Nurses strive to provide comfort to their patients in whatever environment they practice. A key approach to providing for physical and emotional comfort is to create an environment conducive to healing – a major principle of nursing first stated by Nightingale (1859). Nightingale’s philosophy was to place the patient in the best condition for the natural processes of healing to occur. Along with fresh air, sunshine, adequate nutrition, and other factors, she recommended quiet as essential for healing. However, in looking at the environment in which we practice nursing, we see that it may not be optimal for nature to act in beneficial ways for our patients. We, as providers of care, have yet to observe a time in which patients on a cardiac unit are not subjected to noise, interruptions, as well as a myriad of monitoring alarms.

Comfort theory is a middle range theory developed by Kolcaba (2003) that has as a foundation Nightingale’s environmental principles of providing care (Selanders, 1998). This theory can be used to enhance the environment of patients in cardiac care through the use of a “quiet time” intervention. A loud and chaotic environment can negatively affect healing process of patients. The purpose of this article is to describe comfort theory as applied in care of cardiac patients and to demonstrate the use of a specific intervention called quiet time, derived from comfort theory, to improve cardiac patients’ experiences of comfort across four domains of care. We also call attention to the need for research into the effectiveness and use of this theory-based intervention.

1. Case study 1

It has been shown that rest promotes healing, recovery, and well-being (Tullmann & Dracup, 2000). However, the hospital environment presents unique challenges for patients to obtain rest periods. Consider the following case of a patient admitted to the hospital with diagnosis of suspected acute coronary syndrome:

John arrived at the emergency department with complaints of chest pain. He is certain this is the “big heart attack” his father had. He is taken to the main emergency department, which is one large area with stretchers aligned side by side with only a curtain between each stretcher offering minimal to no privacy. It seems that someone appears every few minutes to check his blood pressure, draw blood or ask him more questions about his health history. The noise of the other patients, staff and monitoring equipment is so loud it is difficult for him to hear the providers’ questions. Time passes. Now John has been in the emergency room for over 12 hours and he has not rested. When he finally starts to close his eyes and relax the nurse’s aide begins placing him on a different monitoring device, with no explanation, just the statement, “You are going upstairs.” The cardiac floor where he arrives is not much quieter. John is placed in a four-person room. Both patients on the other side of the room have their televisions on and one of the IV pumps continuously alarms. John is feeling discomfort in his chest similar to what he felt in the Emergency Department. He has been unable to contact his wife because the battery on his cell phone went dead. He is anxious about what will eventually happen to him.

This case is devoid of any comfort measures provided by John’s care providers and results in the escalation of his chest pain and...
and promotion of health care regarding comfort needs. Nursing practice. Fig. 1 illustrates that regardless of the patient and show broadly how her comfort theory exacerbations of chest discomfort. This brief case presentation alerts to the potential usefulness of a theory on comfort in everyday practice, and to the relevance of a specific intervention that promotes quiet time in cardiac care.

2. Comfort theory

Kolcaba (2010a,b) created a conceptual framework (Fig. 1) to show broadly how her comfort theory fits into the flow of care in the practice setting. Comfort was described as the product of holistic nursing practice. Fig. 1 illustrates that regardless of the patient and family needs for health care, there is always a place for the assessment and promotion of health care regarding comfort needs.

Kolcaba’s theory of comfort was first developed in 1991 when she conducted a concept analysis to examine the literature from multiple disciplines on comfort (Kolcaba & Kolcaba, 1991). The analysis generated three forms of comfort and four contexts of holistic human experience from which a taxonomic structure was created as a map to guide areas of patient comfort for assessment in practice and for measurement in research.

In comfort theory, specific concepts in the theory are organized in terms of three forms and four contexts of comfort. The three forms of comfort are relief, ease, and transcendence. Patients experience a sense of relief when their individual comfort needs are met. Patients are at ease in situations that enable them to be calm or content. The comfort state of transcendence occurs when a person rises above their challenges. The four contexts in which comfort is experienced are physical, psychospiritual, environmental, and sociocultural. The physical concerns bodily sensations and homeostatic mechanisms, the psychospiritual pertains to the internal awareness of self, the environmental is the external surroundings and conditions, and sociocultural refers to interpersonal and societal relationships (Kolcaba & Fisher, 1996).

