



REVISIONES

Comfort of patients in palliative care: an integrative review

Conforto de pacientes em cuidados paliativos: revisão integrativa

Confort de los pacientes en cuidados paliativos: una revisión integradora

Mariana Cristina dos Santos Souza¹

Rosângela Garcia Jaramillo²

Moema da Silva Borges³

¹ Nurse, Master in Nursing and Doctoral Candidate in Nursing, Graduate Program in Nursing, Nursing Department, University of Brasília - Brazil. marianacristinassouza@gmail.com

² Nurse, Master and PhD in Nursing, Brasília, Brazil.

³ Nurse, Master and PhD in Health Sciences, Professor of the Postgraduate Program in Nursing, Nursing Department, University of Brasília - Brazil.

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ABSTRACT:

Objective: Identify and synthesize the research on the comfort of patients in palliative care.

Method: Integrative review in 11 databases, with the following research question: "What are the strategies used to minimize the comfort needs of patients in palliative care?". The selected studies were submitted to content analysis; with the aid of the software *Interface de R pour les Analyses Multidimensionnelles de Textes et de Questionnaires* – IRAMUTEQ.

Results: The research identified 8,109 articles. After applying the inclusion and exclusion criteria, 16 articles were selected and analyzed. The dendrogram generated in the analysis performed with the aid of the IRAMUTEQ software made easier the identification of the main strategies used to minimize the comfort needs of patients in palliative care, as follows: social support network, comfort interventions and communication in palliative care.

Conclusion: The synthesis of the studies analyzed indicated that the main strategies used to reduce the patients' comfort needs in palliative care are support (from the team, social and family), physical contact, affection, communication, knowledge, pain relief, kindness, bathing, music therapy, radiotherapy, contact with the external environment (nature), recreation, contact with other people and spirituality. The studies showed that several non-pharmacological interventions, which seem trivial and of little technological complexity (such as availability, affection, support, bathing), have the ability to significantly affect the patients' state of comfort.

Keywords: Nursing; Patient Comfort; Palliative Care; Palliative Care in the End of Life; Thanatology.

RESUMO:

Objetivo: Identificar e sintetizar as pesquisas que versam sobre o conforto dos pacientes em cuidados paliativos.

Método: Revisão integrativa em 11 bases de dados, com a seguinte questão de pesquisa: "Quais são as estratégias utilizadas para minimizar as necessidades de conforto dos pacientes em cuidados

paliativos?”. Os estudos selecionados foram submetidos a análise de conteúdo, com auxílio do *software Interface de R pour les Analyses Multidimensionnelles de Textes et de Questionnaires* - IRAMUTEQ.

Resultados: Foram identificados 8.109 artigos. Após a aplicação dos critérios de inclusão e exclusão, foram selecionados e analisados 16 artigos. O dendograma gerado na análise realizada com auxílio do *software* IRAMUTEQ facilitou a identificação das principais estratégias utilizadas para minimizar as necessidades de conforto dos pacientes em cuidados paliativos, a saber: rede social de apoio, intervenções de conforto e a comunicação nos cuidados paliativos.

Conclusão: A síntese dos estudos analisados indicou que as principais estratégias utilizadas para diminuir as necessidades de conforto dos pacientes em cuidados paliativos são o apoio (da equipe, social e familiar), contato físico, carinho, comunicação, conhecimento, alívio da dor, gentileza, banho, musicoterapia, radioterapia, contato com o ambiente externo (natureza), brincar, contato com outras pessoas e a espiritualidade. Os estudos demonstraram que várias intervenções não farmacológicas, que parecem triviais e de pouca complexidade tecnológica (como disponibilidade, carinho, apoio, banho), tem a capacidade de afetar significativamente o estado de conforto dos pacientes.

Palavras-chave: Enfermagem; Conforto do Paciente; Cuidado Paliativo; Cuidados Paliativos na Terminalidade da Vida; Tanatologia.

RESUMEN:

Objetivo: Identificar y sintetizar las investigaciones que tratan sobre el confort de los pacientes en cuidados paliativos.

