

ORIGINAL RESEARCH

Comfort of the hospitalized elderly

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ABSTRACT

The purpose of this pilot study is to identify the specifics of comfort in the hospitalized elderly population. This is a descriptive-exploratory pilot study, with a qualitative approach. Data was collected between January and February 2018, being included 12 elderly participants hospitalized in the pulmonology/oncology department. Semi-structured audio-recorded interviews were conducted to obtain the data. The central theme of the comfort phenomenon for the hospitalized elderly individuals comprises four categories that represent the perceptions of the subjects, namely: needs that were felt/experience's context; intervenients' role/experience's context; ways and means of causing comfort/discomfort; attributes associated with the concept of comfort/discomfort. The analysis of each of these categories showed the importance of developing skills, in order to satisfy the comfort needs of the hospitalized elderly. The elderly constitute a group which is socially more vulnerable and fragile. For this reason, nurses and students should be available to provide relief, well-being and comfort to this population with specific needs. The findings of this study reinforce the results of previous research efforts, highlighting categories and subcategories that allow to achieve a balance between needs, expectations and wishes, and an integrated comforting care that should be considered and object of deep research by nursing students.

Key Words: Elderly, Hospitalization, Comfort

1. INTRODUCTION

Aging population is one of the most worrying phenomena affecting all societies worldwide. The increasing development of knowledge and technology has enabled the treatment of several pathologies that were previously fatal, thus contributing to an increase in the average life expectancy, that is, a population with more elderly people. However, this increase in longevity does not always correspond to an increase in quality of life. The lengthening of life leads to multidimensional changes, inherent to the aging process, and brings with it a greater susceptibility and vulnerability to an increase in the situations of potentially incapacitating chronic and degenerative diseases, as well as difficulties in the functionality

and weakness of the body mechanisms, leading to prolonged and constant hospitalizations.^[1]

It is thus essential to create new challenges in the health system, specifically in the model of organization and management of health care, that respond to this population which needs special attention. The chronic elderly often resorts to health care, being constantly subjected to the hospitalization processes. Once conscious of this reality, it becomes essential that health professionals, namely nurses, are prepared to deal with the issues inherent to the aging process, in order to establish an effective communication, stimulating the patient's autonomy, and are attentive to his/her needs

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of adaptation to new contexts and vulnerabilities specific to individual's condition.^[2]

The hospitalization process is experienced by the elderly in a distressing manner, because it changes totally the patient's daily routine. Taken away from his/her environment and family, the elderly become more dependent, functionally and emotionally, exhibiting fears related to his/her health process and treatment.^[3]

As the elderly population continues to grow, knowing how to intervene and take care of this population is fundamental. Therefore, nursing care should focus on the individuals whose needs are not satisfied due to the disease, or who require help to maintain and promote health, well-being and comfort, as it is the case with hospitalized elderly individuals.^[4] Authors such as Melleis and Kolcaba^[5,6] mention that Nursing is considered a human response of help and comfort to the practice of care, related to life experiences between the nurse and the individual which receives care.

Comfort is defined by some authors as a feeling of relief from discomfort, a state of calm and satisfaction,^[7] a need of all human beings throughout life, in health and in sickness, especially for the elderly, because they constitute a group socially more vulnerable and fragile, that often resorts to hospitals due to exacerbations of a chronic situation.

The concept of comfort is part of the history of Nursing care, marking its development, not only as a discipline, but also as a profession. Several nursing theorists have studied this concept, from which we highlight the work developed by: Jean Watson, who defines comfort as the essence of the nursing practice; Hildegard Peplau, who, through the Theory of Interpersonal Relations, underlines the emotional management of individuals being cared for by nurses; Irma Callista Roy, who, with her Adaptation Model, brings about the emergence of psychological comfort; Madeleine Leninger, founder of ethnonursing and cross-cultural health care, who argues that caring is essential to maintain or reacquire the well-being of individuals or groups; and Katherine Kolcaba, who dedicated herself to the development of the Comfort Theory, whose concept is based on the situation experienced by the individuals that receive the comforting actions.^[8] Katherine Kolcaba's Comfort Theory has been applied in studies whose participants are elderly patients in various contexts with the objectives of analyzing the concept itself and measuring comfort in this population.^[6]

The concept is complex, in itself, and comforting is also a complex intervention, difficult to operationalize in practice. Therefore, some research has been carried out to clarify the classifications of the concept. One of those recent studies

reveals that most authors/researchers often classify comfort as a "state" with certain attributes and interventions inherent to the comforting process. For this reason, comfort is seen more often as a noun (comfort) and, less often, as a verb (to comfort).^[9]

The concept of comfort is complex and emerges from the balance between well being, wishes and expectations of the elderly. Therefore, it is essential to develop bigger and better interventions that should begin with nursing schools. Training on comfort is essential both at the level of basic graduation and also at the post-work level.

