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Review Article

The Use of Comfort Kits to Optimize Adult Cancer Pain Management

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ABSTRACT

Background: Pain is one of the most feared of all symptoms for the cancer patient. Some studies estimate that up to 90% of all cancer patients experience pain. Advances in pharmaceuticals and expert provider knowledge have improved pain management overall for the patient with cancer; however, complementary therapies can synergize medications to provide optimal pain relief while decreasing the side effect profile. Despite this, nurses may have limited access to such resources. Many therapies can be administered directly by the bedside/chairside nurse with minimal training and the nurse can then teach the patient and family how to use the selected complementary therapy after leaving the hospital or clinic.

Objectives: The oncology nurse will be able to identify several easy-to-implement complementary therapies that can supplement pharmacologic pain management for cancer patients.

Methods: As a quality project, comfort kits, containing such items as handheld massagers, guided imagery audiotapes, and aromatherapy essential oils, were distributed for use with patients through unit-based pain resource nurses.

Analysis: More than 500 comfort kit items were tracked by the pain clinical nurse specialist during the comfort kit trial, both by medical record review and by follow-up phone calls to patients. During the comfort kit trial, average pain intensity decreased by 2.25 points on a 0-10 scale in the 24-hour period after use of the item from the comfort kit. Patients also had an overall decrease in the use of pharmacologic pain interventions and an increase in ambulation in the 24-hour period after implementation.

Conclusions: Comfort kits allow nurses easy access to inexpensive tools to supplement pharmaceutical pain management. Optimizing nonpharmacologic pain management can increase patient and nurse satisfaction, improve overall pain management, and decrease untoward side effects.

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Pain is one of the most feared of all symptoms for the cancer patient. Some studies estimate that up to 90% of all cancer patients experience pain (Eaton, Meins, Mitchell, Voss, & Doorenbos, 2015). Advances in pharmaceuticals and expert provider knowledge have improved pain management. However, some studies have reported that complementary therapies can synergize medications to provide optimal pain relief while decreasing the side effect profile (Hokka, Kaakinen, & Polkki, 2014). Despite this, nurses have limited access to resources that could immediately be used in this manner. Many therapies can be administered directly by the bedside nurse if available and the nurse can then teach the patient how to use the selected complementary therapy after discharge from the hospital or clinic.

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Background and Significance

Cancer Pain Management

The American Cancer Society (2017) estimates that 1,688,780 new cancer cases will be diagnosed in 2017 and more than 15 million Americans are currently living with a history of cancer. With the staggering number of Americans being newly diagnosed or living with a history of cancer, the common symptoms of cancer, including pain, and its treatment are of great importance to a significant portion of the population (Running & Seright, 2012). Most common among patients' fears is experiencing, managing, and living with pain. One study surveyed 117 patients with advanced cancer who had received a referral for pain management and found that not only was fear of pain significant but it was also a significant predictor of the patient's functional limitations (LeMay et al., 2011). Adequate management of symptoms, such as pain, is challenging for physicians, oncology nurses, and patients themselves (Eaton et al., 2015; Klafke et al., 2016).

The rising use of pharmaceutical interventions to treat pain has been widely scrutinized, having a significant impact on the means by which medical providers are caring for patients with oncologic pain (Rauenzahn & Del Fabbro, 2014). The treatment of cancer pain is difficult because of the many different types of pain a cancer patient may experience. An international survey of cancer pain characteristics and syndromes revealed that pain stemming from somatic injury occurred in 71.6% of patients. Visceral and neuropathic pain was noted in 34.7% and 39.7%, respectively (Augusto, Caraceni, Russell, & Portenoy, 1999). Furthermore, pain is subjective with limited objective means for health care assessment (Noble et al., 2005). Patients with similar cancer types and disease progression may experience pain and respond to treatment differently. Therefore, many patients may need multiple pharmacologic agents, interventional procedures, or a combination to treat their pain to a level allowing them to be functional.

