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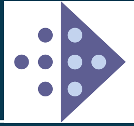

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# SARS-CoV-2 (COVID-19) Hospitalization in Light of Kolcaba's Theory of Comfort in Nursing: A Literature Review

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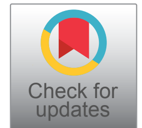

## Abstract

The pandemic has imparted complex threats to patients hospitalized with SARS-CoV-2 (COVID-19) and nursing scholars have identified impaired comfort as a critical patient response secondary to this viral illness. Patient comfort is considered an essential element of quality care that positively influences health, healing, and recovery. 'Comfort' in nursing is conceptualized by Dr. Kolcaba's middle-range Comfort Theory of physical, psychospiritual, sociocultural, and environmental comfort needs that guide nursing care. Qualitative analysis of comfort, alongside quantitative indicators, is needed for true comprehension within patient populations and specialized clinical areas. For COVID-19, no qualitative research explicitly considers Kolcaba's Comfort Theory. However, phenomenological results can be deduced and synthesized within the Comfort Theory. 'Total comfort' is considered greater than the sum of its parts and there is an urgent need to assess the defining characteristics of impaired comfort in patients hospitalized in non-intensive care (ICU) settings with COVID-19 during this global emergency. In doing so, nurses will be in a better position to integrate the comfort needs that are most important to patients within their clinical management and critical thinking responsibilities.

## Keywords

Kolcaba's comfort theory, Patient experience and SARS-CoV-2 (and COVID-19), COVID-19 and nursing, nursing and pandemics, Physical experience and COVID-19, Psychospiritual experience and COVID-19, sociocultural experience and COVID-19, Environmental patient experience and COVID-19, Isolation and nursing, Isolation and patient experience

## Introduction

The SARS-CoV-2 (COVID-19) pandemic has evolved into an extraordinary public health emergency never before seen by the modern nursing profession. Designated COVID-19 units are designed to accommodate large influxes of patients, resulting in extreme pressures and challenges on the healthcare system, nursing, and the patient experience [1]. Most patients hospitalized with COVID-19 are in general care settings, with approximately 20% requiring intensive care. These patients are challenged with distressing symptomatology [2] complicated with barriers such as quarantined rooms, hospital lockdowns, and visitor restrictions [1] that undoubtedly impact one's psychospiritual, sociocultural, and environmental comfort needs in the backdrop of a pandemic [1,3,4]. The spotlight has been on nurses and their ethical imperatives to reduce suffering and discomfort in the most challenging times. In nursing, 'comfort' is an ancient nursing-sensitive outcome from the era of Florence Nightingale (1860) and is now conceptualized according to Kolcaba's middle-range Comfort Theory of physical, psychospiritual, sociocultural, and environmental needs of particular concern for nurses in their therapeutic care planning [5-7].

Analyzing phenomena guided by discipline specific conceptual models and theories is crucial in curating meaning for practice and ensuring patients are the recipients of authentic nursing care [8]. Comfort Theory and COVID-19 has not been explicitly connected other than determining impaired comfort as a crucial nursing diagnosis secondary to this illness [9]. While this is essential, it is increasingly accepted that patient-derived definitions of comfort are required to be truly patient-centered and can be studied within populations of patients with specific clinical needs [10].

At this time, available data that can be deduced and

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synthesized within the Comfort Theory framework is largely dominated by the psychospiritual and sociocultural domains, which is considerably influenced by the identification of poor outcomes during the SARS-CoV-1, MERS-CoV, and Ebola epidemics [11-15]. The physical domain has proliferated within the medical model [2], and other conceptual models of nursing [16]. This review of the literature is guided by Kolcaba's Comfort Theory to evaluate which comfort needs are present in patients hospitalized with COVID-19 in non-ICU settings to assist nurses in their clinical prioritization to safeguard patient-centered care during this global emergency.

## Kolcaba's Comfort Theory

The tenets of Comfort Theory explain "it is through comfort and comfort measures that nurses provide strength, home, solace, support, encouragement and assistance" [6]. Kolcaba identified comfort needs within three technical senses (relief, ease, and transcendence) and four contexts (physical, psychospiritual, sociocultural, and environmental) that make up the taxonomic structure of comfort in nursing [5,6]. Relief and ease are similar and commonly differentiated as the experience of having a specific need met and a state of calmness, respectively. Transcendence is a unique experience and occurs when one can rise above pain or challenges [5,6]. Physical comfort is influenced by bodily sensations, symptoms, and homeostasis. Interpersonal, socio-cultural, and family relationships make up sociocultural comfort. Self-concept and meaning affect one's psychospiritual comfort, and the backdrop of human experience (such as light, noise, temperature, and ambiance) encompass environmental comfort [5,6].

