

Original article

Palliative care for older adults in light of the Theory of Comfort: perspectives of healthcare professionals*

Cuidados paliativos em idosos à luz da Teoria do Conforto: perspectivas dos profissionais do cuidado

Cuidados paliativos en personas mayores desde la perspectiva de la Teoría del Confort: puntos de vista de los profesionales sanitarios

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Abstract

Objective: to analyze professionals' understanding and practices at a Long-Term Care Facility (LTCF) regarding Palliative Care (PC), in light of the Theory of Comfort. **Method:** descriptive, qualitative study conducted at an LTCF with 17 care professionals, between August and October 2024. Data were collected through semi-structured interviews and analyzed using Reflexive Thematic Analysis. **Results:** three thematic categories emerged: lack of knowledge about PC among care professionals; common sense versus scientific knowledge; parameters applied to initiate PC; and comfort measures provided to older adults correlated with the needs proposed in the Theory of Comfort. **Conclusion:** a lack of scientific knowledge about PC and the absence of tools to validate its initiation were evidenced. It was found that the usual comfort practices at the institution are related to the assumptions of the Theory of Comfort; however, they proved insufficient for a palliative approach.

Descriptors: Homes for the Aged; Patient Care Team; Palliative Care; Patient Comfort; Nursing Theory

Resumo

Objetivo: analisar a compreensão e a atuação dos profissionais de uma Instituição de Longa Permanência para Idosos (ILPI) sobre os Cuidados Paliativos (CP), à luz da Teoria do Conforto. **Método:** estudo descritivo, qualitativo, realizado em uma ILPI com 17 profissionais do cuidado, entre agosto e outubro de 2024. Os dados foram coletados por meio de entrevistas semiestruturadas e analisados pela Análise Temática Reflexiva. **Resultados:** emergiram três categorias temáticas: insipiência do conhecimento sobre os CP pelos profissionais do cuidado: senso comum versus senso científico; parâmetros aplicados para iniciar os CP; e medidas de conforto ofertadas aos idosos correlacionadas às necessidades propostas na Teoria do Conforto.

Conclusão: evidenciou-se a escassez de conhecimento científico sobre os CP e a ausência de ferramentas que validem seu início. Constatou-se que as práticas de conforto habituais na instituição se relacionam com os pressupostos da Teoria do Conforto, porém demonstraram ser insuficientes para a abordagem paliativa.

Descritores: Instituição de Longa Permanência para Idosos; Equipe de Assistência ao Paciente; Cuidados Paliativos; Conforto do Paciente; Teoria de Enfermagem

Resumen

Objetivo: analizar la comprensión y la actuación de los profesionales de un centro de larga estancia para personas mayores (ILPI) en relación con los cuidados paliativos (CP), desde la perspectiva de la Teoría del Confort. **Método:** estudio descriptivo y cualitativo, realizado en una ILPI con 17 profesionales de la atención, entre agosto y octubre de 2024. Los datos se recopilaron mediante entrevistas semiestructuradas y se analizaron mediante el análisis temático reflexivo.

Resultados: surgieron tres categorías temáticas: escaso conocimiento sobre los CP por parte de los profesionales asistenciales: sentido común frente a sentido científico; parámetros aplicados para iniciar los CP; y medidas de confort ofrecidas a las personas mayores correlacionadas con las necesidades propuestas en la Teoría del Confort. **Conclusión:** se puso de manifiesto la escasez de conocimientos científicos sobre los CP y la ausencia de herramientas que validen su inicio. Se constató que las prácticas habituales de confort en el centro se relacionan con los supuestos de la Teoría del Confort, pero demostraron ser insuficientes para el enfoque paliativo.

Descriptores: Hogares para Ancianos; Grupo de Atención al Paciente; Cuidados Paliativos; Comodidad del Paciente; Teoría de Enfermería

Introduction

In accordance with the terminology proposed by the World Health Organization (WHO), Palliative Care (PC) aims to improve quality of life by relieving the suffering of patients and their families who face problems associated with life-threatening illnesses. Thus, it is considered a systemic approach centered on four human dimensions, including the physical, psychological, social, and spiritual dimensions.¹

In this perspective, PC should be implemented from the diagnosis of the disease through the end of life, extending to family members during the bereavement phase, to provide a better quality of life throughout the older person's trajectory.² Therefore, PC is guided by principles that place people with life-threatening illnesses at the center of care, encompassing the management of signs and symptoms, multidisciplinary practice, and an emphasis on autonomy, which, when applied in Gerontology, provide support for humanized and high-quality care.³

