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Comforting Interventions Applied to the Adult/Aged Individual at the End of Life in a Hospital Context: Integrative Review

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Abstract

***Background:** At the end of life, the adult/aged individual experiences suffering and discomfort, resulting, in most cases, in the need to be hospitalized. Thus, the health care requires a multidisciplinary and individualized approach, centred on the promotion of comfort.*

***Purpose:** To identify comforting interventions, in the care of adult/aged individuals at the end of life, considering a hospital context.*

***Methods:** According Whittemore&Knafl, an integrative review of the literature was performed, using the EBSCOhost and RCAAP databases, within the period comprised between 2012 and 2018. The data analysis was conducted according to Morse & Field and Amado.*

***Results:** Among the various ways and means of comforting, we identified 71 comforting interventions, within all the comforting contexts, which were divided in comfort strategies (≈ 89%) and personal moments of comfort (≈ 11%), taking into account the suffering and discomfort of the patient and his/her family.*

***Conclusions:** Respecting the individual in his/her uniqueness and globality, the provision of comforting care to the hospitalized adult/aged patient at the end of life is achieved through interventions that try to acknowledge the basic and more complex needs, which presupposes flexibility and intentionality when providing care, especially in the field of nursing.*

Keywords: *Patient Comfort, Hospitalization, Terminal Care, Adult, Aged.*

Introduction

The world's population is getting older. By 2050, in all regions, except Africa, almost a quarter of the inhabitants will be over 60 years of age [(1)]. The global number of elderly individuals is expected to be 1.4 billions, by 2030, and 2.1 billions, by 2050 [(1)]. Portugal is no exception to this tendency. In 2013, it was the fifth country with the highest aging and elderly dependency ratio, within the 28 countries that form the European Union [(2)].

The increased longevity is related to the scientific and social progresses achieved throughout the 20th century and the first decade of the 21st century, which lowered the incidence of death after a short period of disease [(2,3,4)].

Currently, the end of life is often experienced in a hospital environment [(3,4)]. In 2010, approximately 62% of the deaths in Portugal occurred in a hospital context [(4)]. Socially, the hospital is considered a place with human and material resources that allow the maintenance of life, being able to give a last hope regarding the prognosis. In addition, the social

changes, the unknown, the fear of death and the lack of family resources contribute to the hospitalization [5,6].

Providing care to the adult/elderly patient at the end of life is complex, involving an individualized and multidisciplinary approach. Once hospitalization is required, it becomes paramount to optimize care and to transfer the palliative care competencies to the new context, aiming to provide the maximum level of comfort.

Comfort is a key element and a fundamental value in nursing care [8,9]. Usually, it is applied in the various contexts and it is part of the routine language of nurses, being frequently associated with the physical dimension of the individual. However, the concept transcends this dimension [10].

Comfort is defined as a condition in which several basic needs are met, related to: the states of relief (states in which the patient's needs are satisfied, being essential to restore his/her normal functioning), tranquility (a state of calmness or satisfaction, necessary to an efficient performance), and transcendence (a state in which an individual feels that he/she has the skills or the potential to plan, control his/her fate, and solve his/her problems) [11,12]. It can also be defined as the state experienced by a person, when he/she feels comforted: able to feel more and better. It can be perceived as getting better (to gain control and capacity, and to obtain relief and satisfaction), or as feeling more valued through the nurse's action (feeling support and affection, having a purpose and meaning, and feeling confidence) [13].

The state of comfort can be experienced in four contexts: physical (related to the body's sensations and homeostatic mechanisms), social-cultural (including interpersonal, family and social relationships, as well as family traditions, rituals and religious practices), psycho-spiritual (including self-awareness, self-esteem, the concept of sexuality, the meaningfulness in someone's life, and faith), and environmental (referring to external environments, conditions and influences) [11,12].

Nursing interventions should promote comfort, since the latter is a care factor and a competence of the nurse [14]. The nursing care should be adjusted to the individual, responding to his/her uniqueness and needs, in order to be comforting [11,13,14,15]. However, nursing care is a complex social, multi-contextual, integrative, individualized and subjective process, that deals with multiple dynamic variables and assumes a logic of commitment, intentionality and mutuality throughout its duration [14,15].