Método: Revisión integradora en 11 bases de datos, con la siguiente pregunta de investigación: "¿Cuáles son las estrategias utilizadas para minimizar las necesidades de confort de los pacientes en cuidados paliativos?". Los estudios seleccionados se sometieron a análisis de contenido, con la ayuda del *software Interface de R pour les Analyses Multidimensionnelles de Textes et de Questionnaires* - IRAMUTEQ.

Resultados: Se identificaron 8.109 artículos. Después de aplicar los criterios de inclusión y exclusión, se seleccionaron y analizaron 16 artículos. El dendograma generado en el análisis realizado con la ayuda del *software* IRAMUTEQ facilitó la identificación de las principales estrategias utilizadas para minimizar las necesidades de confort de los pacientes en cuidados paliativos, a saber: red de apoyo social, intervenciones de confort y comunicación en cuidados paliativos.

Conclusión: La síntesis de los estudios analizados indicó que las principales estrategias utilizadas para disminuir las necesidades de confort de los pacientes en cuidados paliativos son el apoyo (del equipo, social y familiar), contacto físico, afecto, comunicación, conocimiento, alivio del dolor, amabilidad, baño, musicoterapia, radioterapia, contacto con el entorno externo (naturaleza), juego, contacto con otras personas y espiritualidad. Los estudios han demostrado que varias intervenciones no farmacológicas, que parecen triviales y de poca complejidad tecnológica (como disponibilidad, afecto, apoyo, baño), tienen la capacidad de afectar significativamente el estado de confort de los pacientes.

Palabras clave: Enfermería; Comodidad del Paciente; Cuidados Paliativos; Cuidados Paliativos al Final de la Vida; Tanatología.

INTRODUCTION

Death, as well as birth, consists of a natural episode in human existence. Throughout the twentieth century, it ceased to be experienced in the dying man's homes, together with his family members — the “tamed death” — to be undergone in hospitals, in a solitary manner, with the patient surrounded by invasive devices and heavy technology — the “wild death” (1, 2).

At the present time, there is a consensus that the death process and dying need to be experienced in the most dignified and comfortable way possible. In this context, it is possible to point out the palliative care as an integrative model in the transition between life and death, referring to a historical rescue of the old practice of “tamed death”. The palliative care is “an approach that improves the quality of life of patients and their families facing the problem associated with life-threatening illness, through the prevention and relief of suffering by means of early identification and impeccable

assessment and treatment of pain and other problems, physical, psychosocial and spiritual” (3).

Palliate means comfort, relieve symptoms, listen, respect, share, welcome, follow the patient and family members until the end and after life. From this point of view, providing the maximum comfort to the patient is one of the main objectives of palliative care (4, 5).

Comfort, from the Latin word *confortare*, means to fortify, corroborate, provide, console, relieve, take care, help and assist (5). Comfort can be described as a complex and multidimensional construct, and it consists of a subjective, positive and individual experience, which can be lived in situations of the individual’s illness and/or treatment, and the desirable end lies in the patient care (5, 6). Kolcaba defines the comfort as the condition experienced by people who receive comfort measures. It is the immediate and holistic experience of satisfying (actively, passively or cooperatively) the needs of the three types of comfort — relief, tranquility and transcendence — in the four dimensions of human experience (physical, psycho-spiritual, environmental and social) (7).

Relief can be defined as the condition of a person who had a specific need met; tranquility, as the condition of calm and contentment; and transcendence, as the condition in which the individual overcomes problems and suffering (7).

This way, comfort can be experienced in four dimensions, as follows: 1 - physical, concerning the sensations of the body; 2 - psychospiritual, related to the inner self-awareness, including self-esteem, sexuality, self-concept, the meaning of life and relationship with a higher order or being; 3 - environmental, concerning the environment, conditions and external influences; and 4 - social, related to interpersonal and family relationships (7).

In this sense, knowing the patients’ comfort experiences becomes a relevant aspect for the palliative care practice, with the objective guiding the care provided according to the patients’ needs, in order to maximize the effect of comfort interventions (4). In this context, this review study aims to identify and synthesize the researches that deal with the patients’ comfort in palliative care.