In an integrative review, Wensley, et al. [10] concluded that patient comfort positively influences health-seeking behaviors, recovery, adaptation, acceptance, coping, healing, and optimal health and functioning [6,17-30]. Patient comfort is contextual and unique. Decisions must be made while considering one's clinical condition and entire psychospiritual and cultural status. Nevertheless, patient derived definitions of comfort show similarities within certain clinical conditions and care settings such as emergency, pediatric, surgical, and palliative care [10]. Kolcaba advocated for nurses to investigate the meaning of comfort in specialized settings or patient populations [5].

Comfort is often mistakenly narrowed to the physical dimension and pain control [31]. While this remains a critical aspect of patient-centered care, triggers such as vulnerability, loneliness, anxiety, functional decline, and grief can impact significantly on one's total comfort [9,31]. Achieving comfort is an essential part of nursing's history and contemporary practice [32,33] and comfort exists as a unique domain in nursing diagnostics derived from Kolcaba's Comfort Theory [9].

*Impaired comfort* is characterized by a "perceived lack of ease, relief, and transcendence in physical, psychospiritual, environmental, cultural, and social dimensions" [9]. However, current discourse proposes that impaired comfort is better served as a syndrome nursing diagnosis as comfort is a human response that encompasses many diagnoses such as pain, anxiety, nausea, and hopelessness [31]. Comfort requires a multidimensional approach to inquiry, with patient derived definitions [10] along with expert clinical assessment of nursing diagnoses [9,34,35] to provide a true understanding to guide nursing care.

## Impaired Comfort and COVID-19

Experts in nursing diagnostics developed the Nursing Care in Response to Pandemics Model that aims to organize the nursing knowledge required to care for patients in community and inpatient settings at the individual response [9], family response [35], and community response [34]. Impaired Comfort is a foundational nursing diagnosis in the care of patients with COVID-19 [9] at the individual level, with multiple outcomes and interventions to guide therapeutic care planning to achieve total comfort. The defining characteristics of impaired comfort secondary to COVID-19 include agitation, anxiety, depression, discomfort level, fatigue, fear, rest, sleep, and symptom severity [9]. Strength of this approach is the identified outcomes of impaired comfort in COVID-19 infection but is limited in incorporating patient derived meaning. Isolating impaired comfort as a singular diagnosis presents a limitation considering the multifaceted patient responses that affect comfort, and may better be represented as a syndrome nursing diagnosis [31].

For example, many patient responses to COVID-19 will impact the overall comfort of hospitalized patients such as ineffective breathing pattern, anxiety, death anxiety, fear, risk for loneliness [9], and interrupted family processes [35]. Currently, no qualitative studies directly link Kolcaba's Comfort Theory and COVID-19. Nevertheless, clinical research and qualitative analyses of the patient experience uncover the complexity that COVID-19 has caused on each comfort domain. The following section discusses these multiplex patient responses of *impaired comfort* secondary to COVID-19 infection and non-critical hospitalization.

## Physical Comfort and COVID-19

Symptom management is a crucial indicator of patient comfort [28,36-38]. More than 80% of patients display an excessive attention to their symptoms. Changes to their nutritional status and insomnia were also negatively influential [1]. The symptomatology of COVID-19 is complex [2] and the effect on the pulmonary system cannot be understated [1]. Dyspnea and pyrexia are particularly distressing symptoms among patients with COVID-19 secondary to this pathology. "I feel chest tightness, difficulty breathing, and coughing that make me uncomfortable, and I feel weak after abatement of the fever" [1]. Preliminarily, dyspnea, cough, and hyperthermia are given priority by patients. Pyrexia, cough, dyspnea, fatigue, anorexia, myalgia, anosmia, and ageusia are some of the most frequent symptoms non-critical patients with COVID-19 endure [2]. Endothelial dysfunction, dysfunctional alveolar-capillary oxygen transmission, and impaired oxygen diffusion capacity are characteristic of COVID-19 infections which are under investigation within medicine [2]. Through an objective nursing lens, ineffective airway clearance and breathing pattern, impaired gas exchange, acute pain, hyperthermia, and activity intolerance (amongst others)

were identified through taxonomic triangulation within the 29 most prevalent patient responses to COVID-19 [16].

Prone positioning has long been used in intensive care units to improve oxygenation of mechanically ventilated patients [39]. The benefit of pronation primarily functions to reduce intrapulmonary shunt by increasing aeration to the dorsal lung, thereby improving pulmonary functioning [40]. Placing non-intubated patients in prone positioning is a new practice that is receiving considerable attention for patients with moderate COVID-19 illness requiring supplemental oxygen. Promisingly, this cross-sectional study demonstrates that pronation of the conscious patient not only improves the partial pressure of oxygen ($PaO_2$) but also patient comfort [41]. 73.3% and 86.7% of patients reported an improvement of comfort during and after pronation, respectively [41].

