行政院國家科學委員會補助專題研究計畫成果報告

由病人角度看何為舒適：以紮根理論的方法探討(II)

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行政院國家科學委員會專題研究計畫成果報告

由病人角度看何為舒適：以紮根理論的方法探討(II)

Exploring comfort from patients’ perspective: A grounded theory approach (II)

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一、中文摘要

在文獻中，許多作者對護理人員對舒適措施的提供及舒適的評價提出呼籲。在護理的文獻中顯示舒適不僅僅被視為一個概念，它可以是一個描述護理臨床工作的一個架構，包含舒適相關因素及其互動過程。然而，對於舒適概念或模式的探討仍僅止於理論或學術上的討論，忽略了照護對象之聲音。所以，本研究的目的是在於由病患角度探討舒適的概念及其架構。藉此將這一重要概念架構作一深入之研究，並期望能真正陳明此一臨床中護理的重要特性。

本研究為延續上一年之計畫，應用已完成訪談指引之設計，以及參考前趨研究的相關整理工作於本年度的研究中，同時，持續相關文獻查證、資料收集、整理、確認的工作。在本年度中仍以開放式問題指引，運用理論性取樣的理念，選擇內外科病患、家屬及臨床專業人員為對象進行訪談，資料的收集將涵蓋訪談之錄音、研究者之觀察記錄、分析過程筆錄及相關文獻之整合。應用持續比較分析技巧於所得資料中發展最具代表性之項目及其之間的關係。資料分析將持續進行至舒適概念模式之形成。

研究結果包含五個範疇：不舒服的經驗及其過程、與護理人員及醫療專業人員的互動、緩解不舒適的情境、影響病人的環境因素、以及身體不舒適影響其生活及家人。此五範疇是延續第一年之分類並加以充實其向度。

關鍵詞：舒適，紮根理論，訪談指引

Abstract

Many authors contended that nurses are the health professionals who always provide comfort. From review of nursing literature, not much information was provided in the empirical studies in relating nursing care to patient comfort. In addition, only a few studies found in nursing literature examine comfort from a theoretical perspective. Comfort has been viewed as a concept as well as a clinical practice framework.

However, the framework of comfort has not been found in an empirical study derived from patients' perspective. Therefore, the purpose of this study is to investigate the theoretical framework of comfort from the patient's own private language of health care needs. Through this endeavor, more efficient, satisfying, and goal-directed practice can be better illustrated.

This is a second part of two years study. In the first year, the design, the test, and the modification of the interview guide were finished. In this current year, the grounded theory approach was applied. Potential subjects were selected using theoretical sampling. Data were in the form of transcripts from tapes, field notes, and analytic and process memos. The constant comparative technique was utilized to discover the core category that explained most of the variation and integrates the data, codes and memos.
Five categories were found in this study: the process of being experiencing uncomfortable, interaction with nurses and other health professionals, conditions ease patients' discomfort, environmental factors affect patient comfort, and physical discomfort may affect their life and their family. These categories were similar with the first year's finding. For each category, more descriptions were added.

**Keywords**: comfort, grounded theory, interview guide

三、緣由與目的

The public's concern about the quality and spiraling cost of health services has been an important issue in the current era of health care circumstances. Among the health care professionals, nurses are directly concerned with the well being of patients and, therefore, play a pivotal role in assuring the delivery of quality care. They are also constantly faced with the need to provide patient care, both physical and psychological, within the health care arena. Therefore, the nursing profession must be able to demonstrate the impact of care provided by its practitioners.

Recently, the nursing profession has put lots of emphases on the philosophy of patient-focused care. Nursing staff must have an understanding of the needs and experiences of hospitalization and the sensitivity to elicit the patient's own private language of health care needs. Comfort has been explored and expressed as an essential in the nursing literature. However, the majority of the literature on comfort was derived from a theoretical perspective. The purpose of this study is to conceptualize a theoretical framework of comfort from patients' and their families' (or their significant others) perspective.

When exploring reasons why consumers seek health care services, researchers have found that services are sought to relieve distress. For example, discomfort or pain is the most likely reason for a health care visit of the indigent (Brecht, 1990). In a health care situation, patients may suffer from an impending procedure, a diagnosis, or a family problem. The traditional goal of nursing has been to provide comfort, thereby relieving multidimensional pain and distress, and restoring the health of the patient. To evaluate patient comfort is an important task for evaluating quality of nursing care. The measurement of comfort has not been widely explored in nursing literature. This study provided information on quality of care from patients' and their families' perspectives. By using a qualitative approach, the patient comfort was explored and conceptualized from patients and their families.

From the review of the literature, comfort is a broad concept that can be seen as an action or a state and can be viewed from physical, psycho-spiritual, social, and environmental perspectives. Many authors contended that nurses are the health professionals who always provide comfort. Different perspectives also have been shown in the literature. For example, Kolcaba (1992) asserts that comfort is pleasant, positive, multidimensional, and the result of purposive nursing action. On the other hand, Morse and her colleagues argued that "attaining comfort is a paradox best understood by reflecting not on the concept of comfort per se, but on its converse" such as pain, fatigue, and so on (Morse, Bottorff, & Hutchinson, 1995). In addition, comfort or comfort care has been articulated as a theoretical framework for nursing practice. However, not much information was provided in the empirical studies in relating nursing care to patient comfort. A framework (or a theory) of comfort needs to be derived form the patients' point of view so that more efficient, satisfying, and goal-directed practice can be better illustrated.

