Comfort Theory: A Guide for Practice of Neonatal Nursing

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“Theories, as reflections of our understanding, guide our actions, help us set forth desired outcomes, and give evidence of what has been achieved” (Parker, 2005, p. 4). The purpose of this paper is to identify one theory that can be used to guide the practice of neonatal nursing. The Comfort Theory, developed by Kolcaba, was chosen because of its universal application to include even the smallest of patients. This middle range theory could be easily operationalized for the Neonatal Intensive Care Setting (NICU). An overview and description of the theory will be discussed, followed by a clinical practice example that will identify the aspects that can be philosophically and realistically applied to the neonatal patient. Although the primary goal is to address the theory’s application to the neonatal patient, certain aspects of the theory (by design) are better utilized within the context of family centered care.

Comfort Theory Overview

In 1991, Katharine Kolcaba published a concept analysis of comfort. By the end of the decade, she had completed the intervention study that finalized the framework of comfort in a middle range theory (Dowd, 2010). Nurses often take a critical look at theories and Kolcaba was not immune to the skeptics. During one of the first public releases of her theory, the audience was actually hostile to the idea that she was making ‘comfort’ so complicated. In this case, nurses were associating comfort with the absence of physical discomfort. While comfort is often viewed as a basic nursing action, comfort should be looked at as a primary patient objective (Gropper, 1992). Kolcaba has successfully proven that, “comfort is used in many ways and has many meanings” (Kolcaba, 2003, p. 9). She defines holistic comfort as, “the immediate experience of being strengthened by having needs for relief, ease, and transcendence met in four contexts (physical, psychospiritual, social, and environmental)” (Kolcaba, 1997).
Literature Review

The relative newness of the theory (compared to other nursing theories) limits the return during a literature search including the World Wide Web, PubMed, CINAHL, and Medline. Kolcaba’s first book was published just seven years ago. Her web site includes a comprehensive list of her publications, which includes reliable examples of theory’s acceptance by the nursing community. According to Dowd, the theory, “has been selected frequently by students and nurse researchers as a guiding frame for their studies” in a variety of patient populations (2010, p 713). There is evidence that the comfort theory has been chosen by hospitals as criteria for MAGNET consideration (Kolcaba, Tilton & Drouin, 2006). The perianesthesia nurses have chosen the Comfort Theory as an integrated part of their Clinical Practice Guidelines. The theory is also included in the Core Concepts of Advanced Nursing Practice because of its universal application (Dowd, 2010).

Most of the examples mentioned by Kolcaba that utilize the comfort theory to improve patient outcomes are related to adult clinical situations. She does include newborn nursery as one of the settings in which nurses have asked for her expertise, however, the exact reference is not made available. Her reference list does include an application to Pediatrics.

This search did not produce any literature connecting Kolcaba’s comfort theory as an application for newborns and/or NICU. ‘Neonatal comfort’ was found associated in two clinical situations. The first association was made with end-of-life comfort measures and the second was found relating to family focused developmental care and/or The Newborn Individualized Developmental Care and Assessment Program (NIDCAP). NIDCAP will be discussed later.
Conceptual Design

Types and contexts of comfort.

Relief, ease and transcendence are identified as three components of comfort. Kolcaba defines relief “as the state of a patient who has had a specific need met” (2003). The definition of ease, “is the state of calm or contentment” and transcendence, “is the state in which one rises above one’s problems or pain” (2003). Kolcaba identified four contexts in which the patient experiences comfort; physical, psychospiritual, social, and environmental. Physical pertains to, ‘bodily sensations and homeostatic mechanisms” (Kolcaba, 1997). Psychospiritual pertains, “to internal awareness of self, including esteem, concept, sexuality, and meaning in one’s life; one's relationship to a higher order or being” (1997). Environmental effects include, “external surroundings, conditions, and influences” (1997). Sociocultural relates to, “interpersonal, family, and societal relationships” (1997). A taxonomic structure (TS) is commonly found in literature when the three types of comfort are juxtaposed with the four contexts of experience. This TS is a visual grid to map the “content domain of comfort” (Dowd, 2010 p. 708); to design interventions where indicated; and to formalize a questionnaire to address patients’ comfort (Kolcaba, 2001). Kolcaba recognized the research potential of the TS and designed a general comfort questionnaire (GCQ) to measure holistic comfort. The GCQ and directions for its use can be downloaded from her comfort line web site and tailored to the population of interest.

Major concepts and definitions.

The conceptual framework of the comfort theory begins with the identification of health care needs. Health care needs arise “from stressful health care situations that cannot be met by recipients’ traditional support systems” (Dowd, 2010, p. 709). These needs can be in any one of the four contexts. During interaction with the patient, the needs are identified and comfort
Interventions are targeted toward those needs. The nurse must take into account any intervening variables. These are, “interacting forces that influence recipients’ perceptions of total comfort” (p. 709). At this juncture, enhanced comfort is expected immediately. “Comfort is the state experienced by recipients of comfort interventions” (p. 709). The holistic, strengthening experience occurs when the three types of needs are addressed in the four contexts. Health seeking behaviors (HSB) are measurable outcomes. For example: Within a pediatric setting, “Comfort is a positive outcome that theoretically empowers children and their families to engage in health seeking behaviors” (Kolcaba & DiMarco, 2005, p. 189). According to Kolcaba, HSBs are also related to institutional integrity. Outcomes like improved patient/family satisfaction and nurse contentment can be measured. Institutional integrity yields best practices and best policies. Better patient outcomes can be reflected in a shorter length of stay and/or lower readmission rates (Dowd, 2010, p. 709).

