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NURSING STUDENTS' PERCEPTION OF COMFORT

by

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A thesis submitted to the faculty of

Gardner-Webb University School of Nursing
in partial fulfillment of the requirement for the
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Abstract

One of the most important goals of nursing care is to provide comfort to patients and their families. In order to provide comfort, nurses must be able to recognize and respond to patients in distress. Inconsistencies in the delivery of comfort care are based largely on the nurse's educational preparation. The degree to which comfort and comforting is evidenced in nursing performance depends in great measure on the way upcoming nurses perceive the concept during their education.

In this descriptive study guided by Kolcaba's Comfort Theory, the researcher surveyed a convenience sample of Associate Degree Nursing students to assess their perception of comfort. Data was collected utilizing Kolcaba's General Comfort Questionnaire as well as demographic information. Statistical analysis utilizing descriptive statistics, central tendencies and independent samples *t* tests revealed that students recognized statements of comfort in the psychospiritual and sociocultural domains more often than those in the physical and environmental domains. Positive statements of enhanced comfort were recognized almost twice as often as negative statements indicating healthcare needs. Results also revealed a statistically significant difference ($p<.05$) in students scores on perception of comfort with first year students ($M = 129.1$, $SD = 20.3$) scoring higher than second year students ($M =115.9$, $SD = 9.7$). There was no statistically significant difference in the scores of students currently employed in healthcare and those not employed in healthcare.

Findings from this study have the potential to identify influencing factors and areas needing improvement in teaching comfort measures to nursing students.

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CHAPTER I

Introduction

One of the most important goals of nursing care is to provide comfort to patients and their families (Yousefi, Abedi, Yarnogammadian, & Elliott, 2009). Since the time of Nightingale, comfort has been cited as a desirable outcome of nursing care (Kolcaba & Kolcaba, 1991). Nursing professionals generally accept that they have the inherent responsibility for attending to and being accountable for their patient's comfort and sense of well-being (Castledine, Grainger, & Close, 2005). Goodnow (1935) (as cited by (Kolcaba & Kolcaba, 1991 pg. 1303) wrote that "a nurse is judged always by her ability to make her patient comfortable". According to McIlveen and Moores (1995) (as cited by Castledine, Grainger, & Close, 2005), comfort is the central goal of nursing and medicine because it is through comfort that recovery is achieved. Comfort viewed as a positive outcome has been empirically linked to successful engagement in health-seeking behaviors among hospitalized patients (Cantrell & Matula, 2009).

Though considered to be essential in nursing, a universal definition of comfort is not readily evident (Wilby, 2005). Comfort has been defined in numerous ways, ranging from a basic human need, to a process, function or an outcome of nursing (Yousefi et al., 2009). Merriam-Webster (2007) defines comfort in a variety of ways: (a) to give strength and hope to; (b) to ease the grief or trouble of; (c) freedom from pain, troubles or anxiety; (d) something that consoles. In these definitions, comfort can be used as a verb or a noun. It can be negative, neutral, or positive. By the very diversity of these definitions, it is evident that comfort is a complex term.

Significance

While comfort is considered to be a central part of nursing, the value placed on it may have diminished over time (Tutton & Seers, 2004). One explanation of this could be that comforting strategies are so integrated into routine care that the nurses themselves take them for granted (Roche-Fahy & Dowling, 2009). Tutton and Seers (2004) suggest that comfort has moved from being the essence of nursing to a minor strategy within nursing care. In addition, the modern acute care hospital is cure-oriented and high-tech, often rendering the provision of comfort unrecognizable and unacknowledged (Roche-Fahy & Dowling, 2009), contributing to the feeling that today's professional nurse has become more "preoccupied with medical technology and the need to embrace the concept of cure rather than pursue the comfort needs of the patient" (Castledine, Grainger, & Close, 2005, p. 928).