The comforting process requires knowing the patient subjected to care, and managing the comfort and the risk [13]. Thus, through their objective purpose, the different manners of comforting: seek to facilitate comfort, to alleviate discomfort and/or to invest in the potential comfort; lead to an increased perception of control over life and the experienced situations; contribute to the feeling of normality and allow the patient to look ahead, even during hospitalization [14,15]. The comforting interventions translate into comfort-promoting strategies used by the nurse and personal moments of comfort [14]. The latter emphasize the individual's uniqueness and the respect for his/her identity, highlighting the nurse's values during a comforting action based on the profession's standards and principles [16].

Being comfort a concept of extreme importance for nursing sciences and of great applicability in the context of care practice, it is fundamental to study the comfort phenomenon in a way that is also beneficial to those who receive nursing care.

With the purpose of contributing to a broader knowledge of this phenomenon, we sought to answer the following research question: which are the comforting interventions applied to the adult/aged individual at the end of life, in a hospital context? The construction of the research question followed the PICO methodology [17].

The objective of this integrative review is to identify the comforting interventions applied to the adult/aged individual at the end of life, in a hospital context, based on the available scientific evidence.

Method

Research Strategies

An integrative literature review is a research method that synthesizes past empirical or theoretical literature, to provide a comprehensive understanding of a phenomenon [18]. It includes the analysis of relevant research that supports the decision making process and the improvement of clinical practice, it enables the synthesis of the existing knowledge regarding a

phenomenon, and it identifies knowledge gaps that need to be filled with further studies [19]. It is considered a method of great importance for nursing, since it allows the development of policies, protocols and procedures, as well as critical thinking in the provision of care [20]. The integrative review methodology was selected, since there are few primary works about the researched phenomenon and it allows gathering studies that employ a broad methodological approach. The research was conducted using the following databases: EBSCOhost — Research Databases (CINAHL® Plus with Full Text, MEDLINE® with Full Text, Nursing & Allied Health Collection, MedicLatina); and RCAAP — "*RepositóriosCientíficos de AcessoAberto de Portugal*". In these databases, we searched for scientific evidence between January 2012 and January 2018.

In EBSCOhost — Research Databases, the search was based on the following "Boolean phrases": "Patient Comfort", "Terminal Care", "Palliative Care", "Hospitalization", "Quality of Life", "*Conforto*", "*Hospitalização*" and "*CuidadosPaliativos*", combined in many different ways, using the "AND"/"OR" search operators. We searched the descriptors within the full text and we only considered reviewed articles in the "Full Text" system, with available references, analyzed by experts, included in academic and scientific journals, and published in English and Portuguese. On the other hand, in RCAAP — "*Repositório Científico de Acesso Aberto de Portugal*", the search was based on the subsequent "Boolean phrases": "*Conforto*", "*Hospitalização*" and "*Cuidados Paliativos*", combined with the "AND"/"OR" search operators. The descriptors were searched in the full text and we considered scientific papers, Master's Dissertations and PhD Theses, published in English and Portuguese.

We obtained an initial sample of 2088 studies which were evaluated according to the following inclusion criteria: adult/aged individual at the end of life, in a hospital context; comforting interventions applied to the adult/aged individual; comforting interventions applied to the adult/aged individual in need of palliative care; comforting interventions applied to the adult/aged individual at the end of life. Through the analysis of the titles, of the abstracts and, later, of the each paper's full text, we eliminated the articles that did not met the criteria, as well as those which were repeated. As a result of this selection, we obtained a bibliographic sample of five studies.

Method's Synthesis

The integrative review was conducted according to the methodology suggested by Whittemore&Knafl[18]. It includes the following steps: 1) problem's identification; 2) search; 3) data evaluation; 4) analysis; 5) presentation of the results [18].Subsequently, a table was created for the extraction of data, based on the analysis table proposed by Ursi[21], taking into account the following aspects: a) article's title; b) authors; c) journal's title; d) publication date; e) descriptors; f) method; g) evidence level; h) objectives; i) participants; j) interventions; k) results; l) notes/ other information.

Qualitative Analysis

The selected studies' analysis was conducted by two reviewers, the authors. After the data extraction, its qualitative analysis was performed, according to the methodology proposed by Morse & Field [22] and by Amado [23], exploring, in depth, specific topics. The quality of the obtained information was the most relevant criterion that we took into account [22,23].

Results

Studies' Description

The five analyzed studies were authored by nurses, were published between 2012 and 2017, had an academic or scientific scope, and corresponded to qualitative studies, literature reviews and Master's dissertations.