METHOD

The study carried out an integrative review in a systematic way. In order to elaborate the research question, the study used the PICO strategy (acronym for patient, intervention, comparison and outcomes). This way, the question that defined the research was “What are the strategies used to minimize the patients’ comfort needs in palliative care?” According to the question, the strategy first element (P) consists of the patient in palliative care; the second (I) one relates to strategies; and the fourth element (O) concerns the patient's comfort. It is important to observe that, depending on the review method, not all elements of the PICO strategy are applied. In this integrative review, the third element, that is, the comparison was not used.

The study based the research strategy on the PICO combination, generating the following selection: (“Patients” OR “Hospice Care” OR “Palliative Care” OR “Terminal Care” OR “Palliative Medicine” OR “Neoplasms” OR “Death” OR “Aged”) AND (“Nursing Care” OR “Patient Care” OR “Patient Care Planning” OR “Hospice and palliative care

nursing” OR “Patient Care Team” OR “Nurse-Patient relations” OR “Nursing” OR “Oncology Nursing” OR “Interpersonal Relations” OR “Palliative Care” OR “Patient Comfort” OR “Holistic Nursing”) AND (“Patient Comfort”).

The research was carried out in November 2019 and adopted the following inclusion criteria: original articles published in Portuguese, English and Spanish; articles published from January 2009 to November 2019, made available online and with full text. The exclusion criteria were: repeated articles that did not address the topic of comfort in palliative care.

The databases used were: Scientific Electronic Library Online (SciELO), Latin American and Caribbean Health Sciences Literature (LILACS), Nursing Database (BDENF), Medical Literature Analysis and Retrieval System Online (MEDLINE), US National Library of Medicine (PUBMED), American Psychological Association (APA), Cumulative Index to Nursing and Allied Health Literature (CINAHL), CUIDEN, Web of Science, Cochrane and Scopus.

The analysis of the selected studies was submitted to content analysis with the aid of the software *Interface de R pour les Analyses Multidimensionnelles de Textes et de Questionnaires* (IRAMUTEQ), which performs quantitative analyzes of textual data based on the similarity of vocabulary, using tables, individuals/words. The corpus was elaborated through selected and translated studies, excluding tables, charts and references, organized in a single text file. Thus, the set of 16 selected articles constituted the corpus analyzed by the software.

RESULTS

The research identified 8,109 articles and, after the screening and eligibility steps, included 16 articles for analysis (figure 1).

Figure 1: Flowchart of the study selection process. Brasília, DF, 2020.

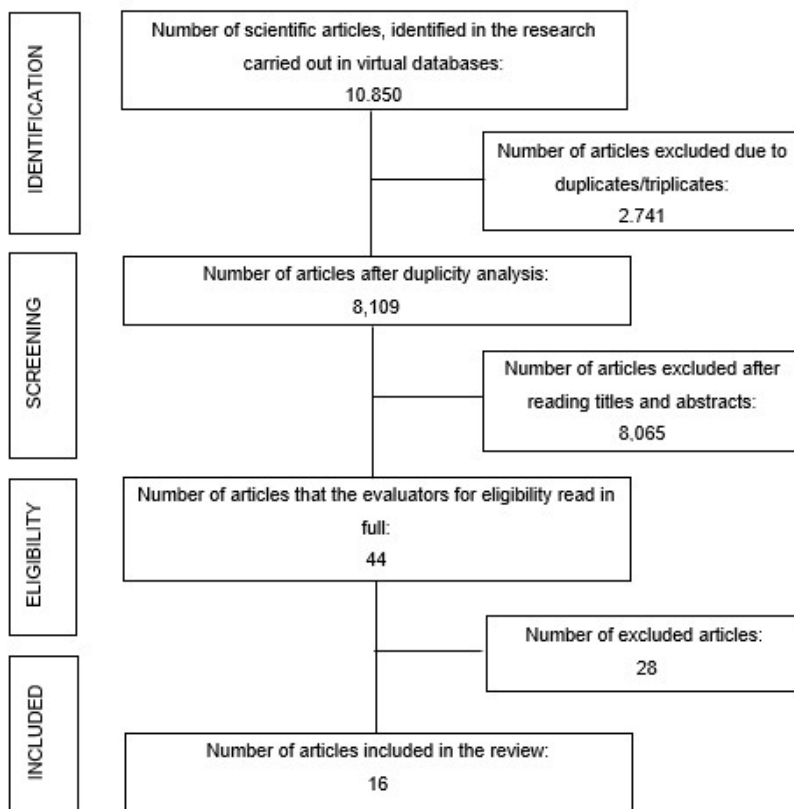


Chart 1 gathers relevant data obtained from the articles, such as authors, journals, location, year of publication, objectives and methods.