Background

Caregivers and patients may have different perspectives regarding comfort (Newson, 2008). To know what kind of comforting is appropriate, nurses need to increase their understanding of the phenomenon of comfort, boost their sensitivity for people's need of comfort, and develop readiness to mediate comfort (Ohlen & Holm, 2005). In order to provide comfort, nurses must be able to recognize and respond to patients in distress (Wilby, 2005). Assisting suffering persons in distress to experience comfort can be considered a primary goal of nursing, which accordingly should be evident in nursing education and curriculum (Ohlen & Holm, 2005). During the last decade, there has been an effort to change the previously vocationally-oriented and medical centered education to a research based education with an emphasis on critical thinking and systematic

problem solving. This shift of focus has been met with ambivalence and worry from nurses dedicated to caring that the very essence of nursing is being pushed into the background (Ohlen & Holm, 2005).

Purpose of Study

Inconsistencies in the delivery of comfort care are based largely on the nurse's educational preparation (Briggs, 2010).The degree to which comfort and comforting is evidenced in nursing performance depends in great measure on the way upcoming nurses perceive the concept during their education (Guzman, Perla, Palacios, & Peralta, 2007). The purpose of this study is to explore the nursing student's perception of comfort.

Theoretical Framework

Comfort has been an important concept in numerous nursing theories. According to Orlando (as cited by Tutton & Seers, 2003), the role of the nurse is to focus her attention on anything that interferes with the physical and mental comfort of the patient. In her science of caring, Watson (as cited by Kolcaba & Kolcaba, 1991) named comfort as a variable that affects both external and internal environments. Other theorists that identify comfort as central to nursing include Hall, Paterson & Zderad, and Roper, Logan and Tierney (Tutton & Seers, 2003). The theoretical framework chosen to guide this study is Katherine Kolcaba's Comfort Theory (CT).

Kolcaba (2003) defines 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)" (p. 14). The first sense of comfort is relief, described as the "experience of a patient who has had a specific comfort need met" (Kolcaba, 2003, p. 9). For example, the administration of pain medication following

surgery leads to *relief* of postoperative pain (March & McCormack, 2009). Ease is a "state of calm or contentment" (Kolcaba, 2003, p. 9), such as the feeling of *ease* after having one's anxiety reduced (March & McCormack, 2009). Kolcaba (2003) describes transcendence as the "state in which one rises above problems or pain" (p. 9). An example of comfort in this form is evident in the patient participating in a diabetes support group. There are four domains in which comfort occurs (Kolcaba, 2003). These are further described in Table 1.

Table 1: Domains of Comfort (Kolcaba, 2003, p. 15)

Physical	pertaining to bodily sensations, homeostatic mechanisms, immune function, etc.
Psychospiritual	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
Environmental	pertaining to the external background of human experience (temperature, light, sound, odor, color, furniture, landscape, etc.)
Sociocultural	pertaining to interpersonal, family, and societal relationships (finances, teaching, health care personnel, etc.) Also to family traditions, rituals, and religious practices

The conceptual framework of the CT posits that when healthcare needs of the patient are met through appropriate nursing interventions, the outcome is enhanced comfort (March & McCormack, 2009). As patients and their families become more comfortable, they become more fully engaged in health-seeking behaviors, which leads to benefits to the institution by reducing cost of care and length of stay and increasing patient satisfaction (Kolcaba, Tilton, & Drouin, 2006). Institutional integrity is further enhanced through the

development and implementation of best practice and policies (March & McCormack, 2009). Kolcaba (2003) identifies 6 major concepts in her Comfort Theory:

- Healthcare Needs of Pt/Family
- Comforting Interventions
- Intervening Variables
- Enhanced Comfort
- Health Seeking Behaviors
- Institutional Integrity