The three types of comfort and the four contexts of care can be incorporated into a hospital’s model of care (Kolcaba, Tilton, & Drouin, 2006). In addition, this taxonomy of comfort can be applied to specific patient cases to delineate various comfort needs of the patient.

3. Comfort theory applied to care of cardiac patients

Kolcaba’s Comfort Theory is readily applicable to cardiac patients. Table 1 presents an example of applying comfort theory to the case study of John and his comfort needs. Data from the case study were entered into the 12 cells of the table, organized according to the four contexts of care and the three types of comfort needs. John’s specific comfort needs are indicated in the relief column. Entries in the ease column point to interventions for promoting a sense of calm or contentment in John. Patient-based expressions in the transcendence column highlight John’s expressed concerns that need to be addressed to foster his sense of empowerment and ability to overcome the challenges of the illness. Comfort is dynamic and an ever-changing state, and the entries in the table may also change over the course of a patient’s hospital stay.

4. Quiet time intervention

A quiet time intervention has significant potential for not only reducing noxious stimuli but also for creating opportunities for needed privacy and supportive interactions. Research findings have shown that quiet time can improve patient outcomes and increase consumer satisfaction with acute care health services, both of which are of increasing importance in the contemporary health care environment (Gardner, Collins, Osborne, Henderson, & Eastwood, 2009). Other research findings indicate that quiet time in a chaotic, noisy neuro-intensive care unit can create an atmosphere of recuperation (Dennis, Lee, Woodard, Szalaj, & Walker, 2010).

The quiet time intervention has not yet been studied in the emergency department. However, the taxonomy of data from the cardiac care case in Table 1 indicates targets where this intervention can be especially relevant to care of cardiac patients. A quiet time protocol was derived from comfort theory to promote comfort across the four contexts of care.

In the physical domain, quiet time can help minimize events in the cardiac care setting that have detrimental physical effects on an already compromised patient. Of particular concern is a patient’s sleep, which is essential for multiple physiological and psychological processes. Numerous mechanical devices as well as hospital routines and procedures can significantly impair a patient’s ability to sleep. Sleep deprivation has been linked to rising incidence of patient falls, confusion, and increased use of medication and restraints (Mazer, 2006).

Long established recommendations from the U.S. Environmental Protection Agency, Office of Noise Abatement and Control (1974) state that the hospital noise levels should not exceed 45 decibels. However, studies have shown that the peak hospital noise levels exceed 90 decibels, which is similar to the levels of heavy truck traffic. Prolonged effects of excessive noise exposure on patients and staff alike can have deleterious effect on their health and well-being (Christensen, 2007). The chemical epinephrine and other endogenous stimulants are released in response to environmental stimuli, which in turn increase the patient’s heart rate and blood pressure (DeKeyser, 2003). Quiet time interventions can prevent stimulation of the sympathetic nervous system that occurs with an environment of
constant noise, bright lights, and interruption of sleep, and promote Kolcaba’s form of comfort called relief.

In the psychospiritual domain, most cardiac patients can express a range of feelings from mild anxiety to impending doom related to their symptoms. Studies have indicated that there is a positive correlation between stress levels and serum cortisol, which can their symptoms. Studies have indicated that there is a positive correlation between stress levels and serum cortisol, which can ultimately result in a depressed immune system (DeKeyser, 2003). Patients’ exposure to increased stimuli and noise levels contributes to agitation. Quiet time can be a designated time in which patients may meditate, pray, rest, or converse with significant others. The resulting restfulness and decreased anxiety supports what Kolcaba’s form of comfort called ease.