Chart 1: Summary of the articles selected by author, journal, location, year, objective year and method. Brasília, DF, 2020.

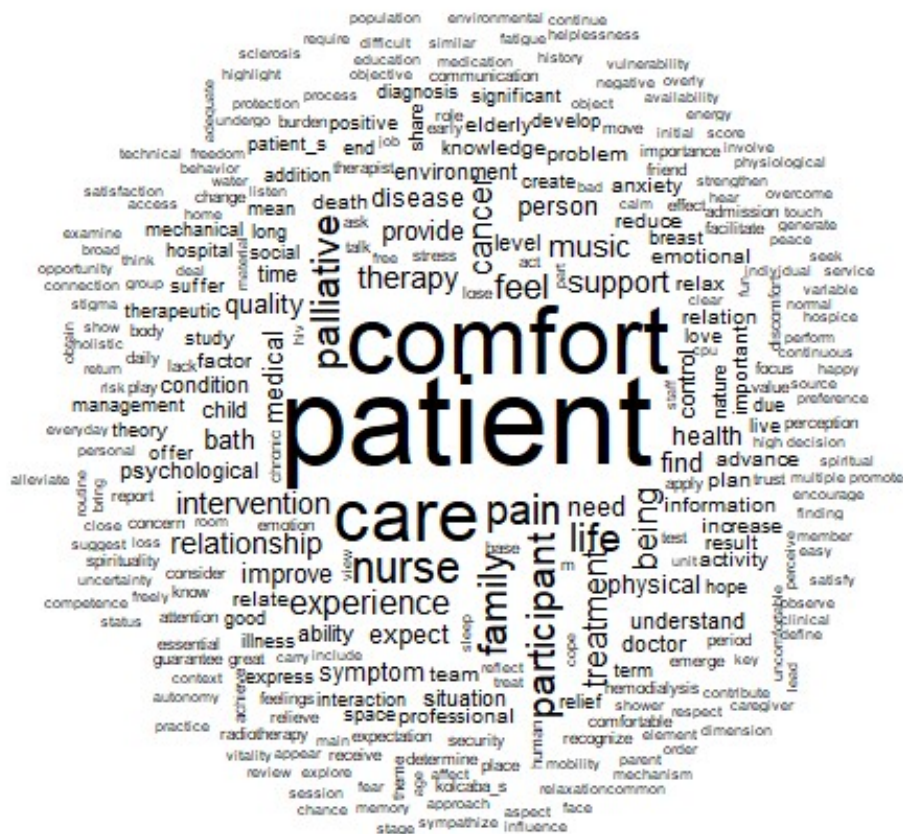
Nº	Authors	Journal, location, year	Objective and Method
1	Porter S, McConnell T, Clarke M, Kirkwood J, Hughes N, Graham-Wisener L et al ⁽⁸⁾ .	BMC Palliative Care, Ireland, 2017.	Examine the processes and experiences involved in the introduction of music therapy as a complementary therapy to palliative care. Mixed method.
2	Pehlivan S, Kuzhan A, Yildirim Y, Fadiloglu C ⁽⁹⁾ .	JBUON, Turkey, 2016.	Determine the comfort and quality of life in breast levels, in cancer patients undergoing radiation therapy. Quantitative.
3	Coelho A, Parola V, Escobar-Bravo M, Apóstolo J ⁽⁴⁾ .	BMC Palliative Care, Portugal, 2016.	Describe the comfort and discomfort experienced by patients hospitalized in palliative care units. Qualitative.
4	Skaczkowski G, Moran J, Langridge	Complementary Therapies in Clinical	Examine the level of bath intervention (spa) to reduce the pain and anxiety perception, and