Healthcare needs of the patient and family and *enhanced comfort* are the two concepts of the CT used to guide this study of nursing student's perception of comfort. Kolcaba defines healthcare needs as needs for comfort which arise from stressful healthcare situations that cannot be met by the patient's traditional support systems and include physical, psychospiritual, social, and environmental needs (Tomey & Alligood, 2002). These needs are made apparent through "monitoring and verbal or nonverbal reports, needs related to pathophysiological parameters, needs for education and support, and needs for financial counseling and intervention" (Tomey & Alligood, 2002, pg. 433). In this study, healthcare needs for comfort will be defined as a lack of comfort in four contexts; physical, psychospiritual, social, and environmental. The General Comfort Questionnaire (GCQ) will assess the student's ability to recognize verbal cues indicating needs in the four contexts of comfort through negative statements. The second concept that will be tested is enhanced comfort, described by Kolcaba as the "state that is experienced by recipients of comfort measures" (Tomey & Alligood, 2002 pg. 433). In this study, enhanced comfort will be defined as freedom from discomfort in four

contexts; physical, psychospiritual, social, and environmental. The nursing student's perception of enhanced comfort will be assessed via the GCQ, through recognition of positive statements indicating comfort in four contexts (physical, psychospiritual, social, and environmental). The conceptual – theoretical – empirical linkage for this study is further outlined in Table 2. Through analysis of the student's responses, reflecting their ability to recognize the three types of comfort in four contexts, an overall perception of comfort can be assessed.

Table 2: Conceptual Theoretical Empirical Structure

Conceptual Model Concept	**Theoretical Definition**	**Mid Range Theory Concept**	**Operational Definition**
Healthcare Needs of the Patient and Family	Needs for comfort arising from stressful healthcare situations that cannot be met by patient's traditional support system	A lack of comfort in four contexts; physical, psychospiritual, social, and environmental	General Comfort Questionnaire negative response statements indicating discomfort
Enhanced Comfort	The state experienced by recipients of comfort	Freedom from discomfort in four contexts; physical, psychospiritual, social, and environmental	General Comfort Questionnaire positive response statements indicating comfort

CHAPTER II

Review of the Literature

Comfort has been the subject of a number of research studies in the literature. The majority of studies found were concerned with the effects of interventions on the patient's level of comfort. There are also studies that attempt to define comfort and the role it plays in nursing. Only one study was found addressing the nursing student's perception of comfort. This literature review will provide an overview of the different perspectives of comfort research.

Enhanced Comfort as a Desired Outcome

Thermal comfort is an integral component of the perioperative patient's sense of well-being. The sensation of feeling cold not only produces discomfort, it often triggers anxiety about the impending surgery, anesthesia, anticipated pain, and immobility. Therefore, interventions to prevent or treat a patient's thermal discomfort may reduce the feeling of anxiety. A pretest/posttest experimental design study was conducted by Wagner, Byrne, and Kolcaba (2006) to compare the effects of preoperative warming with warmed cotton blankets versus patient-controlled warming gowns on patients' perceptions of thermal comfort and anxiety. A sample of 162 patients undergoing surgery at a large public hospital in the southeastern United States over a five month period was selected for this study. Tools used to measure thermal comfort included the thermal comfort inventory (TCI) and a numeric visual analog scale (NVAS). An additional NVAS was also used to measure the patient's level of anxiety. Findings concluded that both warming interventions contributed to the patient's comfort and sense of well-being.

Patients using the patient-controlled warming gown also reported a significant reduction in preoperative anxiety (Wagner, Byrne, & Kolcaba, 2006). Study limitations include the fact that the NVAS tool for thermal comfort was not tested prior to the study, the possibility of compensatory rivalry as a threat to internal validity, and the significant difference in ambient room temperature for the test groups (Wagner, Byrne, & Kolcaba, 2006).

Building on the focus of comfort for hospice patients, Kolcaba and Steiner (2004) tested the efficacy of hand massage for enhancing the comfort of hospice patients. The experimental design randomized 31 patients from three hospice agencies into treatment and comparison groups. The treatment group received hand massage twice weekly for three weeks while the comparison group received the intervention only once at the end of the study. Data was collected utilizing the Hospice Comfort Questionnaire and the Symptom Distress Scale. The study did not yield any significant differences in comfort and symptom distress between the groups over time. However, comfort increased somewhat in the treatment group as the patients approached death while the comfort scores in the comparison group decreased steadily over time. Problems with recruitment were identified as a limitation in this study (Kolcaba & Steiner, 2004).