Metaparadigm concepts.

Nurses are the intended providers of the interventions based intuitive or subjective assessment results. Besides direct patient/family interaction (verbal and behavioral cues), the nurse needs may need to rely on objective data (such as, lab results). According to Dowd, the patient is identified “as individuals, families, institutions, or communities in need of health care” (2010, p. 711). Nurses can also be recipients of comfort when positive working conditions exist. The environment is any setting (patient, family, institution) that can be “manipulated by nurse(s), loved one(s), or the institution to enhance comfort” (p. 711). The definition of health includes “the optimal functioning of a patient, family, health care provider, or community as defined by the patient or group (p. 711).
Assumptions.

The theory offers an efficient way to establish interdisciplinary approach to follow the individualized interventions. Kolcaba presented these assumptions for pediatric nursing:

1. Children/families have holistic responses to complex stimuli.
2. Comfort is a desirable, positive, holistic outcome that is relevant to the discipline of nursing, the specialty of pediatric nursing, and to a lesser extent, other health care disciplines.
3. Children and families strive to meet, or to have met, their basic comfort needs; it is an active endeavor and sometimes requires the help of the nurse or supportive others.
4. Children/families vary significantly in their personal need or desire for certain levels of comfort.
5. Prevention of discomforts, including those related to physiological or psychological stressors, is easier than treating discomforts. Prevention is also better for children and families.
6. When discomforts such as environmental chaos or pain cannot be prevented, children/families can be assisted to experience partial or complete transcendence through comfort interventions that convey hope, success, caring, and support for their fear.
7. When nurses apply Comfort Theory, they efficiently consider and minister in a caring way to the uniqueness and complexity of each whole child within the context of the family system (2005, p. 189).

Application to Neonatal Intensive Care Nursing

Comparison: NIDCAP with theory’s conceptual framework.

The NICU is the new ‘home’ for critically ill infants due to congenital abnormalities, compromised fetal environment, prematurity, obstetrical complications or poor adaptation to extrauterine life. Unlike the dark, soft, quiet, complex maternal environment, the NICU is a place of sensory bombardment with an inappropriate pattern of stimulation (Gardner & Goldson,
Once admitted, the critically ill infant must adapt to this new, challenging environment. Preterm infants are especially vulnerable because of their immature neurologic system. The NICU nurse must balance necessary interventions while minimizing the negative environmental effects. “Research has shown medical, developmental, and cost benefits to low-birth-weight infants from individualized behavioral and environmental care in the NICU. The most effective interventions follow the NIDCAP program (Gardner & Goldson, 2006, p. 288-289). In general nursing terms, NIDCAP is also referred to as family focused ‘developmental care’.

Als et al. developed NIDCAP in 1986 as a means to study the behavior of infants so that those caring for the infant “could provide more support and comfort” (East, 2000, p. 192). Developmental support is now the expected standard of care. It is “a philosophy of practice that is integrated into everyday routines, family-staff relationships, policy, and the overall NICU culture” (Carrier, 2004, p. 236). It is within the framework of developmental care that the comfort theory can easily be superimposed.

The four standards of developmental care follow Kolcaba’s metaparadigm concepts. Standard 1: Caregiving is flexible and individualized based on observations and the infant’s feedback. In order for this to occur, nurses must make moment-to-moment adjustments with the interventions “while in interaction with an infant” (Carrier, 2009). Standard 2: Every infant (patient) and family will be provided with a developmentally supportive environment. Standard 3: Parents are viewed to have the most important relationship with their infant. Standard 4: Clinical and developmental support of the infants and families requires collaborative and consistent caregiving (Carrier, 2009). Overall health benefits have been proven. This includes: Decrease incidence of major complications, decrease ventilator use, less sedation needs, increase
daily weight gain, cardiorespiratory stability, improved quality of parent/infant interaction, and early development of feeding skills (Gardner & Goldson, 2006).

According to Carrier (2009), “randomized controlled trials (RCT) have shown positive benefits of developmental care and clinical, neurobehavioral, cost, and parent outcomes.” In this study, the mothers reported less personal stress and felt more competent in their parental role. Carrier also reported the long term benefits found in a separate RCT. The results showed significantly better neurobehavioral functioning up to nine months of age. These types of anticipated results are present in the theoretical assertions of the comfort theory (Dowd, 2010).

NIDCAP incorporates the infant as a whole. The program contains explicit assessment tools that address the infant’s health care needs, strengths, stress cues and vulnerabilities. Developmentally nurturing interventions are recommended to help balance the loss of the normal development process (loss occurs with the NICU admission and separation from the parents) (Gardner & Goldson, 2006). The framework is extensive, so only an overview can be presented.