In the environmental domain, the nurse can initiate quiet time interventions that provide all forms of comfort for the patient (Olson, Borel, Laskowitz, Moore, & McConnell, 2001). Dimming the lights in the patient’s room and hallway can reduce unnecessary stimuli. Maintaining correct limits and volume of cardiac monitoring alarms, pulse oximetry, blood-pressure cuffs, and IV pumps can minimize inappropriate alarming. Alarms are addressed quickly, overhead paging and unnecessary conversations in patient care areas are limited, and staff and visitors are asked to speak in low tones. Health care team rounding, consultant visits, routine deliveries, and other services can be scheduled to observe periods of quiet time so as to maximize the patient’s rest time (Taylor-Ford, Catlin, LaPlante, & Weinke, 2008).

In the sociocultural domain, quiet time provides an opportunity to assess interpersonal and cultural aspects. This is a period of time when the nurse can have an unhurried and meaningful conversation with patients and significant others, and facilitate patient and family needs for information, respect, validation, and emotional support that promote comfort in the form of Kolcaba’s transcendence.

5. Case study 2

In contrast to the first case study above, the following case is an example of a patient admitted to the hospital with diagnosis of suspected acute coronary syndrome where the care providers applied quiet time interventions from comfort theory.

James arrived to the Emergency Department with complaints of chest pain. The Emergency Department has a designated chest pain observational unit that is completely separate from the main area. After patients are quickly triaged, they are taken to the quiet section of this observational unit. The unit itself has only six beds with ample space in between each stretcher that allows for easy movement of staff and privacy for the patient. James is placed on oxygen to help relieve the shortness of breath and the team leader provider processes and accurately documents patient history to ensure that questions will not have to be repeated. The nurse explains the protocol to determine the diagnosis of Acute Coronary Syndrome to the patient and customizes the time for the necessary interventions that allows for periods of rest and reduced stimulation between required blood draws and EKG’s.

Explaining and educating James on what the care plan will be helps reduce his anxiety. The nurse remains within this closed unit so there can be quick response to any patient requests, alarms from the monitoring devices, or IV pumps. Comfort measures relating to James’ symptoms of chest pain, shortness of breath or anxiety can also be addressed with pharmacological measures as well as holistic measures. The nurse calls James’ wife to explain what is going on with her husband and then moves the portable phone to bedside for his use. A patient representative is contacted to obtain a charger for the James’ depleted cell phone battery. James reported no further episodes of chest pain and was awaiting the results of pending blood work to rule out acute coronary syndrome. He was able to close his eyes and sleep. The Comfort Theory-based intervention of Quiet Time provided an improved standard of care and outcome for this patient as well as other cardiac patients.

6. Research implications: Next steps

Quiet time is an intervention that has been evolving in practice but research is needed to validate its usefulness and refine its applications in specific patient settings.

While anecdotal reports of nurse and patient satisfaction with quiet time are positive, systematic study is needed of measurable outcomes in cardiac patients to see if and how it affects patient anxiety, physiologic parameters (heart rate and blood pressure), pain and comfort. Additionally, research into the effects on nurses by the use of comfort care theory is also needed since applications of this theory may enhance the work environment and well-being among health care providers as well as the patients.

There is a plethora of comfort questionnaires that have been developed for specific populations such as: pediatric, peri-anesthesia, and end of life and hospice. However, to date none have been found that are unique for the cardiac population (Kolcaba, 2010a,b). Some of these questionnaires may be useful in studying cardiac patient perceptions of comfort in their care. Many can be found at Kolcaba (2010a,b) Comfort Line Web site. In addition, outcome data on how organizations provide comfort care can be collected from responses on Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) results and patient interviews.

7. Conclusions

Nurses have resources from their theories and their practice to guide research into comfort-focused interventions for patients. Nightingale’s ideas provide a significant foundation for considering all dimensions of the patient and environment that relate to comfort. Kolcaba’s middle range theory identifies a taxonomy of factors to consider in assessment and intervention. Nurses’ practice experiences and anecdotal evidence provide additional insights into what comprises comfort care. These resources coupled with clinical research.
can help equip hospitals and nurses with effective methods to improve patient comfort and facilitate healing. As Kolcaba and Fisher (1996) stated, if patients experience comfort, then they are more satisfied with the care given, and the nurses as well as the institution will benefit. What can be more germane to nursing than comfort?

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