They were all developed in a hospital context, namely in internal medicine services [16,25,27] and in an intensive care unit [26]. They were conducted in several geographic regions, with very different political and economic backgrounds: Portugal [16,25,27], Brazil [24] and Turkey [26].

Table 1. *Search results* [16, 24, 25, 26, 27]

Article's title	***O Cuidado Geriátrico: Modos e Formas de Confortar*** [16]
Author(s)	Ribeiro PCPSV, Marques RMD, Ribeiro MP
Journal's title	REBEn
Publication date	2017
Country	Portugal
Descriptors	*Enfermagem Geriátrica*; *Idoso*; *Hospitalização*; *Cuidados*; *Promoção do Conforto*[ii]
Method	Ethnographic study with a qualitative approach. • Data collection methodology: participant observation and semi-structured interview.
Evidence level [28]	Level 4
Objectives	To know the ways and means of comforting perceived by the hospitalized elderly, in an internal medicine service.
Participants	22 elderly chronic patients, admitted to an internal medicine service (intentional non-probabilistic sampling).
Interventions	Data was collected through semi-structured interviews with elderly patients, and through observation focused on any nursing intervention that happened with (or to) the elderly patient; it has led to the definition of: comforting strategies and personal moments of comfort.
Results	Comforting strategies: clarification/information; positive interaction/communication; music therapy; touch; smile; unconditional presence; empathy/complicity relationship; integrating the elderly/family as a partner in care; relieving discomfort through massage/mobilization/therapy. Personal moments of comfort: first contact; moments of personal hygiene and preparation; family visits.
Article's title	***Conforto como Resultado do Cuidado de Enfermagem: Revisão Integrativa*** [24][iii]
Author(s)	Ponte KMA, Silva LF.
Journal's title	Journal of Research Fundamental Care Online
Publication date	2015
Country	Brazil
Descriptors	Comfort Care; Nursing; Nursing Care
Method	Integrative literature review
Evidence level [28]	Level 4
Objectives	To identify comforting actions as a result of nursing care, in the papers published by Brazilian nurses, taking into account the principles of Katharine Kolcaba's "Theory of Comfort".
Participants	Hospitalized patients with comfort needs.
Interventions	Analysis of the selected papers' content, through the integrative literature review methodology.

Results	Through the analysis of the selected studies, 181 thematic analysis units were identified, and these were grouped according to the comfort contexts of Katharine Kolcaba's "Theory of Comfort". 1. Physical Comfort: pain relief; palliative care; touch/ direct contact; positioning; food; hygiene; dressings; skin care; relieve of pressure zones; massage; therapeutic baths for pain control; avoidance of unnecessary and invasive handling; O_2 support and aspiration of secretions; ostomy care; application of heat/cold; providing affection/ attention; pads with alcohol; providing a suitable pillow; absence of injuries; good food; nausea and vomiting control; medication administration; rest; non-invasive mechanical ventilation; being healthy and receiving warmth, affection and attention; sedation in patients with severe respiratory failure; vital signs control; breathing methods; satisfying basic needs; relief of symptoms; presence and caresses; cuddling; respecting privacy and modesty; providing protection. 2. Social-cultural comfort: family's presence and support; music therapy; offering support to the family members; good understanding; health education; giving advice about the disease; being available to the patient; welcoming the patient; care by family members; family interaction; being by the patient's side; having/providing quality of life; interaction with family and friends; entertaining the patient; family members as caregivers, supporting the daily life activities; seeing other patients (in the same situation); integrating social, psychological and spiritual aspects; mediated reading; leisure activities; having the team's support and attention; social support; respecting the social-cultural aspects; interaction between the team members. 3. Psycho-spiritual comfort: spiritual support; listening and dialogue; therapeutic communication; emotional support; providing hope and confidence; reflection about the meaning of life; paying attention to non-verbal communication; integrating psychological, social and spiritual aspects; physical, mental and emotional balance; appropriate language and voice tone; calling by name; sense of support, trust, sympathy and health perspective; helping to experience the death process; reducing anxiety; relaxation. 4. Environmental comfort: clean and bright environment; being at home (a dependent elderly); avoiding unpleasant sounds and noises; warm, attentive and loving environment; having a bathroom, a telephone and furniture available to the family members in their waiting room; locating the waiting room close to the patient; having a place for the family members to be alone; aromatherapy; controlling the environment.
Article's title	***O Conforto do Doente Idoso Crónico em Contexto Hospitalar: Contributos para uma Revisão Sistemática da Literatura*** **(25)** *iv*
Author(s)	Ribeiro PCPSV, Costa MAM.
Journal's title	Revista de Enfermagem Referência
Publication date	2012
Country	Portugal
Descriptors	*Conforto*; *Idoso*; *Hospitalização*; *Revisão da Literatura*. *v*
Method	Systematic literature review, according to Sandlowski& Barroso, with meta-summary.
Evidence level **(28)**	Level 4