The effects of guided imagery (GI) on comfort, depression, anxiety, and stress of psychiatric inpatients with depressive disorders was the subject of a quasi-experimental design study performed by Apostolo and Kolcaba (2009). Sixty short-term hospitalized depressive patients were selected for this study; 30 in the experimental group and 30 in the comparison group. The experimental group listened to a GI compact disc daily for ten days. The comparison group received the standard treatment protocol. Data was collected

using the Psychiatric Inpatient's Comfort Scale and the Depression, Anxiety, and Stress Scale. Results indicated that the treatment group had significantly lower depression, anxiety, and stress and higher comfort, suggesting that GI used as a complementary intervention could contribute to the reduction of antidepressive medication dosage and their related side effects (Apostolo & Kolcaba, 2009).

A pilot study to test the effect of an hourly patient comfort round intervention on patient satisfaction and on nursing perceptions of the practice environment was conducted by Gardner, Woollett, Daly, and Richardson (2009). Data was collected over an eight week period on matched acute surgical wards as the experimental and control sites. A quasi-experimental, non-randomized parallel group trial design study utilizing a sample of 61 patients in the intervention group and 68 patients in the control group. Tools used to collect data were the Patient Satisfaction Survey (PSS), developed by the research team, and the Practice Environment Scale of Nursing Work Index (PES-NWI). Analysis of the results of the PSS showed no significant difference between the experimental and control groups. However, results from the PES-NWI suggest that nurses participating in comfort rounding experienced improvements in their perception of the overall quality of care as well as resource adequacy and professional relations. In contrast, there were unexpected declines in nurse perception of quality of care in the control group. Small sample size was cited as a limitation of the study (Gardner et al., 2009).

Defining Comfort

In an effort to describe the meaning of being cared for and comforted by pediatric oncology nurses, a hermeneutic analysis was conducted by Cantrell and Matula (2009) utilizing the qualitative research method of interpretive phenomenology. Eleven

childhood cancer survivors treated at an oncology treatment center in the northwestern United States participated in the study; four of the survivors participated in a focus group while the remaining seven were interviewed via one-on-one telephone interviews. Content analysis of the interviews generated five themes; a) you just can't pretend to care, b) try to take the hospital experiences out of the hospital, c) I'm not just another kid with cancer, d) caring for me also includes caring for my family, and e) nurses make treatment experiences more bearable through their small acts of caring. All of the participants agreed that simple acts of caring by their nurses provided both physical and emotional comfort (Cantrell & Matula, 2009). The findings suggest that communication which includes respect, empathy, and comfort is the most important to pediatric patients (Cantrell & Matula, 2009).

Using an ethnographic research method, Tutton and Seers (2004) performed a study to investigate what comfort means to both older people and their healthcare workers. In-depth interviews were conducted with 19 older people and 27 staff members. In addition, the study employed 130 hours of participant observation which was complemented by additional weekly visits to the study ward. The study identified three key themes; the nature of comfort/discomfort, key determinates of comfort/discomfort, and the underlying factors that influence the achievement of comfort/discomfort. The findings indicate that comfort is typically perceived as the opposite of discomfort. Comfort was not consistently provided, as the staff tended to react to problems rather than proactively working to create an environment that promotes comfort (Tutton & Seers, 2004).

In order to explore how staff recognizes that a resident is dying and to present a typology of comfort measures, Waldrop and Kirkendall (2009) conducted an exploratory descriptive study. Semi-structured interviews were conducted with 42 staff members at a 120-bed nursing home. Staff members identified comfort care as the interrelationship between symptom management, family care, interpersonal relationships, and complementarity between interdisciplinary roles. Comfort care was further defined as holistic and person-centered, focusing on the interrelationship between physical, psychosocial, and spiritual issues. Limitations include the fact that only one nursing home was utilized and that the perspectives of the physicians, residents, and family members were not considered.