2. METHODS

2.1 Aims

The main objective of this study is to identify the specifics of comfort in hospitalized elderly.

The specific objectives are to characterize the hospitalized elderly, to know the needs of comfort and the intervenient' role in the satisfaction of those needs, to identify moments and comforting strategies associated with the concept of comfort and also to identify the attributes associated with the concept of comfort/discomfort.

2.2 Design

The study design was a descriptive-exploratory pilot study, with a qualitative approach, carried out in accordance with Bardin's theoretical referential.^[10]

2.3 Participants

The participants were 12 elderly patients that were hospitalized in the pulmonology/oncology department of a public hospital in the area of Lisbon. The inclusion criteria were: being 65 years old, or older; being aware and oriented, or able to respond orally and produce a coherent speech, accepting to participate in the study, by sharing his/her "comfort/discomfort" experience.

2.4 Procedure

The data was collected through semi-structured audio-recorded interviews, in order to explore the meaning attributed to comfort by the elderly. The interviews were later transcribed, contemplating closed-ended questions related to the characterization of the sample, and semi-structured open-ended questions related to the needs and the concept of comfort/discomfort.

2.5 Data collection

The participants were asked to remember their hospitalization experience, regarding pleasant moments/situations of comfort and well-being, and also unpleasant moments/situations,

in order to identify the needs which were felt and their importance for the individuals' comfort and well-being, the care providers who responded to those needs, as well as the concept of comfort/discomfort.

2.6 Data analysis

According to Bardin,^[10] the qualitative data resulting from the collection of information were subject to thematic content analysis, with subsequent categorization, according to the characteristics defined for each category. Prior to the categorization process we define: unit of record as the unit of signification to be coded, being that we include words or phrases contained in the interview records; unit of context while the unit of understanding to encode the unit of registration and, which at present are identified as categories; units of enumeration as accounting for frequency units, with consideration for the reasons for comfort. For the categorization process we are based on the analysis model of the doctoral work of Pontífice-Sousa.^[1]

The last stage of the analysis was conducted with the purpose of identifying the main theme: between needs/expectations/wishes and an integrated comforting care. We are faced with a multi-contextual phenomenon, that balances needs/expectations/wishes and a care which is integrated and adjusted to the individuality of the hospitalized elderly patient.

2.7 Ethical considerations

The collection of this data took place in 2018, during the months of January and February, with the approval of the hospital's Ethics Committee. A favourable opinion was issued, thus respecting all the ethical and legal precepts.

3. RESULTS

3.1 Recruitment

The participants in the study were 12 elderly individuals with ages between 65 and 91 years old, of whom 7 were women and 5 were men. They are patients coming from the emergency service, with different pathologies, mainly of respiratory and oncological nature.

3.2 Main findings

Hospitalization has an impact on the comfort of elderly patients and in this study, four categories were discovered: needs that were felt/experience's context; intervenients' role/experience's context; ways and means of causing comfort/discomfort; attributes associated with the concept of comfort/discomfort.

4. DISCUSSION

4.1 Needs that were felt/experience's context in which they are inserted

In this category, 4 subcategories were identified, which intersect with the needs presented in Pontífice-Sousa's study. Considering the whole of the person, Pontífice-Sousa stresses that comfort needs are related to needs which emerge from different situations causing tension or stimulation where their intentional appreciation becomes crucial.^[1]

Regarding the changes in the health-disease process, they relate to the expressed wish to obtain relief from physical discomfort, and to obtain information/clarification.

Concerning the relief from physical discomfort, pain and other discomforts, like shortness of breath, interfere in the comforting experience:

[...] When they take the pain away, logically, I feel a lot better immediately! (E 6, 3)

[...] I feel the need to breathe better. (E 1, 2)

[...] I need to breathe better, in order not to get so tired. (E 1, 3)

[...] I felt the need to breath better, so I could do the small things, like going to the bathroom alone... shaving... eating. (E 7, 2)

It is clear that there is a predictable relationship between the mentioned discomforts, and the health-disease process and hospitalization, therefore the relief of these discomforts, such as pain and the disruptions of respiratory function, should be viewed as a concrete concern of the nurses and a real need for feeling comfortable.^[1] The relief of pain and other discomforts is a desirable goal, so that the person is able to restore his/her normal functioning and emotional balance.