	J, Oataway K, Wilson C ⁽¹⁰⁾ .	Practice, Australia, 2018.	improve well-being among palliative patients. Quantitative.
5	Fujimoto S, Iwawaki Y, Takishita Y, Yamamoto Y, Murota M, Yoshioka S ⁽¹¹⁾ .	JJCO, Japan, 2017.	Evaluate, using physiological and psychological techniques, the bath effects in terminally cancer patients. Quantitative.
6	Abolhassani S, Yazdannik A, Taleghani F, Zamani A ⁽¹²⁾ .	Iran Red Crescent Med J, Iran, 2015.	Identify the individuals' expectations with multiple sclerosis, as well as their families', regarding health services. Qualitative.
7	Melo GAA, Aguiar LL, Silva RA, Quirino GS, Pinheiro AKB, Caetano JA ⁽¹³⁾ .	Rev Bras Enferm, Brazil, 2019.	Analyze the factors related to chronic hemodialysis renal patients' impaired comfort. Quantitative.
8	Ito Y, Okuyama T, Ito Y, Kamei M, Nakaguchi T, Sugano K et al ⁽¹⁴⁾ .	JJCO, Japan, 2015.	Explore the characteristics of a good death for children with cancer. Qualitative.
9	Rustøen T, Gaardsrud T, Leegaard M, Wahl AK ⁽¹⁵⁾ .	Nursing Pain Management, Norway, 2009	Explore the experiences of cancer patients in managing the pain control through nursing, during hospitalization for cancer treatment. Qualitative.
10	Slomka J, Prince-Paul M, Webel A, Bolton FP, Daly BJ ⁽¹⁶⁾ .	J Assoc Nurses AIDS Care, USA, 2017.	Understand how individuals perceive palliative care and advanced care planning. Qualitative.
11	Zimmermann C, Swami N, Krzyzanowska M, Leigh N, Rydall A, Rodin G et al ⁽¹⁷⁾ .	CMAJ, Canada, 2016.	Examine the perceptions about palliative care in patients with advanced cancer and their caregivers. Mixed method.
12	Nuraini T, Andrijono A, Irawaty D, Umar J, Gayatri D ⁽¹⁸⁾ .	Indian Journal of Palliative Care, Indonesia, 2018.	Develop a relational model between the variables of nursing care (information, emotional support, technical support and palliative care); patient coping, family support, patient's spirituality and comfort. Quantitative.
13	Ebrahimipour F, Hoseini ASS ⁽¹⁹⁾ .	Journal of Palliative Care, Iran, 2018.	Apply Kolcaba's theory of comfort to children with cancer. Case study.
14	Olausson S, Fridh I, Lindahl B, Torkildsby AB ⁽²⁰⁾ .	Crit Care Nurs Q, Norway, 2019.	Explore the meanings of comfort from a theoretical and empirical perspective, to increase the understanding of what comfort

			means for ICU patients. Qualitative.
15	Kim E, Kim K ⁽²¹⁾ .	Applied Nursing Research, South Korea, 2017.	Investigate the meaning of comfort experienced by elderly people in hospitals using a phenomenological approach. Qualitative.
16	Johnson SB, Butow PN, Kerridge I, Tattersall MHN ⁽²²⁾ .	International Journal of Palliative Nursing, Australia, 2017.	Explore how cancer patients and their families value autonomy at the end of life and understand how it can affect their development, decisions and end-of-life planning. Qualitative.

The 16 articles were submitted to content analysis of the IRAMUTEQ software, which generated the word cloud (Figure 2). The word cloud organizes the words into graphic groupings, based on their frequency, which is a simple and graphically easy lexical analysis.

Figure 2: Word cloud of the selected articles. Brasília, DF, 2020.



The software carried out the corpus cleavage into 195 text segments (ST), with the use of 151 ST's (77.44%). The result was 6,984 occurrences (words, forms or vocabularies), among these 1,255 distinct words and 589 words with a single occurrence. The study categorized the content analyzed into three classes: (1) class 1: social support network,

with 48 ST's (31.8%); (2) class 2: comfort interventions, with 70 ST's (46.4%) and (3) class 3: communication in palliative care, with 33 ST's (21.9%).

Figure 3: Dendrogram of the analysis of the articles selected for the study. Brasília, DF, 2020.