Objectives	To determine the best available evidence, regarding the nature of the comfort process of the hospitalized chronic elderly patient, clarifying the interrelations between the conditions (structure), the actions (process) and the consequences, and contributing to the synthesis and integration of the resulting knowledge about the comfort phenomenon, through qualitative studies.
Participants	Hospitalized elderly patients, in an internal medicine context, and nurses/caregivers.
Interventions	Comfort phenomenon: construction process and comfort responses.
Results	Four primary studies were analyzed, in which it was possible to identify: 1. Comfort promoting interactions/strategies; 2. Comfort standards; 3. Experiences and meanings of comfort; 4. Nature of comfort/discomfort; 5. Comfort needs. It implies: patient acknowledgment, respect, sensitivity, commitment, concern, knowledge, physical and affective proximity, communication, touch and humor.
Notes	Although the obtained results provide some clues, they are not sufficiently conclusive.
Article's title	**The effect of Music on Comfort, Anxiety and Pain in the Intensive Care Unit: A Case in Turkey** [26]
Author(s)	Çiftei H, Oztunç G.
Journal's title	International Journal of Caring Science
Publication date	2015
Country	Turkey
Descriptors	Anxiety; Comfort; Intensive Care; Music Therapy; Pain;
Method	Experimental Study
Evidence level [28]	Level 2
Objectives	To identify the effect of music therapy in pain control, anxiety and patient comfort, in Intensive Care Units, with a diagnosis of Cerebrovascular Accident.
Participants	72 hospitalized patients, in an intensive care context, diagnosed with Cerebrovascular Accident.
Interventions	Data was collected through the Patient and Vital Signs Identification Form, using the "Visual Analogue Scale" (VAS) to identify the pain level, the "Faces Anxiety Scale" and the "State Trait Anxiety Inventory" to identify anxiety level, and the "General Comfort Questionnaire" to identify the comfort level.
Results	It was found that music increased the general comfort level and pO_2. Also, the arterial systolic blood pressure, the Pain Level, the State Anxiety Level, and the Face Anxiety Scale Index, all decreased significantly with music therapy. Music is a type of therapy that contributes to the patients' comfort, reducing pain and anxiety.
Article's title	***O Conforto dos doentes em Fim de Vida em Contexto Hospitalar*** [27][vi]
Author(s)	Nicolau CVV.
Journal's title	----------

Publication date	2013
Country	Portugal
Descriptors	*Conforto*; *Fim de vida*; *CuidadosPaliativos*; *Qualidade de Vida*. [vii]
Method	Descriptive-correlational study.
Evidence level [28]	Level 4
Objectives	To identify the social-demographic and clinical characteristics of patients at the end of life, in a hospital context; to evaluate comfort and quality of life of patients at the end of life, in a hospital context; to determine the relation between the comfort of the patients at the end of life and the social-demographic, familial, clinical and context related variables.
Participants	63 patients at the end of life, admitted to the Centro HospitalarLisboa Norte — Hospital de Santa Maria.
Interventions	Interview applied to a non-probabilistic/intentional sample of 63 hospitalized patients at the end of life, in an internal medicine context.
Results	Comforting strategies identified in this study: 1. To promote support, help and trust; 2. Attentive presence, availability, listening skills and a receptive attitude; 3. Authentic presence, inter-subjective dialogue, emotional and physical touch, and concern or interest, through a prompt and sensible response; 4. Family members' presence/support; 5. Allowing the expression of feelings; 6. Control of symptoms.

Comforting Interventions

Comforting interventions, also defined by literature as the different ways and manners of comforting, seek to facilitate comfort, to relieve discomfort and/or to invest in the potential comfort. Thus, they lead to an increased feeling of control over life and the experienced circumstances, contributing to the perception of a normal life, while looking towards the future, even during hospitalization [14,15]. In this sense, the situations which represent comforting care translate into comfort-promoting strategies, mobilized by the nurse, and into personal moments of comfort [14].