It is understood that senescence entails numerous challenges arising from the multiple changes associated with aging, resulting in greater susceptibility to chronic

diseases. Consequently, this population requires comprehensive and humanized care, making the indication of PC essential.⁴

In that sense, concerning Long-Term Care Facilities (LTCF), a literature review that analyzed national and international studies on the profile of institutionalized older adults identified a high prevalence of chronic comorbidities, particularly hypertension, cognitive impairment, and significant functional impairment, conditions that highlight the need for a palliative approach integrated into the routine care of these older adults.⁵

From this perspective, LTCF are settings where the palliative approach is an essential component of daily care, since most institutionalized older adults remain in the institution until the end of life.⁶ Moreover, the wishes and preferences of these individuals regarding the end of life are often not considered, reinforcing the need to improve palliative practices in these settings.⁷ This reality reflects a global gap, since, although PC has been growing worldwide, its availability remains quite limited, directly affecting the quality of care provided to institutionalized older adults.²

Regarding the relevance of this issue, Nursing teams in LTCF are at the forefront of care and should recognize the importance of PC to provide the best care conditions associated with the individuality and needs of each older adult resident.⁸

In this context, comfort stands out as a fundamental component of PC, and its provision is an essential responsibility of the Nursing team. It is necessary to achieve comfort models grounded in an interpersonal relationship capable of positively addressing the needs of older adults, promoting autonomy, integrity, and well-being.⁹

In line with this perspective, the Theory of Comfort proposed by Katherine Kolcaba provides a foundation for Nursing care and proposes a humanized approach structured around three states: "relief, ease, and transcendence". These states are embedded in the physical, psychospiritual, sociocultural, and environmental contexts.⁸

Given that PC presupposes comprehensive care addressing the needs of older adults,² it is relevant to understand how professionals recognize and operationalize this approach in the context of LTCF. Furthermore, as a central element of PC,² its promotion requires the articulation of the different dimensions of care.⁸ In this sense, the Theory of Comfort presents itself as a framework capable of broadening the understanding of older adults' needs and supporting the planning of Nursing care.¹⁰

In view of the above, this study aims to analyze the understanding and practices of professionals at an LTCF regarding PC, in light of the Theory of Comfort.

Method

This was a descriptive study with a qualitative approach, conducted in accordance with the guidelines of the Consolidated Criteria for Reporting Qualitative Research (COREQ). Qualitative research is based on understanding participants' experiences and behaviors, either individually or in small groups, to identify the reasons and meanings of phenomena beyond their quantification.^{7,11}

The study setting consisted of a philanthropic LTCF located in southern Minas Gerais, whose purpose was the institutional care of low-income older adults over 60 years of age who were in situations of social vulnerability, abandonment, and without an immediate family. The study population consisted of 17 care professionals working at the institution during the data collection period, including a nurse, Nursing technicians, and older adult caregivers, all of whom were invited to participate to encompass the comprehensive perspective of the team and who also constituted the study sample. There were no refusals.

The eligibility criteria were age 18 years or older and being professionally active at the LTCF during the study period. The exclusion criteria were professionals away from their work activities (due to maternity leave, vacation, or health reasons), as well as those with less than one month of experience at the institution. Participation took place upon signing the Free and Informed Consent Term (FICT). Data collection took place between August and October 2024. First, a sociodemographic questionnaire was administered to characterize the participants, containing variables such as sex, age, education, and length of professional experience.

Subsequently, individual, face-to-face semi-structured interviews were conducted by the female researcher, an undergraduate Nursing student. It should be noted that, during the interviews, the undergraduate researcher was supervised by the faculty member responsible for the study, who was also female and held undergraduate, master's, and doctoral degrees in Nursing.

Thus, the interviews took place at the institution itself, in a location that ensured participants' privacy, upon prior scheduling of the day and time, with an average duration of approximately 16 minutes. They were audio-recorded using digital devices and transcribed in full as a strategy to ensure the rigor and reliability of the data.

The interview guide consisted of three guiding questions: What is your knowledge about PC? What parameters are used to initiate PC in older adults? What comfort measures are prioritized for older adults receiving PC?