DISCUSSION

Word cloud

According to Figure 2, the most prevalent words were patient, comfort, care, palliative, life and pain. In the palliative care scenario and according to the analyzed articles, it is possible to understand that the patient is the focus of care and that the patient comfort is the main objective of this care. The end-of-life care is seen in a palliative manner, due to the development of the underlying disease. However, the palliative condition aims to seek the patient's quality of life and minimize the pain, caused by the disease condition.

Class 1: Social Support Network

In its first definition, the expression "social support" is understood as the interpersonal exchanges that include the following elements: affection, affirmation and help. The affective exchanges involve liking, admiring, respecting and/or loving; The affirmation exchanges imply the recognition of the other person and the legitimation of his actions; the help exchanges are those related to assistance or help regarding resources, money, information and care ^(23, 24). This social network permeates the individual's entire life and,

throughout it, the network is transformed ⁽²⁵⁾. As examples of these networks, it was possible to identify, in the selected texts, the health team, family, friends, society and employment, providing psychological and financial support.

The patients reported that the simple fact of staying in a hospital, under the care of the health team, already transmitted comfort. Anxiety was reduced when they realized the doctors and nurses' role in care. The presence of both provided a reduction in the feeling of loneliness and brought relief ⁽²¹⁾.

The support offered by the health team is so important that one of the articles reported the case of a patient who decided to change his doctor because the professional did not pay attention to him and was not sympathetic to his needs ⁽¹²⁾.

The nurses were described as affable, helpful, kind, understanding, fantastic, friendly and close. Skills such as caring, empathy, being present and trustworthy appeared as a common definition for nurses ⁽¹⁵⁾. The medical team contributes to the relief of anxiety, fear and the feeling of powerlessness, while companions are a link between the patient and the health team, providing emotional support and security, and helping with advice for life after discharge ⁽²¹⁾.

In the children's view, the professionals help when they spend time playing with them, being trustworthy, wishing the best for them, having a friendly relationship, looking for the best for their health, demonstrating that they care and visiting them when they are alone ⁽¹⁴⁾. In this context, health professionals guarantee the safety and protection of patients when establishing relationships with them ⁽²¹⁾.

As a form of comfort, the patients expressed the need for psychological support, not only during the diagnosis, but also throughout the course of their disease. They expect professionals to consider their needs and sympathize with them ⁽¹²⁾.

During hospitalization, the patient also lives with other patients in the same situation and with their companions. This is also a form of support, in which everyone helps each other and, if they need something, they get support from the closest people ^(15, 21). A study involving a hospitalized child showed that living with another child improved his comfort scale. The authors described that this intervention not only helped to satisfy the need for relief, but also satisfied the need for tranquility, due to the continuity of the interactions and emotions of children who supported each other. If cancer patients have each other, gaining support against tension, loneliness and helplessness, the hope and desire to maintain life is reborn among them. The consequences of these interactions can help to overcome pain and achieve transcendence ⁽¹⁹⁾.

The family support is present in patients in palliative care. One of the articles indicates the wishes of children in terminal care regarding this support, presented as: the presence of family members when children are anxious; a close family; support from the family; reliving memories with the family; a good relationship with the brothers; not wanting the family to lie; not wanting the family to give bad news; not feel like a burden; realizing that relatives are not overly concerned about health; feel that he/she is not a nuisance for family members; not wanting to see relatives excessively sad, but happy and smiling ⁽¹⁴⁾. Promoting an environment in which patients are able to truly connect with their relatives and family is an important factor in achieving a good death.

Financial support is another assistance mentioned in the articles. Those who had jobs would like their employers and companies to understand the moment they are going through, and expressed fear of being fired due to their disease. Some expected financial support due to the need for continuous treatment in various services, the use of expensive drugs, the impact of the disease on their work and income, and problems in meeting treatment costs ⁽¹²⁾.

In the study of patients with Multiple Sclerosis, the patients mentioned the social support. They wanted the establishment of a cultural conscience, because they experienced the social stigma resulting from an inadequate awareness of this disease and people's bad behavior, and believed that the media could be effective in this change of thought, through reliable information about the disease and the education aimed at the population ⁽¹²⁾.

The study that listed the reasons for the patients' discomfort indicated that nurses should reduce and modify some variables that unleash the impaired comfort, seeking to reestablish the social and family bonds that may have been lost. Thus, the interpersonal support importance during the terminal patient care becomes evident ⁽¹³⁾.