With regard to the need for information/clarification, it assumes a significant expression:

[...] I felt so much need for information [...] and I thought that I was already free of all this. (E 5, 1)

[...] The main need I felt, and still feel, is being told things. (E 8, 1)

The need for information/clarification is a right of the individual and one of the ways in which the patient becomes aware of his/her situation, thus assuming a reorganizing role. Information is the basis of autonomous decisions making. These findings corroborate the research carried out in this area, stressing the importance of information for the comfort state of the elderly.^[1,6,7] When constructing a comforting

action, it is essential that the nurse seeks to know what the elderly patient needs and in what way he/she wants to be informed. In the elderly patient's reports, it was verified that the needs seemed to relate to attitudes towards "oneself and life", materializing in trust/safety, as a comforting way in the relationship with the care provided.

[...] I felt great uncertainty [...] a person already comes in fear. (E 8, 3)

[...] I do not wish anyone that insecurity and fear. (E 8, 6)

[...] Here in the hospital [...] I feel distressed and ashamed [...] to have confidence is fundamental. (E 3, 2)

Conquering trust is a condition to be able to help the patient and promote his/her safety, thus constituting a comforting instrument. Nursing literature highlights the importance of the nurse in this relationship of acceptance and trust, and, for this, a constructive dialogue is fundamental. The willingness of the elderly individual to trust someone is, in itself, positive and therapeutic.^[1]

Still in this study, it emerged, as a desire and will of the patient, wanting to feel helped/cared for.

[...] I felt needs [...] the worst is the issue of the bag [...] 3 years have passed and I cannot get used to it [...] at my son's house, it's my daughter-in-law who changes the bag and plates. (E 3, 1)

[...] The assistants help me in my hygiene, in the bathroom. (E 7, 6)

[...] Here, the nurses help me in everything I need and, so, I feel safer. (E 1, 15)

The elderly patient, as an ontological individual, has needs and particularities, being protagonist in the aging process and a social actor in his/her own story. Thus, he/she presents specific needs, in the disease process, that lead to specific care, in the sense that the person feels cared for.^[11] We have found that the option of asking for help falls into the hands of nurses, operating assistants and family members. However, nurses distinguish themselves by undertaking a professional action, acknowledged by the elderly, which responds to the different needs. In this regard, Bermejo^[12] argues that nurses are positioned as an essential element in the role of providing help and support when caring for the elderly.

Regarding the subcategory structure/functioning of the service, the participants stressed the privacy/individuality of the territorial space:

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[...] I felt the need to have the curtains closed

[...] Here, I have this gentleman next to me

[...] I don't like it. (E 2, 2)

Hospitalization is a constant invasion of privacy, since the space for care is public. The respect for privacy is a right that assists all patients, including the elderly. Therefore, its recognition is a basic right and a pillar of professional action. The lack of respect for this right may be associated with an increase in anxiety, stress, lack of confidence in the health professionals and refusal to undertake physical exams, possibly impairing the recovery of the cared Person.^[13]

Also in the subcategory structure/functioning of the service, the participants identify, as desirable needs, food which is well-prepared and adequate to the palate of the elderly individual and favourable environmental conditions:

[...] My Maria, when it's one o'clock, brings lunch, and that's when I feel better. (E 4, 15)

[...] The silence at night ... here it's complicated, you can't rest. (E 4, 4)

[...] Here, I have a television, that, believe it or not, keeps me company. (E 6, 2)

Promoting an adequate nutritional functioning is fundamental for the elderly patient in a hospitalization context, since it has great influence on metabolic functioning and hydro-electrolytic balance. The way foods are made and presented can contribute to the loss/increase of appetite. Research shows that a balanced and varied diet, based on an nutritional plan adjusted to each elderly individual, is a comforting response to these changes.^[14,15]