Because of the complex nature and etiology of cancer pain, pharmaceutical agents are used as part of the treatment regimen. Nonopioids, such as acetaminophen and nonsteroidal anti-inflammatory drugs (NSAIDs), may be used for mild to moderate pain (Dworkin et al., 2007). Opioids are often used to treat moderate to severe pain. Various antidepressants, anticonvulsants, lidocaine patches, and other medications can be used to treat neuropathic pain (Attal et al., 2010). Patients may have a combination of the aforementioned medications as part of their pain treatment plan. Although they can be efficacious for the management of pain, there are known side effects. Acetaminophen and NSAIDs may mask a fever. NSAIDs can contribute to bleeding and cardiovascular complications or worsen kidney function. These adverse effects may prohibit or decrease their utility in a patient undergoing active cancer treatment (Dworkin et al., 2007). Sedation, nausea, vomiting, delirium, myoclonus, pruritus, respiratory depression, and constipation are among the most common notable side effects of opioids (Dworkin et al., 2007). Dizziness, sedation, peripheral edema, nausea, and anticholinergic side effects, among others, may occur with treatment of the antidepressants and anticonvulsants used primarily for neuropathic pain management (Dworkin et al., 2007). These side effects alone may be burdensome. When combined with cancer-related treatment side effects or disease sequelae, they may be unbearable.

In addition to adverse effects, pharmacologic agents can be costly. There are no studies evaluating the costs of cancer pain at the time of publication. However, a study using data from the 2008 Medical Expenditure Panel Survey evaluated the direct and indirect costs associated with non–cancer-specific pain syndromes, including headache, stomach, abdominal, and back pain. This study found the total incremental cost of health care related to pain was $261-$300 billion in 2008 (Gaskin & Richard, 2011). Furthermore, a study using data the National Ambulatory Medical Care Survey evaluated costs of pain medication in patients with chronic nonmalignant pain in the United States from 2000-2007 and found that the total costs of prescription medications for pain was $17.8 billion annually based on 690,205,290 weighted outpatient visits (Rasu et al., 2014). Patients with malignant pain may be especially susceptible to higher costs of pain management. Weingart et al. assessed the quality of pain care in 85 adult ambulatory patients with advanced cancer. They discovered that 34% of patients reported severe pain within 30 days of the index visit (Weingart et al., 2011). In an effort to address uncontrolled severe pain, dose escalation or a combination of medications may be used, which may drive up patient prescription drug costs. Indirect costs may also be pertinent with severe pain leading to higher indirect costs. Schaefer et al. (2014) found that indirect costs were a primary driver and significant differences in cost existed among pain severity levels in 684 patients with nonmalignant neuropathic pain in the United States (Schaefer et al., 2014).

Inadequate pain management in patients with cancer can increase use of services and cause overall higher cost of care. One retrospective quality study on 2,531 inpatient admissions at a tertiary cancer hospital found that readmissions as a result of uncontrolled pain accounted for roughly 3% of readmissions (Saunders et al., 2015). A thorough nurse case manager assessment of unplanned cancer readmissions at The James Cancer Hospital & Solove Research Institute was analyzed to determine the impact uncontrolled pain may have on the oncology population. Based on the nursing review findings during the hospital's fiscal year 2015 (July 2014–June 2015), uncontrolled pain accounted for 12% ($n = 223$) of the readmissions. Given the significant role pain has on a patient's success in cancer treatment, health care providers must use all available resources to control pain in patients with cancer.

Complementary and Alternative Medicine

Complementary and alternative medicine (CAM) is defined as a group of diverse medical and health care systems, practices, and products that are not generally considered part of conventional medicine (Bahall, 2017; Rojas-Cooley & Grant, 2009). Interest in the use of CAM has grown over the past two decades because of a range of factors, including the following: CAM allows users to have an active role in their health care, CAM treats the “whole person,” CAM techniques are well tolerated and comparatively inexpensive, and conventional techniques have been ineffective for some patients (Bahall, 2017). Often patients' self-care journey leads them to investigate various CAM therapies, including those from alternative medicine systems, biologically based practices, energy medicine, manipulative practices, body-based practices, and mind-body medicine (Hokka et al., 2014; Klafke et al., 2016; Kwekkeboom, Cherwin, Lee, & Wanta, 2010; Running & Turnbeaugh, 2011; Singh & Chaturvedi, 2015). These options may be particularly useful for meeting the biopsychosocial needs and preferences of patients with cancer (Leppin, Fernandez, & Tilburt, 2016). Despite this, a discussion of and referral to CAM therapies is not routinely incorporated into clinical oncology care (Sarris & Bryne, 2011). Also, patients using CAM do not always disclose it to health care providers, which can create issues when combining CAM therapies with conventional treatment (Bahall, 2017; Rojas-Cooley & Grant, 2009). When the use of CAM therapies is not known by care providers, they cannot provide information to patients regarding possible interactions with known cancer treatment.