Synthetic glucocorticoids which treat the hyper-inflammatory nature of COVID-19 have shown promise in reducing mortality [42]. Health Canada has approved the use of intravenous dexamethasone (or equivalent glucocorticoid) for patients hospitalized with supplemental oxygen, along with pharmacotherapies such as antipyretics and antitussives to ease the symptoms of COVID-19 [43]. Medication administration and monitoring is a significant nursing responsibility [44], and further evaluation of these treatment modalities will aid in determining their influence on patient comfort.

## Psychospiritual Comfort and COVID-19

Literature on the psychospiritual domain is robust, likely related to the epidemics of SARS-CoV-1, MERS-CoV, H1N1 influenza, and Ebola and the startling occurrence of depression, anxiety, and post-traumatic stress among patients [11-15]. Hospitalized patients with COVID-19 have exhibited significant anxiety, anxiety related to death, and fear on initial diagnosis and admission. One patient describes "the first thought I think of is death, I feel like I can't live, and I'm scared" [1]. The emotional turmoil of being infected with a highly virulent pathogen is complicated by the background of a pandemic. A threat to self-esteem and compromised human dignity are evident within patient descriptions secondary to the guilt, shame, and stigma attached to COVID-19 and the perception of 'feeling dangerous' [1,45]. Feder, et al. [46] stated that addressing emotional and spiritual needs is necessary for patients with COVID-19 yet is challenging due to the priority of limiting contact with infected patients.

Care from the healthcare team has been reported as the most important protective factor in the psychospiritual domain. One patient reported … "Doctors and nurses treat me very well and care about me, I am really touched, I can't live without them [crying]" [1]. Five themes of the psychological experience during hospitalization were identified using phenomenology; (1) Attitudes toward the disease, (2) Stressors, (3) Responses of mind and body, (4) Factors promoting epidemic prevention, and (5) Psychological growth and outlook [1]. The early stages of disease bring about anxiety, anger, fear, and helplessness [1] consistent with previous epidemics [15,47-49] indicating a general psychological stress response to epidemic emergencies [1]. Frontline nurses have also identified significant spiritual distress amongst patients as stated by one nurse… "the patients in this ward are in dire need of spiritual care" [50].

The use of therapeutic nursing techniques such as active listening, empathy, communication, patient education, and anticipatory guidance are critical in mitigating the negative psychological manifestations experienced early on [1]. Many clinically stable patients with COVID-19 have developed post-traumatic stress disorder (PTSD) prior to hospital discharge [51], and nurses must recognize when more intense psychotherapy or psychiatric evaluation is warranted. Promising practice examples have indicated that having health care providers trained in psychological care directly on COVID-19 wards leads to the identification of crucial psychological needs [45]. With the help of nurses, the multidisciplinary team, and self-comforting activities most patients progress through the middle and later stages of disease to a state of psychospiritual ease while accepting the disease, and then transcendence [1]. "This illness made me learn a lot and I will never forget it. As the saying goes 'if you don't die, you will have blessings. Thank you for this pneumonia" [1], is an example of transforming one's perspective to gratitude. Ferrell, et al. [52] advocated that all who have contact with patients during COVID-19 hospitalization should be spiritual care generalists and recognize when specialists are needed. Patients must feel safe in expressing their spiritual concerns and have the ability to partake in spiritual practices that bring them comfort [52].

## Sociocultural Comfort and COVID-19

Isolation precautions are necessary during COVID-19 hospitalization to prevent transmission and protect staff [45]. A systematic review of patient experiences during isolation revealed troubling effects such as anxiety, depression, loneliness, and fear [53]. Nurse-interaction with patients has been found to be significantly reduced while in isolation [54] and patients have expressed a need for contact with nurses during the COVID-19 pandemic to reduce the effects of anxiety, loneliness, and fear [1,4].

Widespread hospital lockdowns are a major threat to the sociocultural status of patients and family functioning [35]. Kumar, et al.'s [55] cross-sectional study highlighted the impact that impaired socialization and personal responsibilities have on isolated patients with COVID-19. They reported that confinement can contribute significantly to psychological morbidity. Multiple studies indicated that communication between patient, family, and the healthcare team are essential to mitigate the effects of isolation [3,4,56].

In current times where patients may have limited external support, nurses become the most important source of social comfort and the "therapeutic use of self may enhance comfort more than nurses might realize" [21]. Demonstrating professional presence is the most powerful influencer of therapeutic nurse-patient relationships realized through attentiveness, therapeutic touch, compassion, respect, integrity, and active listening [57]. The reality of nurses spending less time in isolation rooms presents a risk for patient wellbeing which has led to the perception of

lack of 'true presence' or 'being with' that can negatively impact feelings of social isolation [53,58]. Nevertheless, it is also apparent that nurses are rising above challenges and providing considerable amounts of social comfort to patients in this pandemic [1]. Further evaluation of how nurses adapt to this reality to connect with patients in isolation with COVID-19 is urgently needed.