Data analysis was performed using reflexive thematic analysis,¹² with the Theory of Comfort⁸ as the guiding framework for interpreting the category related to comfort measures. Reflexive Thematic Analysis understands themes as interpretive constructions developed by the researcher through reflective dialogue with the data, valuing subjectivity, creativity, and a critical stance.¹²

The analytical process was divided into six phases: in the first, a text editor was used to become familiar with the data and correct the transcripts; in the second, initial coding was performed using colors to identify the codes; in the third, the codes were organized into themes and subthemes; in the fourth, the themes and subthemes were reviewed at two levels, verifying their coherence; in the fifth, the themes were refined, redefined, and renamed; and in the sixth, the final report was prepared, selecting the excerpts that best described the participants' experiences.¹²

Thus, to ensure participants' anonymity, they were identified by their position, designated as Collaborator (C), and by an Arabic numeral. Accordingly, they will be referred to as C1 to C17.

The project was approved by the Research Ethics Committee (REC) on May 14, 2024, under protocol CAAE 79652224.2.0000.5116, in accordance with Resolution No. 466/12 of the Brazilian National Health Council (CNS).

Results

Among the 17 participants working at the LTCF, there was a predominance of females (n=11), with ages ranging from 18 to 58 years and a mean age of 39.5 years. Regarding professional training, the team consisted of one nurse, the technical manager, with an undergraduate degree and a *lato sensu* postgraduate degree in

Occupational Nursing, seven nursing technicians, and nine older adult caregivers. Among the nine caregivers, five had additional training as nursing technicians, although they worked as caregivers at the institution; the remaining four had completed a course for older adult caregivers.

Among the 17 participants, the length of professional training ranged from nine months to 27 years. Regarding their length of professional experience at the LTCF, three professionals had up to one year of experience at the institution; nine, up to seven years; and five, ten years or more.

Based on these data, three thematic categories were extracted that represent the perception and practices related to PC among the care staff at the LTCF: lack of knowledge about PC among care professionals: common sense versus scientific knowledge; parameters applied to initiate PC; and comfort measures provided to older adults correlated with the needs proposed in the Theory of Comfort.

Lack of knowledge about palliative care among care professionals: common sense versus scientific knowledge

In this category, we sought to identify the professionals' understanding of what PC is.

In my understanding, care means taking good care of them, providing all the assistance that is necessary; it is about what they ask for, so that we can arrange things, do for them whatever we can do that is best, in my understanding. (C10)

I think it is about knowing how the patient is doing and how you are going to administer the oral medications, the schedules and days, to see how long they will be taking them as well and how they are responding to them. That's how I understand it. (C14)

The statements reveal an understanding of PC predominantly associated with care provision and practical tasks, such as medication administration and direct assistance. In this sense, collaborators such as C10 and C14 relate care to everyday actions and patients' immediate needs. From this perspective, PC is understood as merely basic daily care provided at the institution, without distinction from routine care practices.

However, for most professionals at the institution, PC remains linked to the conception, still common in popular understanding, that it should be offered only to patients in the terminal stage, especially in the oncology context:

[...] it is a patient who is in the terminal stage [...] then there isn't much left to be done [...]. (C4)

I hear a lot that a person is receiving PC when they have cancer [...] it's because there is nothing else to do [...] it's a more special kind of care, to make them more comfortable, to have a better quality of life. (C8)

Broader perceptions also emerged, associating PC with measures of comfort and dignity and recognizing that it is not restricted to the end of life:

[...] taking care of them in the best way [...] bringing comfort to everyone who is at the LTCF. Not just those who have no possibility of a cure. No, for everyone, because many people mistakenly think that PC is only for those who have nothing else, no therapeutic possibility, but that's not true. (C1)

What I understand as PC [...] is giving the person the maximum possible dignity, comfort. Not only through medication, but also relief from pain. And also, above all, aiming to preserve the dignity of the human person [...] sometimes it can be a terminal condition, or also if the person is very debilitated [...]. (C15)

It is reaffirmed that support for the family, both in coping with their loved ones' illnesses through the end of life and in providing subsequent support during the bereavement phase, constitutes another fundamental premise of PC. From this perspective, participant C6 highlighted bereavement support as an integral part of the palliative approach:

[...] helping the family, helping the patient, these more basic things [...] helping the family with grief. (C6)

In this context, some interviewees demonstrated a practice of not sharing the disease prognosis with older adults who have illnesses that do not respond to disease-modifying treatment, which contradicts another fundamental pillar of PC, effective communication.