During the analysis of the selected studies, we identified 128 units of meaning that correspond to comforting care interventions. These units of meaning were then subjected to a thematic analysis and, through their conceptual similarity, were reduced to 71 units of meaning. The results are available in Table 2 [16, 24, 25, 26, 27].

Table 2. *Ways and means of comforting – Comforting interventions* [16, 24, 25, 26, 27]

- Application of touch/direct contact;
- Avoidance of unnecessary and invasive handling;
- Satisfaction of basic needs;
- Relief of discomfort, through massage/mobilization/therapy;
- Pain relief;
- Control of symptoms;
- Rest;
- Use of suitable pillows;
- Oxygen therapy;
- Aspiration of secretions;
- Moments of personal hygiene and preparation;
- Therapeutic baths to control pain;

- Skin care;
- Food;
- Relief of uncomfortable zones, through positioning;
- Non-invasive mechanical ventilation;
- Application of respiratory control theories;
- Sedation in patients with severe respiratory failure;
- Dressings;
- Ostomy care;
- Application of heat/cold;
- Positive interaction/communication;
- Paying attention to non-verbal communication;
- Use of appropriate language and voice tone;
- Calling by name;
- Providing information/clarification/guidance about the disease;
- Unconditional presence;
- Silence;
- Smile;
- Listening and dialogue;
- Providing affection and attention;
- Empathic relationship;
- Emotional support;
- Allowing the expression of feelings;
- Anxiety control;
- Application of relaxation techniques;
- Attending to the patient's will/desires;
- Addressing the patient's concerns/uncertainties;
- Giving spiritual support;
- Helping to manage expectations;
- Promoting hope;
- Reflecting about the meaning of life;
- Helping to experience the death process;
- Providing the opportunity to function as normally as possible;
- Promoting autonomy;
- Respecting the social-cultural aspects;
- Involve the patients with social exchanges (integrating social, psychological and spiritual aspects);
- Expression of beliefs and traditions;
- Promoting the active participation in choices;
- Integrating the family as a partner in care;
- Offering support to the family members;
- Allowing the family to provide support in the satisfaction of basic needs;
- First contact;
- Family visits;
- Interaction with family and friends;
- Social support;
- Team's support and attention;
- Humor;
- Seeing other patients (in the same situation)/increase the proximity to other patients;
- Mediated reading;
- Leisure activities;

- Respecting privacy and modesty;
- Keeping the environment clean and bright;
- Avoidance of unpleasant sounds and noises;
- Promoting a calm, warm, attentive and loving environment (identical to the family environment);
- Having a controlled environment;
- Having a bathroom and furniture available to the family members in their waiting room;
- Locating the waiting room close to the patient;
- Having a place for the family members to be alone;
- Application of aromatherapy;
- Application of music therapy;

Comforting Care Interventions Vs. Comforting Contexts

As mentioned earlier, the units of meaning which resulted from the final analysis were grouped according to the ways and manners of comforting defined by Patrícia Pontifice Sousa [14,15,16], in her explanatory theory, being inserted in two categories —comforting strategies and personal moments of comfort —,and also according to the four comforting contexts defined by Katharine Kolcaba, in her Holistic Comfort Theory [11,12].

Thus, of the 71 comforting care interventions, 63 (≈ 89%) are comforting strategies and 8 (≈ 11%) are personal moments of comfort. Of the 63 comforting strategies, 16 (≈ 25%) belong to the context of physical comfort, 24 (≈38%) are included in the context of psycho-spiritual comfort, 13 (≈ 21%) pertain to the context of social-cultural comfort, and 10 (≈ 16%) are associated with the context of environmental comfort. Of the 8 personal moments of comfort, 5 (≈ 62.5%) belong to the context of physical comfort, and 3 (≈ 37.5%) pertain to the context of social-cultural comfort. The results of this classification are available in Table 3 [16,24,25,26,27].