Method

This is a second part of two years study. In the first year, the design, the test, and the modification of the interview guide were finished. In this current year, the grounded theory approach was applied. Potential subjects were selected using theoretical
sampling. Data were in the form of transcripts from tapes, field notes, and analytic and process memos. The constant comparative technique was utilized to discover the core category that explained most of the variation and integrates the data, codes and memos. The purpose of this study was to investigate the theoretical framework of comfort from the patients' and their families' perspectives. Deliberate or purposeful sampling was utilized, choosing respondents who can best explain the phenomenon being studied. Tentative theoretical statements were generated and data collection techniques modified to confirm or refute them (Sandelowski, Davis, & Harris, 1989). While attempts were made to limit biases and imposition of prior knowledge, the investigator has done extensive literature reviews.

Potential subjects were selected using theoretical sampling. The continued selection of subjects was determined by the information obtained in the course of the study and the necessity for theoretical completeness. In the first year, open sampling was implemented. A name list of medical and surgical patients were obtained from the charge nurses in the medical and surgical units and the investigator chose anyone who was willing to join the study. The purpose of open sampling was to open to all possibilities. In the second year phase, sampling in axial coding, investigators recruited subjects on the basis of theoretically relevant concepts derived from open sampling.

The principal investigator served as the primary instrument of data collection. It was anticipated that the subjects would be less threatened in talking with a researcher instead of a nursing staff. The subjects were the primary source of data. Other sources of data included observation of the medical and surgical unit environment, review of the charts and literature relevant to the study.

Each subject was interviewed using an interview guide with open-ended questions. All informants were asked demographic questions. The length of the interview for each subject was 45 to 60 minutes. Because the interviews were conducted in medical and surgical care settings, it was anticipated that some of the interviews would be interrupted. The investigator contacted the subjects as necessary until all questions been answered from each subject. Meanwhile, each interview was tape-recorded.

Results and Discussion

The results included the process of articulating the five major categories found in the first year’s study. The final version of interview guide (developed in the first year) served as a guide when the investigators interviewed with patients. Twenty-one patients were contacted and interviewed in a medical center. Ten of them were female. The average age was 52.38 years old. Majority of the subjects were illiterate and jobless. The social economic status of the subjects was slightly below the average.

The investigators contacted each subject and each interview was started with conversations about their health conditions. Subjects were asked to recall their stories during the stay in the hospital. After they finished their major stories, the investigators checked the interview guide to examine if the needed information was gathered. Each interview was tape-recorded and was typed as transcription later by the interviewer. The verbatim transcriptions were inspected line by line to perform the initial coding and naming. All open codes were listed for each subject. Constant comparison and contrast techniques were implemented to search for the meaningful categories. The revise of the five categories developed in the first year were generated from the data.

The process of being experiencing uncomfortable. In the previous year, this category was “experiences of being uncomfortable. However, more subjects focused on the process of the experience. The name for this category was revised as “the process of being experiencing uncomfortable. In this category, subjects described “physical pain” and “discomfort”, and these state were labeled in the analysis as an experience of being uncomfortable. They reported the initiation of their discomfort, how they deal
with the physical distress, and the process to search for medical assistance. For half of the subjects mentioned about how they approach their own physical uncomfortable through “spiritual” power at the very beginning. Some of the subjects would consider the physical pain is related to her/his own fate. They seemed hesitate to visit a physician until they cannot bear physical pain for discomfort. One of the subjects expressed that she was afraid of dying in the hospital. After admitted to the hospital and their symptoms were relived, subjects might agree that to visit a physician and being hospitalized were worth of it.

Interaction with nurses and other health professionals. A number of patients observed that nurses could be busy, running around, caring for a lot of patients, and even understaffed. Some patients reported that they spent more time with nurses than with other health professionals. Having repeated encounters with one nurse in their hospital stay was important. One subject described the experience of nurses being nice and helpful to her. This experience made her feeling “much better”. In other cases, subjects reported that the medical treatments might affect their comfort. For the invasive procedures, their experiences were described as “nightmares”. When their feelings or uncomfortable were not understood by the health care professionals, they felt quite upset. This might cause more uncomfortable in terms of their symptoms and their needs for psychological support.

Conditions ease patients’ discomfort. Subjects reported that timely help was needed to ease to their discomfort. For example, the medication to relief pain should be administered on time. The more important thing was that their feelings and uncomfortable could be understood. Besides the help from the health professionals, helps from patients or their family on the next bed were very nice and would make them feel “being cared by others”.

Environmental factors affect patient comfort. There were not much revision upon this category. Majority of the subjects had negative feeling about the environment surrounding them. Factors such as the moderation of temperature, lighting, cleanliness of the environment, and the sound interference from the next bed, affected patients’ feeling of being comfort. They thought that higher standard for the cleanliness of the hospital settings should be implemented.

Physical discomfort may affect their life and their family. Subjects stated that they would change their life style after being diagnosed with diseases, which cause physical discomfort. The life style of their family members was also affected by the event of hospitalization. Especially, the interactions among family members would also been changed. Usually, subjects would hide their physical discomfort and emotional distress from their family. They would make their family worried if they have expressed their concerns. The most important this was that they have to change their usual habits to accommodate the treatment of their diseases.

Among the five categories, it indicated that each category contained physical, psychosocial, and spiritual aspects. In order to study the relationships between categories, the next step for this study would be appropriate to explore the relationships among the categories. The literature on comfort could serve as a guideline for developing the framework. The physical, psychological, social, and spiritual aspects need to be included in articulating the relationships among the categories.

四、参考文献


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