Quill, Norton, Shah, Lam, Fridd, and Buckley (2006) conducted a retrospective descriptive content analysis of recorded patient responses to the question "What is most important for you to achieve?", a question that is routinely asked of all palliative care patients on the initial consultation, from a sample of 547 patients over a 2 year period. Four major categories were identified including improving quality and meaning, achieving relief or comfort, altering illness trajectory, and preparation for dying. In the subcategory of relief or comfort, 34% of respondents were experiencing immediate distress, with 22% wanting relief from physical distress, 6% requesting relief from emotional distress, and 6% desiring comfort of an unspecified nature. Further analysis revealed that excellent pain and symptom management of both physical and emotional issues was most important to many of these patients. Limitations include limited first-person responses, questions regarding generalizability of the results, and the large number of blank responses (Quill et al., 2006).

Gadamerian hermeneutic phenomenology guided the study by Roche-Fahy and Dowling (2009) to explore the experience of nurses who provide care to palliative care patients in an acute care setting. The aim of the chosen method is the translation and understanding of the lived experience into recognizable meaning that can be used as a knowledge base in nursing practice (Roche-Fahy & Dowling, 2009). A convenience sample of twelve female nurses working in an acute care facility was chosen for the study. Interviews built around the response to the question 'tell me of your experience of providing comfort to palliative care patients on an acute ward' were audio-taped and transcribed verbatim. The data revealed four main themes; time needed to provide comfort, emotional labor of providing comfort, holistic approach, and educational support needs. The need for time to promote comfort was a major theme in the response of the nurses, which suggest that reducing the patient load for the nurse caring for palliative care patients would assist in providing the time necessary to provide comfort care (Roche-Fahy & Dowling, 2009).

Nurse/Nursing Student Perception of Comfort

A search of the literature using the search terms nurse/nursing student perception of comfort returned only one study conducted in the Philippines. The World Health Organization has cited the Philippines as the largest exporter of nurses to foreign countries (Guzman, Perla, Palacios, & Peralta, 2007). In fact, the number of Filipino nurses applying for license in the United States in 2004 were more than four times the number of the next four countries combined (Guzman et al., 2007), making this study relevant in the USA. In this quantitative study, Guzman et al., (2007) purported to describe students nurses' outlook of the words *comfort* and *comforting.* A sample of 163

freshman and 116 senior nursing students were provided with a two part questionnaire. The first part of the questionnaire gathered demographic characteristics of the respondents. In the second part of the questionnaire, the participants were given blank paper and asked to sketch images associated with the words *comfort* or *comforting*, accompanied by a written explanation. Analysis of the data showed that the student's view of comfort could be classified into four categories; physiologic, socio-environmental, psycho-spiritual, and emotional. Overall, comfort was perceived more as something received from one's self brought about by a sequence of events and the presence of defined entities (Guzman et al., 2007).

Chapter III

Methods

It has been established that the degree to which comfort and comforting is evidenced in nursing performance depends in great measure on the way upcoming nurses perceive the concept during their education. In order to provide comfort, nurses must be able to recognize and respond to patients in distress. This study was conducted to assess the nursing students' perception of comfort through the recognition of positive and negative statements indicating comfort/discomfort.

Setting

This study took place at a Christian, Baptist-related university located in a small rural town located in the Piedmont section of western North Carolina. The university is a co-educational, residential, church-related university providing three distinctive academic programs: the traditional undergraduate program, a degree completion program and graduate programs.

Sample/Participants

The sampling procedure used by the researcher was convenience sampling. The participants were restricted to first and second year Associate Degree Nursing (ADN) students in class on the day of the survey. There were 82 participants with the overwhelming majority being female (n = 76); 36 were first year students and 46 were second year students. Ages ranged from 19 to 53 with a mean age of 23.3. The majority of the participants were not currently employed in healthcare (n = 52).

Procedure

The surveys were distributed in paper form to the students in class on the day of the survey. The surveys were color coded; white for first year students and green for second year students. The purpose of the survey was explained and the students were informed that their participation would in no way affect their status as a student. Upon completion of the survey, students returned them to the Nursing Department secretary who held them for the researcher. Of the 144 students eligible for the survey, 82 completed and returned the survey, resulting in a return rate of 57%.