We noticed that the elderly patient, for different reasons (excessive noise and sounds produced by health professionals), has difficulty in falling asleep. Kolcaba warns about the importance of environmental conditions in the comfort of the hospitalized individual, emphasizing that a room/ward environment includes everything that can be manipulated by nurses, such as providing a quiet environment and leisure activities adjusted to the person.^[16] The need to replenish forces and energies during the day is linked to an increase in the number of disruptions during night sleep. In previous research, it is clear that nurses need to maintain a quiet environment, so that the quality of sleep of the elderly is not disturbed.^[1,16]

In the participants' report, it was evident the importance of the presence of the family as a comforting foundation. In this study, the subcategory family/significant people highlights the presence/support of the family:

[...] The part of being near my family, yes [...] my wife stays here until dinner time and helps me eat dinner and all [...] That's good. (E 1, 4)

[...] Talking with my family — when I speak of comfort here, in the hospital, I remember these things. (E 8, 9)

[...] Having my family here, at visiting time, and having my wife during the time of the significant person (it is a privileged moment of comfort). (E 4, 1)

[...] The time that I had to pass in isolation was very complicated, because of their lack (visits). (E 4, 3)

Hospitalization is an unpleasant event for the elderly patient, leading to the need for changes in living habits and the removal from the midst of family/significant people. The family, viewed as a group of individuals linked to each other by various bonds, namely blood, kinship, legal and emotional relations, constitutes a comfort reference for the greater possibility of, not only identifying specific needs in a timely manner, but also responding more adequately to the evidence of comfort.^[17] Family is recognized as an important and decisive resource in understanding the experienced situation, therefore its presence assumes a greater importance in the comforting dynamics.

4.2 Intervenients' role/experience's context

In this study, the elderly confirm the importance of multi-professional complementarity among the different caregivers. The obtained data demonstrates the importance of the nurse's role, as well as that of other intervenients/care givers, namely the doctor, the operating assistant and the chaplain. We thus identify two subcategories: "nurse, privileged actor of comfort" and "other intervenients of comforting care".

Regarding the "nurse, privileged actor of comfort", the importance of this professional is expressed, in the social context under study, by the significant declarations that follow:

[...] Nurses are the ones who comfort me the most. (E 6, 5)

[...] My needs were met by the nurses. (E 7, 3)

[...] You (nurses) strive to help me [...] I feel relieved. (E 1, 5)

[...] Normally, you (nurses) always give me my medication for nausea, you satisfy our needs as you can. (E 9, 2)

The nurse's role takes on a special and fundamental dimension in comforting care. Their particular actions materialize

in a relationship of help, through the capacity to find harmony with the elderly. The nurse reveals himself/herself in the capacity and competence mobilized to respond to the wishes, motivations and needs that orient the performance.^[1] Comfort is regarded as an objective of the nurses' work and as a response intentionally addressed to the needs of the hospitalized elderly.

Likewise, "other intervenients of comforting care" were referred to in the comforting process:

[...] My needs were met by the assistants. (E 7, 4)

[...] The chaplain was called by the nurse and stayed here with me about two and a half hours [...] we talked about my disease, about death, about my life [Pause] I talked about my daughters, my grandchildren [Pause] everything [...] it has done me so much good [...] so much good [...] you have no idea. We prayed together, now I can go in peace. (E 5, 10)

[...] I've been comforted several times, I can't say I haven't. I was comforted by the Doctor after learning my diagnosis, it's a moment I remember. (E 8, 4)

Although we realize that nurses are the health professionals who, in addition to training, have a greater global knowledge of the contexts/patients and their families, and that guarantee the comforting attention through their constant presence, other agents of comforting care can provide support and help in particular moments of the hospitalized elderly's experience. Thus, there is a broad zone of comforting intersection among the various caregivers. Elements of the multi-professional team assume a positive relation between the needs and the state of comfort. Apparently, the relationship and the affable atmosphere can be demonstrative of availability conducive to a humanized practice.

4.3 Ways and means of causing comfort/discomfort

This category was recognized in our research as one that intertwines with the already identified needs. According to the reports of the elderly individuals, two subcategories were defined, focusing on: "significant comfort moments/strategies" and "significant discomfort moments/strategies".

Regarding the "significant comfort moments/strategies", we present a register of seven sub-subcategories relating to: the presence of the family; the personal hygiene and preparation; the respect for the wish/will of the elderly patient; the positioning/mobilization; the positive interaction/communication with the elderly individual; the relief by administration of

therapeutics; and spirituality/religiosity. By contrast, the “significant discomfort moments/strategies” focused on the following six sub-subcategories: the presence of physical symptoms; the inadequate interaction/communication; the decrease/change in self-esteem/self-image; the lack of clarification/information; the unfavourable environmental conditions; and the physical restraint in bed.