Oncology nurses spend much time with patients with cancer during treatment and repeat visits for symptom management.

While providing care and treatment, nurses interact extensively with patients and are well placed to improve supportive care, including CAM therapies, through teaching and referral. It is, of course, essential that nurses who include CAM therapy in their supportive clinical care be well educated in whatever method of CAM is being suggested, including specific contraindications. They must also be knowledgeable about organizational policies and state nurse practice acts. Currently, many oncology nurses are unsure of their role in use of CAM because of roadblocks such as the lack of a supportive clinical environment, lack of education about CAM, lack of supplies, and lack of nursing guidelines for safe use (Blackburn et al., 2017; Klafke et al., 2016; Kwekkeboom et al., 2010; Running & Turnbeaugh, 2011; Singh & Chaturvedi, 2015). The evidence base has been growing to support that many CAMs can be administered or taught by oncology nurses, given their potential to relieve side effects and contribute to emotional well-being and quality of life (Klafke et al., 2016; Rojas-Cooley & Grant, 2009).

Comfort Kits

To better understand the patient with cancer's preferences for nonpharmaceutical interventions, a survey was conducted using The James Cancer Hospital's Patient Advisory Group. This group consists of current or former patients who participate in a variety of ways to improve care at the organization by providing feedback, input, and guidance from their own experiences during diagnosis and treatment. The survey was distributed via e-mail, 35 responses were collected, and results were analyzed. For a copy of the survey, see Table 1.

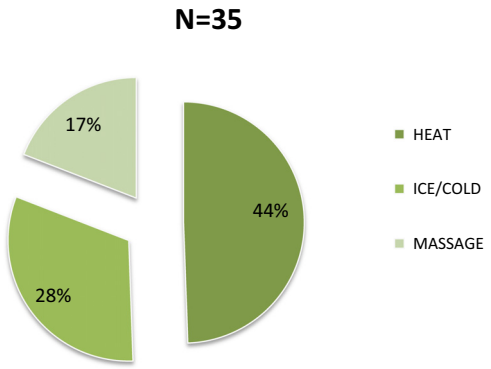

Figure 1. Use of Nonpharmacologic approaches for pain before comfort kits.

Of the survey respondents, 66% (n = 23) indicated that pain affected some to all of their activities of daily living during treatment. Although only 9% (n = 3) responded that their pain was rarely at an acceptable level, 66% (n = 21) did experience breakthrough pain and 59% (n = 19) stated that managing pain was moderately to extremely difficult. When asked about nonpharmacologic methods of pain management, 56% (n = 18) of patients had tried one of these methods. Of those who had tried a nonpharmacologic pain management method, 66% (n = 15) of respondents learned about the method from someone other than a provider at the James. When asked about the methods, those identified included heat, ice or cold therapy, and massage for pain control (Fig. 1). On review of these results, it was determined that a

Table 1
Survey Regarding Pain Management for Patient Advisors, 2016

Intro: In the spirit of continual improvement, The James is trying to explore ways to help our patients better manage pain related to their cancer or treatment after they leave the hospital and between scheduled visits. Your input is critical in helping us better understand what tools and support we can provide to our patients and their families in regards to pain management. Please take a minute to think about your experience with pain, specifically while you were at home in between visits, before answering these questions. Review our draft "Pain Journal" (first created by the wife of a recent patient) and provide your thoughts on how The James can help our patients manage their pain.