Instruments

The instrument used in this study was the General Comfort Questionnaire (GCQ). The GCQ was developed by Katherine Kolcaba from her taxonomic structure (TS) of comfort to measure patients' comfort levels (Kolcaba, 2003). The taxonomic structure provides a two-dimensional roadmap for the domain of comfort, with each cell reflecting the synthesis of two dimensions of meaning where they intersect.

Table 3: Taxonomic Structure (Kolcaba, 2003)

	RELIEF	EASE	TRANSCENDENCE
PHYSICAL			
PSYCHOSPIRITUAL			
ENVIRONMENTAL			
SOCIOCULTURAL			

The GCQ consists of 48 self-report items generated from the TS, with each statement representing comfort/discomfort in one of the four domains of comfort. Students were asked if, in their opinion, the statements were representative of comfort/discomfort. Responses were circled on a four-response Likert scale ranging from “strongly disagree” to “strongly agree”. The tool was reviewed by staff nurses as well as experts in the field and was determined to be an appropriate tool for this study. The GCQ is not copyrighted and permission to use the tool is granted on *TheComfortLine.com*, the website developed by Katherine Kolcaba.

A second instrument, developed by the researcher, was utilized to gather demographic data for the participants. Data collected included age and gender. Information was also collected to determine the number of years students were employed in healthcare prior to nursing school as well as whether or not the participants were currently employed in healthcare.

Ethical Considerations

Ethical considerations were taken into account throughout this study. No incentives or compensation was offered to the survey respondents. Participants were educated using all aspects of informed consent (Appendix B) with specific attention given to voluntary as well as anonymous participation. The surveys were returned to the secretary with consent forms separated from the actual questionnaire. Permission was obtained through the Institutional Review Board of the university and the dean of the Nursing Department.

CHAPTER IV

Results

Analysis of the data utilizing descriptive statistics and central tendencies revealed that students recognized positive statements (M = 3.26, SD = .30) almost twice as often as negative statements (M = 1.87, SD = .61). Recognition of comfort/discomfort in the four domains was ranked as follows:

Table 4: Ranking of the Domains of Comfort

Domain	M	SD
1. Psychospiritual	2.824	.41
2. Sociocultural	2.604	.38
3. Physical	2.474	.41
4. Environmental	2.401	.48

Analysis utilizing descriptive statistics and measures of central tendencies revealed the five statements most recognized by the students as representative of comfort/discomfort and the seven statements least recognized by the students as representative of comfort/discomfort (the fifth, sixth and seventh least recognized statements had equal median scores). These statements support the ranking of the domains with four of the five most recognized comfort/discomfort statements representing the psychospiritual and sociocultural domains and five of the seven least recognized statements of comfort/discomfort representing the physical and environmental domains. The most and least recognized statements and ranking by mean scores can be found in Table 5 and Table 6.

Table 5: Most Recognized Statements of Comfort/Discomfort

Statement	M	SD
"I have a favorite person(s) who makes me feel cared for"	*3.73*	*.522*
"My beliefs give me piece of mind"	*3.73*	*.500*
"I feel good enough to walk"	*3.72*	*.614*
"There are those I can depend on when I need help"	*3.71*	*.598*
"I am inspired by knowing that I am loved"	*3.67*	*.568*

Table 6: Least Recognized Statements of Comfort/Discomfort

Statement	M	SD
"I feel crummy because I am not dressed"	1.40	.890
"This room makes me feel scared"	1.44	.918
"I am constipated right now"	1.50	.972
"This room smells terrible"	1.52	.892
"No one understands me"	1.63	.868
"My pain is difficult to endure"	1.63	1.0
"I am depressed"	1.63	.923

The results of an independent samples *t* test indicated a significant difference between first and second year students in recognition of comfort/discomfort statements

(t (47) =3.51, p = .001). First year students had a significantly greater mean score on the GCQ (M = 129.1, SD = 20.3) than did the second year students (M = 115.9, SD = 9.7). Table 7 illustrates the central tendencies of the GCQ for first and second year nursing students.