Table 3. *Comforting care interventions vs. Comforting contexts* [16, 24, 25, 26, 27]

Ways and means of comforting — Comforting care interventions [14,15,16]		
	Comforting strategies	**Personal moments of comfort**
Physical Comfort	• Application of touch/direct contact; • Avoidance of unnecessary and invasive handling; • Satisfaction of basic needs; • Relief of discomfort, through massage/ mobilization/therapy; • Pain relief; • Control of symptoms; • Rest; • Use of suitable pillows; • Oxygen therapy; • Aspiration of secretions; • Non-invasive mechanical ventilation; • Application of respiratory control theories; • Sedation in patients with severe respiratory failure; • Dressings; • Ostomy care; • Application of heat/cold.	• Moments of personal hygiene and preparation; • Therapeutic baths to control pain; • Skin care; • Food; • Relief of uncomfortable zones, through positioning.

Psycho-spiritual Comfort	• Positive interaction/communication; • Paying attention to non-verbal communication; • Use of appropriate language and voice tone; • Calling by name; • Providing information/clarification/ guidance about the disease; • Unconditional presence; • Silence; • Smile; • Listening and dialogue; • Providing affection and attention; • Empathic relationship; • Emotional support; • Allowing the expression of feelings; • Anxiety control; • Application of relaxation techniques; • Attending to the patient's will/desires; • Addressing the patient's concerns/ uncertainties; • Giving spiritual support; • Helping to manage expectations; • Promoting hope; • Reflecting about the meaning of life; • Helping to experience the death process; • Providing the opportunity to function as normally as possible; • Promoting autonomy.	
Social-cultural Comfort	• Respecting the social-cultural aspects; • Involve the patients with social exchanges (integrating social, psychological and spiritual aspects); • Expression of beliefs and traditions; • Promoting the active participation in choices; • Integrating the family as a partner in care; • Offering support to the family members; • Allowing the family to provide support in the satisfaction of basic needs; • Social support; • Team's support and attention; • Humor; • Seeing other patients (in the same situation)/increase the proximity to other patients; • Mediated reading; • Leisure activities.	• First contact; • Family visits; • Interaction with family and friends.

Environmental Comfort	• Respecting privacy and modesty; • Keeping the environment clean and bright; • Avoidance of unpleasant sounds and noises; • Promoting a calm, warm, attentive and loving environment (identical to the family environment); • Having a controlled environment; • Having a bathroom and furniture available to the family members in their waiting room; • Locating the waiting room close to the patient; • Having a place for the family members to be alone; • Application of aromatherapy; • Application of music therapy.	

Discussion

Five studies were analyzed in this integrative literature review, using a qualitative methodology, with the purpose of: 1) increasing the existing knowledge about the comfort phenomenon; 2) determining comforting interventions destined to be applied to the adult/aged individual at the end of life, in a hospital context. This allows us to plan better the comforting care provided to this population.

According to the reviewed studies, comforting care has a significant expression in the different caregivers, with nurses assuming a privileged action in the provision of comforting care, through the assessment of the adult/aged individual's needs and through the evaluation of the provided care's results [27]. The observed comforting care aimed at relieving discomfort and/or investing in the potential comfort [14,15,16].

Considering the results obtained in the review as a starting point, and knowing that the approach to the adult/aged individual at the end of life implies an attitude intended to alleviate suffering, in order to maintain the highest possible level of comfort and well-being [27], we were able to verify that: nursing interventions are present in all the comforting contexts; the comforting strategies are applied in all contexts, namely in the psycho-spiritual and physical contexts; the personal moments of comfort are particularly noticeable in the physical and social-cultural contexts.

Thus, regarding the physical context, it is clear the weight of the following comforting strategies: touch/direct contact; the relief of discomfort through massage/mobilization; pain relief; symptom control; and the satisfaction of basic needs. These strategies have great importance in the care provided to the adult/aged individual at the end of life, because it is through physical contact that we can transmit security, confidence and tranquillity. In nursing care, physical comfort strategies are seldom applied by nurses, being used only when alleviating discomfort through massage/mobilization, providing pain relief, controlling symptoms and satisfying basic needs.

With respect to the psycho-spiritual context, the following strategies stand out: unconditional presence; silence; listening and dialogue; information/clarification; smile; promotion of hope; promotion of autonomy; nonverbal communication; use of appropriate language and voice tone; calling by name; expression of feelings; anxiety control; relaxation; and giving the opportunity to function as normally as possible. Some of these strategies may accompany other comforting signs of communication, because they convey a sense of warmth, promote confidence and help the search for a meaning in life. The psycho-spiritual context emphasizes one's inner consciousness, being a combination of the mental, emotional and spiritual states. Regarding the social-cultural context, the following comforting strategies are highlighted: humor, and the involvement of the

patient and his/her family. Therefore, it can be observed that interpersonal, family and social relationships are included in this context; in the family's absence, it is the nursing team that needs to promote this social comfort, by provoking feelings of joy and/or providing distractions.