Personally, I don't inform the patient, nor do I discuss anything about it, that it's just palliative, just to maintain them. I always give them hope and take care of them like that [...] the patient doesn't need to know what they have, why should they suffer? Then the patient just keeps going and going, until God says it's time to go. (C11)

Although this approach is based on the perspective of protecting the patient's emotional well-being, it reveals another gap in knowledge about PC.

Parameters applied to initiate palliative care

In this category, we sought to identify the parameters used by the LTCF team to initiate PC in resident older adults. Based on the statements, it was possible to observe that there are no previously established criteria used by the team to initiate palliative care in institutionalized older adults.

[...] the day before, when the arrangements are being made for them to come to the LTCF, I already believe that I go to their home, before getting to know the family and everything, and that's when PC begins for me [...]. (C1)

When their health is very poor, when they are already very debilitated. (C10)

It's from the moment they are no longer able to do anything. (C12)

Thus, the lack of understanding of what PC is and the appropriate time to initiate it demonstrates a weakness in the care provided to residents, which may compromise their well-being and quality of life. When collaborator C7 was asked about residents who returned from hospitals with medical instructions to receive PC and what guidance they received, the participant expressed a perspective centered on prolonging life, conveying the idea that caring necessarily means maintaining life at any cost.

Yes, there have already been patients who came from the hospital and then we continued taking care of them, to prolong, as they say, their days of life [...] let's suppose, if I don't take care of the person there [...] you stop eating, and you won't want to live anymore, you're cutting short the number of days you will live [...]. (C7)

Although there are instruments capable of assisting in the identification of patients for PC, it is observed that such tools are not systematically used in LTCF practice. Although most statements indicate poorly defined criteria for initiating PC, one collaborator highlighted the relationship between functionality, independence, and autonomy as relevant parameters.

[...] when she can no longer perform daily activities, it greatly affects decision-making. Because many times she will have autonomy, but she won't have the independence to do things, and vice versa [...] I see this a lot in older adults here [...] I think that when a person can no longer feed themselves, get dressed, that's when palliative care begins. Not making decisions for them. Always respecting their dignity [...] if they can no longer make these decisions, we step in using common sense for the person's well-being. (C15)

Comfort measures provided to older adults correlated with the needs proposed in the Theory of Comfort

Kolcaba's Theory of Comfort comprises three states: relief, corresponding to the immediate reduction of discomfort; ease, understood as a continuous state of calm and well-being; and transcendence, which represents the ability to overcome suffering even in the face of its persistence, manifested across the physical, psychospiritual, sociocultural, and environmental dimensions.⁸

From this perspective, the comfort measures provided by LTCF professionals to residents receiving palliative care reflect these states and dimensions, as most participants perceived that the concept of comfort extends beyond the physical domain, also encompassing psychospiritual, social, and environmental aspects.

Regarding physical comfort, the statements showed that the comfort measures most frequently mentioned refer to body care, understood as part of the basic routine of care for older adults.

[...] there is physical therapy, which is extremely important, repositioning, a better bed for them, an air mattress [...]. (C1)

[...] repositioning, taking care of proper hygiene, not leaving the patient wet [...] not letting the patient develop a wound [...]. (C7)

[...] for a palliative patient, depending on the severity, what happens? You just keep them hydrated, take care of them, and reposition them. (C12)

In addition to preventive and maintenance care, collaborator C15 highlighted pain relief as a relevant aspect of the palliative care process. Subsequently, collaborator C13 reported the specific measures related to pain that are applied to institutionalized older adults.

And despite the medications that treat the physical aspect [...] we can give a comfort massage. Besides the massage, I put my heart into it. So that it really provides relief [...]. (C15)

First, we ask them, give them a little water to see if it's not just something in their head, and then we report it to the technical manager and say where the patient is feeling pain, what the patient's pain level is. The head nurse gathers some more information from the patient and gives them the appropriate medication; otherwise, they are referred to a hospital. (C13)

It is observed, however, that the measures mentioned do not clearly differ from those used in routine care, with no specific reference to practices directed exclusively at older adults receiving PC.

Regarding psychospiritual comfort, the statements reflected the value placed on emotional and spiritual aspects in the care provided to institutionalized older adults, mentioning practices that include gestures of affection, dialogue, individualized attention, recalling memories, and respect for the person as a whole.

