauma center where Kelli was admitted. The neonatal intensive care unit staff brought the baby girls down to meet Kelli for the first time. After their first introduction, I continued to bring Kelli to the neonatal intensive care unit several times so that she could spend more time with her babies.

Kelli stayed in the hospital for about two months and faced a number of complications, including acute kidney failure requiring continuous renal replacement therapy and liver necrosis requiring a liver resection. Even with these setbacks, Kelli remained optimistic about her outcomes, was motivated to participate in her rehabilitation, and was determined to regain her health and be the best mother and wife she could be.

Application of Comfort Theory

Throughout the weeks that I cared for Kelli as she was admitted to the surgical intensive care unit, I utilized Comfort Theory and provided nursing interventions to help her achieve various kinds of comfort in various contexts. The comfort that Kelli experienced helped her to engage in positive health-seeking behaviors that further improved her health. Lastly, as Kelli's health improved, she was able to be transferred to the acute care unit and be discharged home, which helps to improve the institution's outcome metrics.

Kelli's Achievement of Comfort

Throughout Kelli's admission to the surgical intensive care unit, she was able to experience multiple types of comfort. Several of the specific types of comfort that Kelli experienced were physical relief, sociocultural transcendence, psychosocial transcendence, and sociocultural ease. Each type of comfort and how Kelli achieved each of these types of comfort is further explained below.

Physical relief comfort. As Kelli stabilized and was able to be extubated, I weaned her sedation

slowly. This allowed Kelli to breathe on her own without becoming too agitated, contributing to physical relief comfort. The correct balance of medication allowed Kelli to regain consciousness and begin to breathe yet not be affected by the discomfort of the endotracheal tube or experience withdrawal symptoms from stopping the sedation too quickly.

Sociocultural transcendence comfort. In addition to physical relief, Kelli also experienced sociocultural transcendence comfort: “she required very frequent orientation by myself and her family in order to keep her from panicking.” While Kelli was waking up, myself and her family were there to support her and to make sure that she felt comfortable and was not frightened. If Kelli did start to get anxious or start to panic, we reoriented her, and she would calm down and be coherent, transcending her disorientation.

Psychosocial transcendence comfort. Once Kelli was fully awake and could comprehend everything that had happened to her and her babies in the last several days, Kelli was experiencing psychosocial transcendence comfort. She was understanding the recent days’ events, and she had to cope with the fact that her premature twins were in the neonatal intensive care unit at another hospital. She was “on an emotional roller coaster” yet was able to transcend these difficult circumstances and find comfort in being thankful that she and her babies made it through the emergent delivery.

Sociocultural ease comfort. Another type of comfort that Kelli experienced was a sociocultural ease comfort. This was partly due to Kelli’s husband bringing pictures of the babies for her to look at and the nurses allowing Kelli uninterrupted time to video chat with family members that were visiting them. But the greatest sociocultural ease comfort that Kelli experienced was when she finally got to meet “Baby A” and “Baby B” when they were transferred to the trauma center! The feeling of being surrounded by family, calm and content, holding her babies was when Kelli was most comfortable.

Health-Seeking Behaviors

Because Kelli was able to experience several different types of comfort, she was then motivated to participate in health-seeking behaviors that further improved her health. She was able to participate in physical therapy and occupational therapy, such as walking around the unit or practicing getting dressed, which are external health-seeking behaviors. Prior to Kelli’s endotracheal tube being removed and the sedation being completely weaned, the physical relief comfort that Kelli’s body felt enabled her respiratory system to strengthen so she could begin to breathe on her own. This is an example of an internal health-seeking behavior.

Institutional Outcomes

Although there is no exact data from Kelli’s care that shows that her comfort and her health-seeking behaviors improved institutional outcomes, one could assume that because Kelli had a positive outcome and was pleased with her care, that this would have a positive effect on institutional outcomes. Kelli was able to undergo continuous renal replacement therapy successfully and be discharged without requiring dialysis. She underwent two surgeries- the one to repair her hepatic artery and the liver resection- without complications. Kelli and her family verbalized many times that they were pleased with the care that Kelli received and were appreciative of everything that the nursing staff did for them. Lastly, having the opportunity to

provide nursing care for Kelli at this difficult time in her life enhanced my own personal job satisfaction there on the surgical intensive care unit.

Conclusion

Katherine Kolcaba’s Theory of Comfort and its application to Kelli’s care shows the importance of the basic human need for comfort. When nurses assist patients with feeling comfortable, this impacts not only the patient and their health-seeking behaviors, but entire health care institutions as well (Kolcaba, 2003). By utilizing theories such as Kolcaba’s Comfort Theory, nurses are honoring the profession and its experts and providing dependable nursing care to our patients.