1. Did you experience pain before your cancer treatments started? (Y/N/NA)
2. What best describes how pain affected your daily life during your course of treatment:
   a. No pain
   b. I experienced pain, but it did not limit my daily activities
   c. I experienced pain, and it limited some of my daily activities
   d. I experienced pain, and it limited most/all of my daily activities
3. During your course of treatment, how do you feel your pain was managed?
   a. My pain was always at an acceptable level
   b. My pain was typically at an acceptable level, with periods of "break through" pain
   c. My pain was rarely at an acceptable level
   d. My pain was never at an acceptable level
4. What was the level of difficulty you experienced trying to manage your pain while at home?
   a. Easy
   b. Moderate
   c. Hard
   d. Extremely difficult
5. What could The James have done or provided you to help manage your pain? (text)
6. Do you feel the physicians/staff at The James did all they could to control your pain? (Y/N/NA)
7. Do you feel the physicians/staff at The James were sympathetic to your pain? (Y/N/NA)
8. Do you feel the education you received regarding pain management at The James was adequate? (Y/N/NA)
9. Did you ever place a call to someone at The James (clinic, physician, etc.) to complain of pain? (Y/N/NA)
   a. If Yes, do you feel that the call provided you with what you needed? (Y/N/NA)
10. Did you ever have to return unexpectedly to The James because of pain? (Y/N/NA)
11. Did you ever try a non-prescription method of pain management (massage, heating pad, etc.)? (Y/N/NA)
    a. If yes, what did you use? (free text)
    b. If yes, how did you find out about this method?
       i. A provider at The James
       ii. A provider not at The James (PCP, home health aide, etc.)
       iii. Someone I know personally (friend, family, etc.)
       iv. Found out about it online
12. Do you think you would have benefited from someone at The James reaching out to you between your visits to discuss pain and other symptoms? (Y/N/NA)
13. Please tell us anything else you think we could do to help patients with their pain. (Text)

Y/N/NA = yes/no/not applicable.

Table 2
Comfort Kit Contents Per Unit

Item	No. Per Unit Comfort Kit
Acupressure wrist bands	20
Aromatherapy essential oils	
Lavender	2
Lemon	2
Peppermint	2
Aromatherapy diffuser	2
Aromatherapy diffuser pads	40
CD player	1
Guided imagery audio CDs	
Pain management	10
Breathing deeply for relaxation & stress relief	10
Relaxation	10
Sleeping deeply, easily, restfully	10
Gear bag for comfort kits	1
Handheld massager, electronic	20
Handheld massager, nonelectronic	10
Neck/positioning pillows	10
Reflexology gloves/socks	10
Sleep mask	10
Stress balls	20

broader and more readily accessible set of nonpharmaceutical pain management interventions would benefit the oncology patients in our institution.

Comfort kits were selected as the vehicle for trialing inexpensive nonpharmacologic pain interventions in our patients. A grant for $7,500 from The Ohio State University Wexner Medical Center Service Board supported the purchase of eight comfort kits for trial on eight different inpatient and ambulatory oncology units. Unit comfort kits contained a various array of selected complementary pain management products, which nurses could access and use with patients in pain. The kits were stocked with items each costing approximately $10 or less that could supplement pain management. Comfort kits contained items such as handheld massagers, guided imagery audiotapes, aromatherapy essential oils, and sleep masks (see Table 2 for full comfort kit contents). Nurses identified patients they thought might benefit from use of one of the comfort kit items. The kits were stocked with an estimation of supplies that would be needed on a single unit for the upcoming year, with the knowledge that some units may not use certain items. All of the items were given to the patients to keep and use after their inpatient stay or ambulatory visit, except for the aromatherapy diffusers and CD players, which were kept on each unit.

The trial units were selected by volunteers from eight of the newly trained pain resource nurses (PRNs). Pain resource nurse training was initiated based on the training program developed at the City of Hope Cancer Center (Grant, Ferrell, Hanson, Sun, & Uman, 2011). The PRN training course provides in-depth, 2-day content on expert cancer nursing pain management. The full schedule for PRN training is provided in Table 3. Of note, the course provided several breakout sessions during each afternoon in which participants could select training on various complementary therapies. This training prepared the eight trial-unit PRNs (13% of the total PRNs) to introduce the comfort kits on their units and further instruct unit nurses in use of the various items.