Holistically, I take care of them as a whole, mentally, spiritually, everything [...]. (C1)

Regardless of whether they are in a situation that you already know is irreversible, we prioritize respect, dialogue, understanding, dignity; we never lose sight of that [...] I give thanks, I pray, I talk spontaneously [...]. (C2)

Everyone says, "oh, let's give them medicine", but sometimes medicine isn't even what the person needs, but some affection, sometimes a hug, which many people here like, a little attention [...] many times it's emotional [...] bringing up things from their past to bring them into the present so they can remember them, so they can have a good memory. (C16)

Collaborator C1 identified spirituality as a way of providing comprehensive care to residents receiving palliative care, while collaborator C11 highlighted spiritual comfort, with an emphasis on end-of-life care. Along the same lines, collaborator C12 revealed a perspective of giving new meaning to death, perceiving it as an integral and meaningful part of the care process.

[...] I am always looking for each person's spiritual leader; we have this great concern here [...] so that we can provide the best care possible. (C1)

[...] every human being realizes when they are going [...] when I am close to someone who is going, I always tell the person to go in peace, that they have

already fulfilled their mission, now they can go, go rest [...]. (C11)

Then you pray, you ask [...] this is a place of great care, it's strong, you know? A lot of people pass away here [...], but you also see that it is something beautiful, it's not something sick [...]. (C12)

Therefore, it can be observed that the collaborators highlighted both manifestations of emotional and affective care and the importance of spiritual support, particularly in the context of the end of life.

Within the scope of sociocultural comfort, collaborator C11's statement highlighted the importance of considering religious aspects in the older adults' routine, ensuring space for practices and symbols considered sacred.

[...] religion has existed since the beginning of the world. Each person has their own [...] there was an older woman here who was Umbanda and had lived her whole life with it, her grandchildren became evangelical and took the woman away from the religious center [...] God bless her, she began to suffer, until one day she said to me: do you know Mãe Leia? [...] because she said she needed to talk to someone like that [...] I brought her here, and the two of them talked, and then about two weeks later, the little lady died. So, it's essential. (C11)

Regarding this dimension, the statements also highlighted the relevance of interpersonal and family relationships and traditions in the daily lives of older adults:

[...] we see that forgiveness is missing [...] I seek out the family in some way, even to help them through this process, in this life that is completely different from what they had with their family members. (C1)

[...] the family comes and they are happier on the day they see their family [...] there are a lot of things here, there are games, there are little parties that they really enjoy, at the end of the year they receive many gifts, you see their smiles, their joy. The professional also joins in, giving attention, playing with them, some like to dance, to talk, and some are more serious. (C8)

[...] they are always looking for something they like [...] to eat, like, always looking for something that pleased them in the past, and you feel that they are doing very well because of the connection we have with them, as if they were our own family. Then they feel very welcomed. (C14)

Regarding environmental comfort at the LTCF, the collaborators highlighted some components, namely: the garden, television, room temperature and lighting, organization, and clean clothing.

[...] we put on music from their time, others like church music, we talk to them and ask. There was one who was very ill a little while ago [...] he asked for Agnaldo Timóteo [...] so I played Agnaldo Timóteo for him [...]. (C1)

[...] if necessary, we also take the wheelchair to the garden, to a more ventilated environment [...] "this light bothers them at night, let's put, for example, a brighter one in the bathroom and leave the one in the bedroom turned off," because we need to go in, but not turn the light on directly [...]. (C2)

[...] look, they really like staying near the television, but they don't watch television, we take them to the garden so we can talk [...]. (C14)

[...] issues related to temperature, sometimes it may be hot for me, but not for the person. Always observe this, use common sense [...]. (C15)

[...] the bedroom, the environment, so that they can rest well, it should always be organized, their clothes should always be organized, always clean, the way they like them as well. All of this is included in PC [...]. (C17)

The data presented summarize the overall picture of PC at the LTCF investigated. The reality is marked by empiricism, the lack of formal criteria for decision-making, and the provision of comfort measures primarily linked to routine care and the collaborators' individual perceptions.

Discussion

The insufficient knowledge about PC among the study participants reflects a structural problem that extends beyond the context investigated. The limited coverage of this topic in health education curricula² contributes to professionals working in LTCF reproducing fragmented and culturally ingrained conceptions about the process of providing care in the face of illness and death.