Table 7: Mean and Standard Deviation of GCQ Scores for Students by Grade

Grade	M	SD
First year nursing students	129.1	20.3
Second year nursing students	115.9	9.7

An independent samples *t* test was conducted to determine the difference in the recognition of comfort/discomfort statement by those students currently employed in healthcare as compared to those not currently employed in healthcare. The test was not statistically significant (t (74) = -1.59 (p = .11), indicating no significant difference between GCQ scores for the two groups. Table 8 illustrates the central tendencies of the GCQ for students employed in healthcare and students not currently employed in healthcare.

Table 8: Mean and Standard Deviation of GCQ Scores for Employment

Employment Status	M	SD
Students Currently Employed in Healthcare	117.9	10.8
Students Not Currently Employed in Healthcare	124.2	18.9

CHAPTER V

Discussion

The findings of the study of nursing student's perception of comfort revealed that students were able to recognize comfort/discomfort in the psychospiritual and sociocultural domains. However, lack of recognition of basic physical and environmental comfort/discomfort reveals the need for further education.

Recognition of positive statements twice as often as negative statements suggests that while students were quick to recognize enhanced comfort, they had difficulty recognizing healthcare needs of the patient and family. Since assisting suffering persons in distress to experience comfort has been identified as a primary goal of nursing, this should be reflected in nursing education and curriculum. As identified in this study, comfort is not limited to one, but four domains. Recognition of the domains of comfort can serve as a guide for future nurses as well as nursing instructors. Nursing instructors should emphasize to their students the need to view their patients holistically, incorporating the four domains of comfort into their plans of care.

Study results revealed first year students had better recognition of comfort/discomfort than second year students indicating the need to incorporate assessment of comfort throughout the nursing education curriculum. At the study University, the 2010 incoming ADN students were required to be certified as nursing assistants prior to beginning class. This change in admission criteria, an intervening variable, may have affected the scores for first year students in the study resulting in the difference between first and second year students' recognition of comfort/discomfort.

This finding supports the theory that as nurses become more comfortable incorporating comfort measures into practice, they become less recognizable.

Implications for Nursing Education

It has been established that in order to provide comfort, nurses must be able to recognize and respond to patients in distress. Faculty may wish to consider the results of this study in future development and evaluation of program curricula within schools of nursing. Recognition of comfort/discomfort should be a measureable outcome for students graduating from pre-licensure nursing programs. In addition, faculty may also deem it helpful to assess students' knowledge and misconceptions early in the curriculum and to revisit the topic of comfort/discomfort throughout the course of study to ensure that students are accurately assessing the patient's level of comfort.

Implications for Practice

Since the time of Nightingale, who viewed comfort as fundamental to good nursing care (Newson, 2008), the mission of nursing has been focused on the discomfort of patients and interventions to relieve it. As established in this study, the degree to which comfort and comforting is evidenced in nursing performance depends in great measure on the way new nurses perceive the concept as a result of their education. The results of this study have the potential to impact the delivery of comfort care across the continuum of nursing care. Nurses who are educated to recognize their patients' expressions of comfort and discomfort are more likely to provide quality care resulting in increased healthcare outcomes and patient satisfaction.

Limitations

Limitations of this study include the use of only one student population at one school of nursing, the exclusion of traditional BSN students, and the hypothetical nature of the survey. Lack of a valid tool designed specifically to measure student perception of comfort could also be considered a limitation.

Recommendations for Future Research

The development of a valid and reliable tool to measure the nursing students' perception of comfort is desirable. Further research incorporating secular as well a religion based schools with a larger sample size in needed. Additional studies are also needed to assess the students' perception of comfort in actual clinical situations. Further research utilizing nurses and nursing students' recognition of comfort and discomfort has the potential to add to the body of knowledge regarding comfort care for patients across the continuum of healthcare.

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Appendix A

Survey

Demographics

1. Age _____

2. Number of years experience in healthcare prior to nursing school ____

3. Presently employed in healthcare

___ Yes In what capacity? _____

___ No

4. Gender ____Male _____Female

GENERAL COMFORT QUESTIONNAIRE

Thank you VERY MUCH for helping me in my study of the concept COMFORT. Below are representative statements made by patients. After reading each statement, decide if you feel that it is a statement related to comfort/discomfort. Four numbers are provided for each question; please circle the number you think most closely matches your feeling.