Class 2: Comfort interventions

Kolcaba says that nurses should assess the patient and understand his/her comfort needs, provide nursing assistance and help the patient to strengthen his/her support sources (such as coping, family support and spirituality). According to the comfort theory, it is well known that relaxing interventions (massage, therapeutic touch, etc.) increase the patient's comfort. It is possible to observe changes related to relaxation, positive thinking, feelings of well-being and happiness in patients with greater comfort ^(26, 27).

The palliative care interventions must start at the time of diagnosis and continue throughout the treatment, managing the control of pain and all global symptoms ⁽²⁸⁾. They can be carried out by a multiprofessional team composed of professionals such as nurses, psychologists, doctors, social workers, pharmacists, nutritionists, physiotherapists, phonoaudiologists, occupational therapists, dentists and spiritual assistants ⁽²⁹⁾.

The pain was one of the needs that patients expressed. For pain relief, it was important that nurses had time to listen to the patients' complaints, help them and be aware of the pain discomfort signs. One of the patients reported that the conversation with the nurses relieved the pain. This relief also occurred when nurses hugged them or held their hands ⁽¹⁵⁾. Other articles also related feelings of concern, affection, trust and security to comfort ^(4, 20, 22).

When pain is relieved after admission to the hospital and symptoms are controlled (invasively or not), it is possible for patients to sleep, eat, move and clear the mind, causing the body to return to normal. The pain relief with the doctors and other patients' support helps patients achieve comfort and, by achieving it, they manage to improve their vitality ⁽²¹⁾.

Another need mentioned was the stress management. In the study with children in terminal stages, they said that they wanted relief from pain and physical stress;

suspension of tests, medications and painful and unnecessary treatments; comfort and care/affection; guarantees about tests and treatments; and care and kindness when painful parts of the body were touched ⁽¹⁴⁾.

Two of the selected articles indicated that the bath appears as a comfort intervention. Bathing decreased pain, heart rate, fatigue, anxiety and improved the patients' well-being. Well-being is related to the possibility for the patient to move the limbs, which were normally too heavy to be lifted out of the water, corroborating with other studies that showed that impaired physical mobility accentuated the patients' discomfort ^(10, 13). The answers that the patients gave about the bath reported that it was comfortable, easy, restful, pleasant, relaxing and exciting. When asked if they would like to continue with the practice, everyone answered yes. The bath brought physical and psychological comfort to patients, and it was possible to conclude that the method is safe and analgesic for terminal patients ⁽¹¹⁾.

Music therapy was another intervention identified to achieve the patient comfort. This aid in relieving physical and psychological suffering has the ability to help the patients reconnect with happy memories, help in identifying key moments in life that helped them to define their relationships, help patients to have fun again and strengthen emotional bonds (with friends, family and health team). The patients also stated that music therapy leaves them relaxed, improving mood and well-being. Music therapy helps in the search for transcendence and meaning, creating a lasting environment of comfort for patients and their families ⁽⁸⁾.

Radiotherapy was another strategy mentioned. The study found a positive correlation with comfort after radiotherapy sessions and patients' quality of life, reducing cancer symptoms ⁽⁹⁾.

The palliative care units were mentioned as a source of relief from physical discomfort and as a source of comfort in the human sphere, due to the attention of the health team and quick action in relation to the patients' needs. Some factors such as professional competence and individualized care are differentials for the patient's comfort in palliative care. However, these units are also seen in an uncomfortable way, due to the physical and social losses of the patients admitted there and the awareness of finitude ⁽⁴⁾.

The environment also influenced the feeling of loss of freedom, due to the fact that there is no external space (contact with nature) and due to the need to share the room with another patient, depriving the patient of his/her freedom. For some patients, however, sharing a room represented an improvement in social comfort, allowing them to share their experience with other patients. In short, the importance of providing a physical environment that is as similar as possible to the patients' daily lives becomes evident, so that they can live and establish social relationships normally until their death ^(14, 20).

The comfort also resulted from the relationship with the sacred, represented by God and nature ⁽⁴⁾. Spirituality influences the patient's perception of discomfort and illness. One study showed that patients who approached God were more likely to have better emotional well-being and, on the other hand, those who distanced themselves from God were more likely to have their emotional well-being impaired. Therefore, it is important that nurses encourage patients to improve their emotional well-being through prayer and other spiritual practices ⁽¹⁸⁾.