The pain clinical nurse specialist developed a comfort kit instruction manual and a reference chart for item use. The instruction manual provided detailed instruction on using each item, and the reference chart directed nurses to what type of patient may enjoy which type of therapy (Table 4). Patient education materials were available for each item in the kit, and these were referenced in the manual. Instruction on cleaning the aromatherapy diffuser and CD player were included. The organization's Clinical Standards Committee had recently approved an aromatherapy policy, and this was referenced and all stipulations of the policy were followed should aromatherapy be used. Guidelines were also provided for tracking comfort kit items distributed so that follow-up quality data could be accessed for outcome analysis. The PRNs and the unit nurses on the trial units were encouraged to “think outside the box” in terms of using the items with their specific patient population. They were also to involve the patients' friends and family members with permission, because patients and families who are actively involved in their pain management have described an increased sense of control over a symptom that can have a profoundly negative effect on their quality of life.

Table 3
The James Cancer Hospital Pain Resource Nurses Training Schedule

PRN Training: Day 1	
0740-0800	Pre-test
0800-0815	Welcome
0815-0945	Overview of Pain Management
0945-1200	Pharmacologic Pain Management
1300-1400	Issues in Pain Management
1415-1500	CAM Breakout #1
1515-1600	CAM Breakout #2
CAM BREAKOUT CHOICES for Day 1:	
Diaphragmatic Breathing	
Aromatherapy	
Acupressure	
PRN Training: Day 2	
0800-0900	Equianalgesic Dosing
0900-0945	Communicating about Pain
1000-1100	Interventional Pain Management
1100-1200	Routes of Pain Management
1245-1345	Pain & Suffering
1400-1445	CAM Breakout #3
1500-1545	CAM Breakout #4
1545-1605	Post-test
CAM BREAKOUT CHOICES for Day 2:	
Reflexology	
Therapeutic Touch	
Guided Imagery	

PRN = pain resource nurse; CAM = complementary and alternative treatment.

Results

During the trial of the comfort kits on the eight trial units, the neck/positioning pillows and acupressure wrist bands were used most often with patients. Table 5 shows the full distribution of the use of the various items. Patient satisfaction with pain management was evaluated and benchmarked against like oncology-focused comprehensive cancer centers across the country, measured by percentile ranking. Percentile ranking measures one institution's result in relation to all other institutions included in the benchmark. Figure 2 shows the changes in percentile ranking for patient satisfaction with pain management on the eight trial units from before implementation of the comfort kit versus after implementation. All the trial units reported an improvement in patient satisfaction with pain management. The average increase in percentile ranking points for patient satisfaction with pain management was 31 points from before (the previous fiscal year average) to after the trial, with the greatest increase of 93 points on one ambulatory unit. On the inpatient units, patient satisfaction with pain management was measured using two key statements: (1) “My pain was well controlled”; and (2) “Staff do everything they can to help with my pain.” Of these statements, the second one, reflecting staff attempts to help, had dramatic increases that contributed to the overall increase reported. Increased patient satisfaction with pain management has been sustained on these trial units to a lesser extent than during the initial trial, with current

Table 4
Suggestions for Use of Comfort Kit Items in Specific Patients, 2016

Aromatherapy	• Patients who have used aromatherapy previously and enjoy its effects • Patients without allergies to fragrances, foods, and aromas; asthma; reactive airway disease; or pregnancy • Patients who find a trial of one of the three available scents soothing & relaxing
Guided imagery	• Patients who have used guided imagery previously and enjoy the effect • Patients who are interested in deep breathing • Patients with pain that is associated with tension and anxiety • Patients who are unable to sleep related to pain
Handheld nonelectronic massager	• Patients who have used massage previously and enjoy its effects • Patients who enjoy a deeper tissue massage • Patients who experience trigger point pain • Patients who have visitors who might be interested in helping with pain management
Handheld electronic massager	• Patients who have used massage previously and enjoy the effect • Patients who enjoy a lighter, vibrating tissue massage • Patients who have pain across large body parts or areas • Patients who have visitors who might be interested in helping with pain management
Sleep masks	• Patients who have pain that interferes with their sleep • Patients who find a trial of the scent of the pillow pleasing • Patients with headache pain • Patients with pain or tension or swelling in their face or eye area • Patients who are experiencing a painful treatment or procedure and want to block it out
Neck/positioning pillows	• Patients with neck or back pain • Patients who find support of this area comforting
Acupressure wrist bands	• Patients who have pain and associated nausea • Patients who have experienced acupuncture or acupressure previously and found it effective
Stress balls	• Patients who have pain associated with stress or anxiety • Patients who are experiencing procedural pain

average percentile rankings for these units improved by 11 points over baseline.