		Strongly Agree 4	3	2	Strongly Disagree 1
1.	My body is relaxed right now	4	3	2	1
2.	I feel useful because I'm working hard	4	3	2	1
3.	I have enough privacy	4	3	2	1
4.	There are those I can depend on when I need help	4	3	2	1
5.	I don't want to exercise	4	3	2	1
6.	My condition gets me down	4	3	2	1
7.	I feel confident	4	3	2	1
8.	I feel dependent on others	4	3	2	1
9.	I feel my life is worthwhile right now	4	3	2	1
10.	I am inspired by knowing that I am loved	4	3	2	1
11.	These surroundings are pleasant	4	3	2	1
12.	The sounds keep me from resting	4	3	2	1
13.	No one understands me	4	3	2	1
14.	My pain is difficult to endure	4	3	2	1
15.	I am inspired to do my best	4	3	2	1
16.	I am unhappy when I am alone	4	3	2	1
17.	My faith helps me to not be afraid	4	3	2	1
18.	I do not like it here	4	3	2	1
19.	I am constipated right now	4	3	2	1
20.	I do not feel healthy right now	4	3	2	1
21.	This room makes me feel scared	4	3	2	1
22.	I am afraid of what is next	4	3	2	1

		4	3	2	1
23.	I have a favorite person(s) who makes me feel cared for	4	3	2	1
24.	I have experienced changes which make me feel uneasy	4	3	2	1
25.	I am hungry	4	3	2	1
26.	I would like to see my doctor more often	4	3	2	1
27.	The temperature in this room is fine	4	3	2	1
28.	I am very tired	4	3	2	1
29.	I can rise above my pain	4	3	2	1
30.	The mood around here uplifts me	4	3	2	1
31.	I am content	4	3	2	1
32.	This chair (bed) makes me hurt	4	3	2	1
33.	This view inspires me	4	3	2	1
34.	My personal belongings are not here	4	3	2	1
35.	I feel out of place here	4	3	2	1
36.	I feel good enough to walk	4	3	2	1
37.	My friends remember me with their cards and phone calls	4	3	2	1
38.	My beliefs give me peace of mind	4	3	2	1
39.	I need to be better informed about my health	4	3	2	1
40.	I feel out of control	4	3	2	1
41.	I feel crummy because I am not dressed	4	3	2	1
42.	This room smells terrible	4	3	2	1
43.	I am alone but not lonely	4	3	2	1
44.	I feel peaceful	4	3	2	1
45.	I am depressed	4	3	2	1
46.	I have found meaning in my life	4	3	2	1
47.	It is easy to get around here	4	3	2	1
48.	I need to feel good again	4	3	2	1

Appendix B

Research Participant Consent Form

What is the nursing student's perception of comfort?

You are being asked to participate in a research study. The investigator is a registered nurse studying the nursing student's perception of comfort. The research will be presented to the faculty of Gardner-Webb University Nursing Department in fulfillment of a thesis project.

Your involvement in this study will consist of completing a survey regarding your perception of comfort. Participation in this study will take approximately 15 minutes. The answers will then be analyzed by the researcher to assess the nursing student's perception of comfort.

Your participation is entirely voluntary. You have the right to refuse to participate in this study. Your refusal to participate in this study will not affect any benefits or your relationship with this University. If you would like a copy of the completed study, one will be available to you at no cost.

There are no foreseeable risks or benefits associated with this study. This is an anonymous survey. At no time will your identity be revealed to the researcher or the faculty of Gardner-Webb University.

Any questions or concerns regarding this study should be directed to Norma Mott, RN, BSN at 828-657-5481 or Dr Rebecca Beck-Little at Gardner-Webb University, 704-406-4358.

I have read this consent form and voluntarily consent to participate in this study.

Participant's Signature _____ Date _____