From the “significant comfort moments/strategies”, the presence of the family had a significant expression:

[...] The part of being near my family, yes [...] my wife stays here until dinner time and helps me eat dinner and all [...] That’s good. (E 1, 4)

[...] Talking with my family — when I speak of comfort here, in the hospital, I remember these things. (E 8, 9)

[...] Having my family here, at visiting time, and having my wife during the time of the significant person (it is a privileged moment of comfort). (E 4, 1) [...] The time that I had to pass in isolation was very complicated, because of their lack (visits). (E 4, 3)

Family is a fundamental element in the satisfaction of the elderly’s comfort needs, being recognized as an important resource in the quality of life of those patients.^[18]

Personal hygiene and preparation contribute to a sense of individual well-being, since they not only maintain the body clean, but also promote, on their own — as Kolcaba points out — a sense of relief and well-being that promotes comfort^[18,19] and this is evidenced, by the elderly patients, through the following assertions:

[...] When they took me to the shower a few days ago [...] It felt so good. (E 2, 3)

[...] The shower was great [...] I immediately felt more comfortable. (E 2, 4)

[...] You (nurses of the department) always change this in the bathroom and immediately take the garbage bags away, so the smell doesn’t linger in the hallway [...] I felt better this way. (E 3, 4)

The respect for the will of the person is a fundamental value in the relationship of help, because it is the basis of any interaction, namely in the care of hospitalized individuals, being determinant to reach satisfactory comfort levels. The following respondents’ affirmations allowed to identify, as sub-subcategory, the respect for the wish/will of the elderly patient:

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[...] I can’t fall asleep if I’m completely in the dark [...] Your colleague (nurse) has placed a small presence light here [...] Immediately, I fell asleep better [...] Sometimes these little things suffice. (E 3, 5)

[...] I felt the need to ask them to always change my bag in the bathroom, and not in the infirmary, so that the other patients wouldn’t feel the unpleasant smell. (E 3, 3)

In elderly patients who are bedridden and unable to mobilize independently, it is evident the nurses’ concern in, not only providing a position suitable for the elderly’s rest, but also making the bed itself comfortable (1). It is an excellent method, that aims to increase the closeness between the nurse and the patient, because the alternation of positions implies the act of touching, which is an important comforting action. This was evidenced by the elderly, in the positioning/mobilization sub-subcategory:

[...] During the day that I had to be here in bed rest, it was you (nurses) that supported me. You changed my position. (E 6, 6)

[...] You (nurses) try to help me [...] on the other day, your colleague aided me, because she helped me to change positions and I ended up breathing better [...] I felt relieved and less tired [...] it felt good. (E 1, 5)

Nurses are aware that communication is fundamental in establishing a relationship of trust with the elderly patient, being sometimes affected by the process of senescence or by the disease situation of the elderly individual. It is vital to establish a dialogue which is productive, positive and adjusted to the capacities and needs, in order to achieve a positive communication, intentionally adequate to the elderly’s problems.^[1] The sub-subcategory positive interaction/communication with the elderly individual emerges as a comforting strategy, transforming the context into something significant and valuing the moment of nursing care, through the following assertions referred by the participants:

[...] Nurse X has been here, giving me attention for some time; she talked to me and she also let me speak. It was important. Believe it or not, it helps. (E 8, 5)

[...] It was the conversations that comforted me. (E 8, 7)

[...] I needed to speak with the priest, in this case the chaplain. It was the best thing. That which gave me more comfort. (E 5, 11)

[...] I remember the day the chaplain was here. Those hours brought me more comfort than you can imagine. I felt light [...] free [...] all good, believe me. (E 5, 19)

The sub-subcategory relief by administration of therapeutics is referred by the elderly as a technique that promotes comfort, through the relief of symptoms:

[...] The nurses make those aerosols and I feel better immediately. (E 7, 5)

[...] Normally, you (nurses) always give me my medication for nausea, you satisfy our needs as you can. (E 9, 2)

[...] When my pain is taken away, it is a moment of comfort. (E 6, 16)

Nurses are the health professionals who spend more time with patients and are the most qualified ones, through their interventions of pharmacological and non-pharmacological nature.