Concerning the environmental context, the following comforting strategies are evident: the respect for privacy; a clean and bright environment; the avoidance of unpleasant sounds and noises; music therapy; keeping a calm, warm, caring and loving environment (identical to the family environment); providing a place for family members to be alone. In this context, the focus is placed on the environment, and its external conditions and influences, which increase the sense of well-being of the patient and his/her family.

With respect to the personal moments of comfort, the following interventions are emphasized: the first contact, which allows to reveal availability and kindness, facilitating the therapeutic relationship and the adaptation to the hospitalization; the moments of personal hygiene and preparation, therapeutic baths for pain control, skin care, the relief of sore zones/positioning, that promote a sensation of relief, when performed with comforting intentionality, thus improving the comfort state; family visits and the interaction with family members and friends, which promote comfort, increase autonomy, convey feelings of usefulness, increase self-esteem and create a personalized environment.

The concretization of the comforting interventions applied to the adult/aged individual at the end of life, in a hospital context, implies the establishment of a relationship based on humanization pillars, in a meeting that can lead to informed decision making, allowing the patient to have as much control as possible over his/her life situation [16]. For this, it is fundamental to establish an intentional relationship of trust, authenticity, respect, sensitivity, commitment, understanding, concern and physical and affective proximity; it is also essential to allow the patient at the end of life to maintain, while in the hospital, his/her personal life, remaining as close as possible to the family members, relieving the physical, emotional and spiritual suffering, and improving his/her quality of life [25,27].

Thus, and while placing the adult/aged individual at the end of life and his/her family at the center of care, the promotion of comfort is the foundation of the nurse's actions, allowing attention to detail and to the person in his/her uniqueness, through the understanding of how each individual experiences his/her problems and manifests his/her needs [11,13,15,16].

Implications for Nursing Care Providers and their Leadership

The obtained results clarify the comforting interventions which can be implemented while providing nursing care to the adult/aged individual at the end of life, in a hospital context, and also demonstrate their benefit to the patient. In this sense, they are an aid to the provision of quality nursing care to the adult/aged individual at the end of life, in a hospital context. In addition, they may be structuring to the reformulation of principles and practices related to care and human resources management, as well as nursing care planning and leadership strategies.

Strategies and Limitations

Considering the obtained results as a starting point, while being aware of this field's importance to the provision of nursing care, in a hospital context, and taking into account the complexity and specificity of the studied population's problems, it is evident the need to deepen the research about this phenomenon and to perform studies concerning the promotion of comforting care applied to the adult/aged individual at the end of life. The main limitation of this literature review was the difficulty to find primary studies on the subject under research.

Future of the Research

The provision of comforting care to the patient at the end of life is complex and quite specific. Thus, there is a need to develop research in this area, in the near future, to increase scientific knowledge and contribute to the construction and consolidation of the available information about a nursing phenomenon that is considered noble by several theorists. Therefore, future research may contribute to the identification of new comforting interventions which can be applied to the adult/aged individual at the end of life, in a hospital context, as well as in other contexts.

Conclusion

In the provision of care to the adult/aged individual at the end of life, in a hospital context, the comforting

interventions seek to facilitate/increase comfort, to relieve discomfort and/or to invest in the potential comfort [16]. The promotion of comfort is achieved when the nurse: values the individual's personal moments; performs appropriate and anticipated interventions, seeking to recognize the patient's more or less complex needs, inherent to the experienced circumstances; respects the individual's preferences; seeks informal spaces of readjustment, valuing both the patient's and the family's capacity and will. For this to be feasible, it is essential to establish an intentional relationship of trust, authenticity and understanding, between the adult/aged individual at the end of life and the health professionals. It is equally important that, while in the hospital, the patient is able to keep his/her social and affective life, in order to alleviate suffering in all contexts and to improve the quality of life [27]. Thus, the provision of comforting care to the adult/elderly individual at the end of life, in a hospital context, is achieved through interventions that seek to value both the basic and the more complex needs, respecting the individual in his/her uniqueness and globality, taking into account the patient's and the family's suffering, and presupposing flexibility and intentionality in the provision of care, specifically of nursing care.

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