Class 3: Communication in palliative care

Communication is another form of comfort intervention that can be implemented in terminal patients. Effective communication can enhance the patient's comfort, as well as failures in communication or information omission enhance his/her discomfort and affect the service reliability.

The doctor's omission in relation to the diagnosis was one of the problems faced by some patients. For other patients, the diagnosis was said ambiguously, so that the patient experienced fear and concern due to a lack of adequate knowledge. The expectation was that doctors would give them the diagnosis and provide adequate information about the disease and possible treatments during all stages of the disease, in order to prevent the patient from developing an expectation of a rapid recovery ⁽¹²⁾. The patients expressed a desire to know the truth about their condition and treatment ⁽¹⁴⁾.

The statement that the patient was under palliative care was another factor related to communication. In the study with HIV patients, most participants did not know the meaning of palliative care and some of them, who understood a little better, had a negative perception, shock and fear, for directly relating the palliative care to death. However, when the researcher explained the definition, the participants reported that they did not receive this type of care and that they were eager to learn more ⁽¹⁶⁾.

Another study also showed that the participants related the palliative care to death, that this type of treatment was inserted when there was nothing more to do for the patient. Rejection and resistance were common reactions, and many stated that they tried not to think about palliative care, trying not to be negative. Others did not consider the matter relevant, because they felt that they were not qualified to receive palliative care (denial of the real condition). The resistance to palliative care was a predominant theme, but the participants also stated that their initial doubts were alleviated thanks to the explanation of oncologists or researchers ⁽¹⁷⁾.

Some patients, who have had previous experiences with their terminally ill option, usually followed by an apology. The ignorance of the term meaning may hinder the progress of the palliative care promotion in the early stages of chronic and terminal illnesses ^(16, 17).

It was possible to observe that patients needed to be instructed to obtain more information about the disease and how to assist in the treatment, in order to become a care-promoting agent ⁽¹⁴⁾. Although the nurses asked about the pain, the patient felt, the patient did not talk about his/her pain. Patients expected nurses to provide information and share knowledge. The support offered through adequate information affects the patient's coping with his/her condition, so that he/she experiences less uncertainty and anxiety when information and knowledge are shared verbally and non-verbally ^(14, 18). It was possible to verify that some patients also highlighted the importance of written materials on pain and illness ^(12, 14).

The participants also highlighted the importance of educating their families about the disease and its effects. They realized that this action resulted in a better family acceptance in relation to the patients' problems and in the adjustment of expectations based on the patient's condition ⁽¹²⁾.

Regarding the pediatric patients, considering that children are usually immature and have a limited ability to communicate verbally, playing with other people, including the team, can be a useful alternative in verbal communication and an essential element of care ⁽¹⁴⁾.

Communication goes far beyond words and content, as it includes attentive listening, looking and posture, becoming an efficient therapeutic measure for terminally ill patients ⁽³⁰⁾.

As a study limitation, it was possible to notice that the use of the PICO search strategy in databases, despite the proof of its efficiency in other studies, is still a strategy under development and some studies may not have been captured. As strength points, we can mention the use of software to help identify the most prevalent words and the dendogram, which guided the researchers more efficiently in relation to the contents of the classes to be discussed and the process of searching and selecting articles, thus leaving the selection process more rigorous.

CONCLUSION

The synthesis of the studies analyzed indicates that the main strategies used to mitigate the patients' comfort needs in palliative care are support (from the team, social and family), physical contact, affection, communication, knowledge, pain relief, kindness, bathing, music therapy, radiotherapy, contact with the external environment (nature), recreation, contact with other people and spirituality.

Studies have shown that several non-pharmacological interventions, which seem trivial and of little technological complexity (such as availability, affection, support, bathing), have the ability to significantly affect the patients' state of comfort.

It is necessary to strengthen the use of these interventions in the practice of palliative care, aiming at improving patient's care and palliative care, taking into account the physical, psychological, social and spiritual spheres, as well as training professionals in the use of these interventions and in the comprehensive patient's care.

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