Recently, non-pharmacological interventions have assumed an increasingly relevant role in Nursing care. Spirituality/religiosity is the last sub-subcategory of the strategies that promote comfort:

[...] The chaplain was called by the nurse and stayed here with me about two and a half hours [...] we talked about my disease, about death, about my life [Pause] I talked about my daughters, my grandchildren [Pause] everything [...] it has done me so much good [...] so much good [...] you have no idea. We prayed together, now I can go in peace. (E 5, 10)

[...] I needed to speak with the priest, in this case the chaplain. It was the best thing. That which gave me more comfort. (E 5, 11)

[...] I remember the day the chaplain was here. Those hours brought me more comfort than you can imagine. I felt light [...] free [...] all good, believe me. (E 5, 19)

Spirituality is especially important in the aging process, as it is a personal search for meaning in life. In a situation of illness, the elderly individual is able to develop the capacity for acceptance, through the development of coping processes, leading to a greater sense and purpose of life and to the satisfaction with the latter. Spirituality/religiosity promotes the acceptance of the disease, as well as confidence and optimism regarding the treatment, thus preparing for the idea of

finitude. The difference between spirituality and religiosity is that the former is related to the meaning of one's life and the transcendent, while the latter involves participation or adherence to religious rituals.^[1,20]

At the opposite extreme, appears the subcategory "significant discomfort moments/strategies", in which six sub-subcategories were identified.

The first, the presence of physical symptoms, is reported, by the elderly, as unpleasant experiences inherent to the hospitalization process, being evident the negative way in which this experience is lived by the elderly, as it promotes suffering and discomfort.

[...] They forced me to use the mask all night, because they said I really needed it. (E 7, 1)

[...] The doctor had to take all the liquid out and pierce me here [...] I don't wish this to anyone. It's such a pain [...] it was very uncomfortable. (E 2, 6)

The aging process is multi-factorial, resulting in physiological deterioration of the organism, as well as neurological, articular and vision disorders, which lead to situations of low self-esteem, anxiety, dependence and isolation.^[21] These fragilities contribute to the increase of discomfort.

The decrease/change in self-esteem/self-image emerges as another sub-sub category and is mentioned several times as an uncomfortable moment:

[...] I felt somewhat uncomfortable [...] I realized that the night before I screamed, I tried to get out of bed, I climbed bars [...] anyway [...] I even urinated in bed [...] It felt terrible. (E 5, 13)

[...] For me, the worst is this yellowish colour. I can't even look in the mirror, it's horrible. I really look sick and this colour seems like the calling of death [...] I can't even see it. (E 6, 7)

In the elderly, communication is essential while providing nursing care, and it is fundamental that nurses pay attention to, and value communication with, the elderly patient, who becomes vulnerable due to illness, listening carefully, trying to provide information in a clear and objective manner, clarifying doubts and fears by involving the patient in his/her health process, so that he/she does not feel excluded.^[22] When this does not occur, it causes discomfort, as identified in the inadequate interaction/communication and lack of clarification/information sub-subcategories.

[...] The other day, a nurse came here and, playfully, called me yellow bird [...] Look, I don't

like it. I know the intention is good, you want to cheer us up, but... it was uncomfortable. (E 6, 8)

[...] I asked but they didn't tell me anything. The nurses said it was the doctor, the doctor said it was too early to be sure of the diagnosis. That was the worst phase [...] Anyway, they could have told me something right then. It's better to know, than not to know. I, at least, would prefer it. (E 8, 2)

Unfavourable environmental conditions are the penultimate identified sub-subcategory and they are related to environmental conditions such as light, noise/sounds, equipment (furniture), and the colour, temperature and natural or artificial elements of the environment.^[1,6] With aging, the quality of sleep is disturbed, being necessary to maintain a quiet environment for the elderly individual to sleep and rest. There are several factors that counteract this rest in the wards, such as: noise caused by other patients; sounds caused by the nursing staff; conversations between staff members; and the lights turned on in the ward.^[23] The unfavourable environmental conditions were thus referred to as discomforting in the following assertions:

[...] The nights are always uncomfortable, nurse. (E 1, 8)

[...] During the first nights I couldn't sleep, because of the noise. (E 4, 5)

The last sub-subcategory is physical restraint in bed. According to DGS n.º 8^[23] physical restraint is used in patients who put their safety at risk, or that of third parties, with hostile and/or destructive behaviours. In the context of care, whenever the interacting nurse perceives an act, verbal or behavioural, as aggressive, he/she elaborates a clinical judgment, always taking into account, however, his/her role as a professional. Thus, he/she has the duty to protect the patient from any risk, by placing him/her in a safe place, promoting and guaranteeing his/her privacy, in order to maintain the dignity of the individual.