Additionally, and perhaps more importantly, other key data trends were identified during the trial phase of this project for hospitalized inpatients. First, pain scores decreased by an average of 2.25 points on a standard 0-10 numeric rating scale from the 24-hour period before intervention compared with the 24 hours after intervention (N = 136 patients). Also, patients' use of their prescribed pain medication in average total milligrams decreased when comparing the pre- and postintervention time points (N = 136 patients). Lastly, for the patients who were ambulating, average ambulation increased over the two time periods respectively, according to a comparison of registered nurse or physical therapist documentation of patient movement.

The rollout of the comfort kits to all inpatient and ambulatory oncology units occurred in March 2017, and the additional units began using them immediately. Tracking of the distribution of supplies and data continued as it had during the trial. Figure 3 shows that the use of comfort kit items was fairly equal between the inpatient and ambulatory setting. After rolling out comfort kits to all remaining inpatient and ambulatory units, patient satisfaction with pain management was once again evaluated. Since the rollout, 63% of the inpatient units reported an increase in patient satisfaction with pain management, and for each of these units, the April 2017 percentile rankings were their highest of the year. The average increase in percentile ranking for these units was 16 points, with one unit experiencing a 55-point increase in percentile ranking. In the ambulatory setting, 57% of the 27 ambulatory units reported increased patient satisfaction when comparing their baseline to their April 2017 results. The average increase in percentile ranking for these units was 38 points. For 30% (n = 8) of the ambulatory units, their April 2017 patient satisfaction scores for pain management were their highest of the year.

Table 5
Use of Various Comfort Kit Items During Trial (N = 242 patients)

Neck/positioning pillow	20%
Acupressure wrist bands	20%
Sleep mask	16%
Electric massager	14%
Aromatherapy alone	12%
Stress ball	9%
Aromatherapy by diffuser	3%
Handheld massager	3%
Guided imagery CD	3%

Implications

The implementation of comfort kits has been a success at our institution. The increase in patient satisfaction with pain management could have resulted from an increase in the attention to nonpharmacologic pain intervention by the nursing staff rather than from the specific items used. In addition to consistent increases in patient satisfaction with pain management, nurses have enjoyed increased autonomy in offering inventive additions to pharmaceutical pain management. Many of the PRNs have described clinical situations in which patients have thoroughly

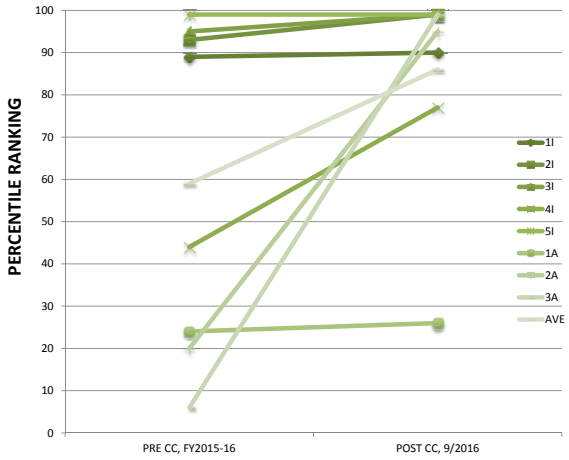

Figure 2. Patient satisfaction with pain management on trial units: before comfort kits versus after. CC = comfort kits; I = inpatient units; A = ambulatory units.