Telecommunication, such as video-calling, between patient and family has been shown to provide a considerable amount of comfort while in hospital during the pandemic [4,58,59]. As described by one patient "every day I am happiest when I have video communication with my family" [1]. Some hospitals have adopted unit-specific tablet devices to facilitate video-communication with worried families, or at the very least ensuring that each patient has access to a telephone [59]. This has allowed patients to reach a state of transcendence during healing "family members did not abandon me or give up on me when it was my most difficult time. I am very happy" [1]. One particularly heartbreaking event that still occurs, but especially at the beginning of the pandemic, was the state of family presence during palliation. Nurses' critical and innovative thinking, for example, helped this family and patient reach relief, ease, and transcendence simultaneously in the restrictions of the current environment.

"It was early in the evening and the patient was close to passing, alone. He would have, if not for his nurse who tried to arrange a virtual connection with the family. She feared she might not have time to be at the patient's bedside due to the demands of providing care to other patients, but she was able to program the tablet with video capabilities and virtually connected her patient and family. Together, they prayed, sang songs, and told stories until, finally, the patient passed peacefully knowing that his family was all around him" [3].

## Environmental Comfort and COVID-19

Kolcaba's definition of environmental comfort is closely connected to Florence Nightingale's Environmental Theory [57]. The environmental domain entailed "color, noise, light, ambience, temperature, views from windows, access to nature, and natural versus synthetic elements" [21]. Patients in isolation reported that having a window is important… "a window to the outside world initially provided a release from isolation and boredom. The window was an opening, an avenue through which other lives could be observed and reflected upon" [53]. The isolation environment is artificial, and the strategic and accessible placement of items is beneficial [53]. In Shaban, et al.'s [60] study, they observed that it was not always possible for a patient with COVID-19 to have an isolation room with a window with natural lighting which highlighted the importance that effective stimulus has on isolated patients.

Additionally, due to hospital lockdowns patients were mostly unable to have familiar comforts from home brought in to therapeutically alter the artificial environment [4]. Given the detrimental effects that isolation can impart of mental health, Voter and Rittenmeyer [53] emphasized the importance of nurses acknowledging how patients interpret their environment. This patients' perspective highlighted the influence impaired environmental comfort can have on patients with COVID-19, "Isolation has been mentally painful. I was in the hospital for 6-7 days in that isolation room. Because I had nothing, no windows, no one to talk to. It's very cold in the room… is very hot, you have to have certain temperature, no TV, nothing" [60]. Conversely, some patients viewed isolation positively in the beginning as a private space and evidence of institutional integrity. Most patients, however, were negatively impacted by this artificial environment [60].

Earlier attempts to therapeutically alter the isolation environment with natural materials show promise, such as a demonstrated decrease in cortisol secondary to achieving environmental comfort through beauty and stimulation [61]. Given that such alterations may not be feasible during a pandemic, nurses can help their patients reach a state of transcendence in this domain when relief and ease might be impossible. An important cross-link to the psychospiritual comfort domain is evident in patients use of self-comforting strategies and diversional activities to mitigate the effects of isolation [1]. Explicit research that evaluates the environmental domain via Kolcaba's Comfort Theory will be helpful in gaining a complete understanding of how isolated patients with COVID-19 interact with their environment and associated therapeutic nursing interventions.

## Conclusion

COVID-19 has assaulted the international community leading to a global public health emergency never before encountered by our modern nursing profession. In nursing, this has caused a humanitarian crisis and nurses have been praised for their strength in their duties to alleviate suffering and discomfort in the most challenging of times. Comfort is a fundamental conceptualization in nursing's body of knowledge described by Kolcaba's Comfort Theory. Scientific inquiry of COVID-19 has proliferated rapidly within medicine and nursing, yet the focus of nursing inquiry has been on clinical assessment and management, and patient experience. In accordance with Fawcett [8], an investigation of comfort guided by discipline specific theories, such as Kolcaba's Comfort Theory, is needed to unlock the implications of impaired comfort during COVID-19 hospitalization to guide nursing care. Data from nursing and allied health profession's research demonstrated the multidimensional consequences COVID-19 has on each comfort domain. However, no studies have explicitly investigated the phenomenon in accordance with Kolcaba's Comfort Theory through qualitative analysis. The author advocates for the nursing research community to prioritize patient comfort guided by Kolcaba's Comfort Theory to place nurses in a better position to integrate the comfort needs that are most important to patients within their clinical management and critical thinking responsibilities.

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