[...] The worst thing I've experienced here was being tied to the bed! That made me crazy [...] it's a sensation, you've no idea [...] It was the worst of it all. They told me it was because I was incoherent and confused [...] but even if I was confused, that wasn't right. (E 7, 10)

Physical restraint, which involves weighing, not only the patient's safety (for instance, the risk of falling), but also

many ethical issues, must correspond to an occasional and sporadic action, duly contextualized, and always keeping in mind that the first option, when treating cases of psychomotor agitation, is chemical restraint (and not the opposite, as it often happens).^[24]

4.4 Attributes associated with the concept of comfort/discomfort

During the last century, the concept of comfort has been integrated into the development of theory, as well as practice. In scientific literature, there are several elements that characterize comfort, yet it remains a concept difficult to define and to apply in practice.^[25]

Comfort and discomfort are very subjective and antagonistic states. The lack of a single concept, and its deficiency when facing several aspects in various situations, points us to the importance of further investigation in this area. In all the definitions of comfort which were found, the satisfaction of the patient's needs, as an individual, appears as a common point, presupposing a knowledge of the phenomenon, from the perspective of patients, and its interaction with the practice of the professionals who provide it, in an action based on the respect for the individuality and subjectivity between the caregiver and the person being cared for.^[1]

In the opinion of the participants, this category presents, respectively, the following synonyms:

Comfort:

[...] It's a bit difficult to explain [...] it's being well. I associate it with well-being. (E 1, 10)

[...] I remember the days when I was a young man without any disease, without needing machines to breathe better [...] Yes... that was comfort! (E 1, 15)

[...] It's being without pain, without shortness of breath, being physically well. (E 1, 11).

[...] It's also being close to our loved ones. (E 1, 12)

[...] It's with the curtain closed, to be at ease. (E 2, 10)

[...] Being able to do all the small things [...] of everyday life [...] going to the bathroom alone. (E 4, 11)

Discomfort:

[...] It's being sick, physically ill. (E 1, 13)

[...] It's being alone without having the chance to be close to our loved ones. (E 1, 14)

[...] It's not being well, it's having something there that destabilizes you [...] I was having that problem with the gentleman next to me. I had no privacy. I was uncomfortable and upset because of it. (E 2, 13)

[...] Discomfort is the lack of information. (E 8, 10)

The essence of comfort, as opposed to discomfort, goes beyond its immediate connotation. The meaning and attributes of "comfort" and "discomfort", as opposing poles, assume a subjective dimension, as already mentioned, being, therefore, decisive to attend to the patient's individuality. Also in this study, assuming a multi-dimensional approach, the expression of the concept gains sense when related to the wish of "being well" and of "well-being", two concepts which are often used in an indistinct way. In this context, perceptions emerge, that are associated with the physical aspect (through the presence of pain, or other symptoms), and with the emotional aspect (through the need to be informed, the lack of autonomy and privacy, and the absence of family). There is, thus, an approach centred on the individual's ability, or potential, for personal harmony, or balance.

5. CONCLUSION

The elderly individuals are a socially more vulnerable and fragile group, which often resorts to hospitalizations. For this reason, nurses and students must be available to provide

relief, well-being and comfort to this population with very particular needs. Through a global analysis, the findings of this study reinforce the results of previous research, highlighting categories and subcategories that allow a balance between needs, expectations and wishes, and an integrated comforting care, adjusted to the individuality of the hospitalized elderly patient. The reality of the action's context has given rise to different domains which, although transversal to other care contexts, allow us to affirm that passing from knowledge to action is a fundamental intervention condition, in order to perceive a specific construction of each situation. Deepening the concept of comfort in this study, as well as in future research within the field of geriatric care, is a fundamental contribution to understand the meaning/sense of the comfort process that should be taken in consideration in training lines of nursing schools.

Nevertheless, the development of nursing knowledge in itself emerges, in research, always in pursuit of excellence in the professional nursing practice and in nursing training (insofar as the studies' results contribute to a reflective and integrative dimension of the theory-practice relationship).

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CONFLICTS OF INTEREST DISCLOSURE

The authors declare that there is no conflict of interest.

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