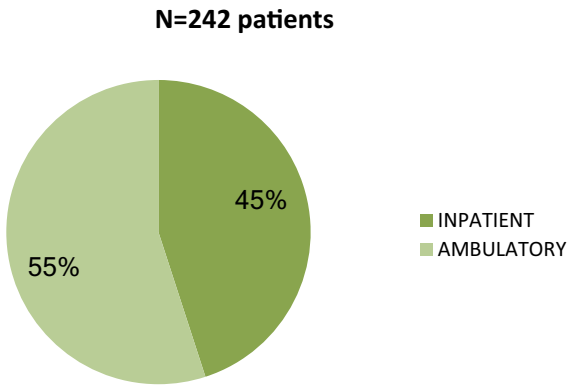

Figure 3. Use of comfort kit items: inpatient units versus ambulatory clinics.

embraced the use of complementary therapies and continued them on a regular basis throughout their treatments and after. Representative comments from patients are displayed in Table 6. Patients definitely seemed to appreciate the fact that they could do something to affect their pain status other than taking prescribed medication. During the trial in one of the ambulatory chemotherapy clinics, a patient was seen relaxing in her lounge chair with a sleep mask on and aromatherapy diffusing a light scent of lavender. That patient commented later that she never imagined that she would compare her first chemotherapy experience to a day at the spa!

As the trial and rollout to units progressed, nurses and patients found inventive ways to use comfort kit items that were not traditionally thought of in the beginning of the project. Some patients who were experiencing painful procedures, such as bone marrow aspiration and biopsy, experienced decreased pain and anxiety by using stress balls during the procedure. Other patients used sleep masks to center themselves and meditate during long scans or radiation treatments. One ambulatory area started giving out inexpensive wooden bead bracelets to patient who enjoyed aromatherapy. The nurses would soak the wooden bead in the patient's favorite essential oil and the scent would sometimes last until the patient's next clinic appointment.

The year-long comfort kit trial and rollout allowed the different clinical units a clear projection of which items might be used most often or not at all, as well as how many items might be needed over the next year. In August 2017, the PRNs came together to share data and stories related to this project. It also gave them the opportunity to swap out items that weren't used on their clinical areas for ones that were in greater demand. This “swap meet” was well received and productive and the PRNs are well on their way to restocking for another fiscal year.

Discussion

This project was not intended to be research focused, but rather a quality project that would increase pain management options for nurses and patient satisfaction for patients in pain. Therefore, several limitations do exist. It is important to not assume cause and effect from the outcomes mentioned, because many variables can affect patient management and patient satisfaction. The individual comfort kit items were not evaluated separately, so we have no knowledge of which items produced the greatest effect. The data for patients who received comfort kit items was not compared with patients who did not receive the same intervention. Clearly, some units embraced this project more readily and tried to implement comfort kit items whenever possible. These units could have had higher-ranking outcome data.

Future quality projects and research in this area could include a time study of the nonpharmacologic nursing interventions to determine that as a factor of influence on the outcomes. Research comparing various methods of nonpharmacologic therapy and resultant impact on pain needs to be structured in a manner to give robust results that will contribute to the body of knowledge.

This project clearly supports increasing oncology nurse autonomy in selecting and implementing inexpensive CAMs with patients in pain, in terms of both nurse and patient satisfaction. There are many points in a cancer patients' journey when control is taken away. This quality improvement project provided increased patient control with minimal training needed to prepare nurses for implementation. The data captured did not include financial impact, but one could extrapolate that if such interventions are effective, patients could experience fewer side effects and hospital readmissions while having greater control of their own care. The practice of nursing has always focused on providing comfort to patients, whether or not cure is possible. No matter how benign or serious the condition, nurses ensure that patients care is holistic and includes measures to enhance comfort. Increasing nursing knowledge and resources toward independent practice actions for patient comfort will only enhance nurse and patient satisfaction and patient outcome.

Table 6
Example of Patient Comments Regarding the Use of Comfort Kit Items

“I used my aromatherapy sleep mask both in the clinic, while I was receiving treatment, as at home at night. I found it comforting and it allowed me to block out painful and anxiety producing aspects of therapy.”
“I used the massager lightly on my legs and feet and it helped with my peripheral neuropathic pain. I talked my husband into helping me use it every evening before bed and it really helped me get to sleep.”

Supplementary Data

Supplementary data related to this article can be found online at https://doi.org/10.1016/j.pmn.2018.01.004.

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