Within the comfort theory framework, intervening variables are introduced. NIDCAP uses ‘barriers to infant development’. Besides separation for parents, other challenges include: Clinical stability, numerous caregivers, medically necessary equipment and interventions, no sleep/wake cycle routines, pain, medications and sensory overload (Gardner & Goldson, 2006). Four bodily systems are consistently assessed moment-to-moment for changes:

- The autonomic system involves breathing, heart rate, color, and tremors. The motor system has to do with tone and movement. The state system deals with the infant’s states of consciousness and transitions through states such as sleep, awake, and crying. Most complex, the social-interaction system has to do with the baby’s ability to look, listen, and respond. Babies must achieve these social-interaction skills if they are to respond to
and interact with their environment and caregivers (Lowman, Stone, & Cole, 2006, p.179).

The final comparison occurs with the comfort theory’s concept of *enhanced comfort* as a state experienced by the recipient. The neonatal nurse who practices meticulous developmental care assists the infant in obtaining his/her best state of self-regulation. (Carrier, 2009). Self-regulation “involves the baby’s ongoing and critical task of balancing his autonomic, motor, state, and social-interaction systems (Lowman, Stone, & Cole, 2006, p.179).

**Physical comfort interventions.**

An unhappy baby can be made more comfortable by being snuggled in a blanket (East, 2000). “Swaddling has been found to provide comfort for neonates” (East, 2000, p.200). NIDCAP interventions include eliminating unnecessary interventions, positioning techniques, kangaroo care (parental skin-to-skin holding), non-nutritive sucking, and ‘clustered’ cares.

**Environmental comfort interventions.**

Decreasing the NICU light intensity is done “primarily to promote comfort, enhanced rest, and assist development” (Bowden & Greenberg, 2008). Other interventions include light/dark cycles, minimize noise levels, quiet times, and increase humidity as needed.

**Psychospiritual and social interventions.**

Developmental nursing care encourages the parental role by acknowledging the parents’ strengths; teaching them how to interact and provide comfort; demonstrating trust in the parents’ abilities; providing privacy; listening while showing respect for their perspectives; and optimizing access to consistent information. Touch, mouth care, and talking to their infant are simple things the parents can do to provide comfort and care (McAllister & Dionne, 2006).
Conclusion

The purpose of this paper was to identify the one nursing theory that drives the practice of neonatal intensive care nursing. This was accomplished by comparing the numerous conceptual and philosophical similarities between Kolcaba’s Comfort Theory and NIDCAP. Both have research proven effectiveness of improved patient outcomes. The practice guides the nurse to understanding pain, stress and comfort in the developing newborn (this was the theme of the 2007 national NIDCAP meeting). The support from the institution is necessary. For example: In 2008, Cincinnati Children’s Hospital Medical Center (CCHMC) created “Comfort Bundles” as a best practice approach to enhancing their NIDCAP unit philosophy (Casper, T. & Lacina, L. 2008).

A more realistic image is seen when a critically ill infant has a decreased oxygen saturation episode while crying. The infant is flailing his/her arms and legs with noted facial grimacing. The nurse simply moves the baby into a better position while supporting his/her arms and legs in a tucked position. Within seconds the saturation improves. He/she has become the recipient of comfort interventions.
**Case Presentation**

Infant Simon was born at 37 weeks gestation to a 35 year old, married mother. This is their first baby. He was admitted to the NICU with a diagnosis of Tetralogy of Fallot (TOF). This is his third of life and he does not have a life-threatening cardiac condition. He is stable enough but remains NPO. He still has desaturation episodes while crying. The mother visits regularly but she is now being officially discharged from the hospital. She does not want to leave her infant. The NICU supports NIDCAP (a family focused developmental care philosophy).

### Taxonomic Structure of Comfort

<table>
<thead>
<tr>
<th>Type of Comfort</th>
<th>Relief</th>
<th>Ease</th>
<th>Transcendence</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Physical</strong></td>
<td>Desaturation</td>
<td>Smooth breathing</td>
<td>Best state of self-regulation</td>
</tr>
<tr>
<td></td>
<td>Crying</td>
<td>Relaxed tone</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Flailing arms and legs</td>
<td>Sucking</td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td><strong>Environmental</strong></td>
<td>Noisy NICU</td>
<td>Self quieting behavior</td>
<td>Best state of self-regulation</td>
</tr>
<tr>
<td></td>
<td>Bright lights</td>
<td>Containment</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Numerous caregivers</td>
<td>(tucked position)</td>
<td></td>
</tr>
<tr>
<td><strong>Social</strong></td>
<td>Irritability and difficulty being</td>
<td>Bright-eyed alert state or</td>
<td>Infant’s readiness for interaction</td>
</tr>
<tr>
<td></td>
<td>consoled</td>
<td>Sleep state</td>
<td></td>
</tr>
<tr>
<td><strong>Psychospiritual</strong></td>
<td>Mother’s anxiety of separation from baby</td>
<td>Mother’s ability to comfort</td>
<td>Parents’ need for spiritual support and reassurance</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Simon</td>
<td>from NICU team and family/friends</td>
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</tbody>
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References