In this regard, an international study evaluated and compared the quality of death in 81 countries, considering parameters such as healthcare expenditures, public awareness campaigns on end-of-life care, national PC strategies, opioid availability, among others, and ranked Brazil as the third-worst country in which to die with quality.¹³ This finding places the results of this study within a broader context of systemic fragility, rather than merely an institutional one.

Although professional education plays an important role in this context, an international systematic review indicated that the implementation of PC in LTCF is also

influenced by organizational factors, such as insufficient institutional resources, challenges related to decision-making in the context of end-of-life care, and the high workload of teams.¹⁴ Such conditions may hinder the incorporation of palliative care principles into routine care, contributing to the persistence of restricted understandings of this approach.

From this perspective, the participants' statements showed that PC is still frequently associated with the end of life and, in some cases, with the oncology context. However, these concepts have transformed over time. Currently, PC is recommended to be implemented concurrently with disease-modifying treatment, with its intensity gradually increased as the condition progresses and the possibilities of modifying the course of the disease become exhausted, with the aim of relieving suffering and promoting a better quality of life for the patient.

It is also noteworthy in this study that one participant advocated withholding the prognosis from institutionalized older adults. This stance reinforces the paternalistic model, in which professionals make unilateral and hierarchical decisions. This conduct contrasts with the mutualistic model, which values shared decision-making among professionals, patients, and family members, seeking to jointly determine what is most appropriate for the patient throughout their trajectory.¹⁵ In this respect, honest and sensitive dialogue, adapted to the patient's level of understanding, strengthens the therapeutic relationship and contributes to a more dignified dying process aligned with individual values.

The restricted understanding of PC observed among the participants in this study has also been described in the literature. A study conducted at a Brazilian LTCF identified gaps in healthcare professionals' knowledge about PC, highlighting conceptual weaknesses and the need for greater qualification for its application in care practice.¹⁶ Similarly, an international study conducted in LTCF identified limitations in professionals' understanding of this approach, particularly regarding the recognition of its principles and its integration into the care of older adults with advanced disease.¹⁷

Given this scenario, it is essential that care professionals develop their knowledge of the principles, philosophy, and appropriate therapeutic approaches concerning symptom control, effective communication, shared decision-making, and support for family members, extending into the bereavement phase.¹⁸

Consequently, this study's results also showed that insufficient knowledge about PC directly affects participants' understanding of the appropriate time to initiate its application, since there were no parameters established by the LTCF. The literature indicates that the curative approach present in Medicine, influenced by professional education and the advancement of life-prolonging technologies, contributed to professionals' reluctance to recognize finitude, resulting in difficulties regarding the PC approach. However, many patients still receive inadequate care.¹⁹

In the context of LTCF, the timely identification of residents with PC needs constitutes a challenge, considering the clinical complexity associated with aging and the presence of chronic conditions. In this regard, screening instruments can assist healthcare professionals in identifying older adults with unmet palliative care needs, favoring the timely implementation of PC.²⁰

Among the instruments described in the literature for identifying patients eligible for PC, the Palliative Care Screening Tool (PCST) is one of the tools used in this context. As a more comprehensive scale, it can accurately assess palliative care criteria. The tool encompasses four parameters: underlying diseases, associated diseases, the individual's functional status, and personal situation.²¹

Thus, regarding the functional status of older adults, it is known that loss of functionality is associated with a worse prognosis and increased dependence on assistance to perform basic activities of daily living. This perception was evidenced by at least one participant in the study.

Once residents eligible for PC have been identified, attention is intensified toward promoting comfort, a fundamental element in the care of institutionalized older adults, recognized as an essential human need and a crucial intervention in different professional theories and practices.⁸ Its effective implementation, particularly in Nursing, requires care grounded in theoretical frameworks that guide systematic assessments and evidence-based clinical decisions.²²

Kolcaba's Theory of Comfort is one of the main contributions in this field, conceptualizing comfort in the dimensions of relief, ease, and transcendence, manifested in the physical, psychospiritual, sociocultural, and environmental contexts.⁸

International evidence has demonstrated the broad application of this framework in different care settings, with a predominance of interventions focused on the physical domain, including health education, exercise, thermal therapies, massages, and other complementary symptom-relief strategies.²³ Within this body of evidence, greater diversity and systematization of comfort practices can be observed when compared with the context of the LTCF studied.

Thus, in accordance with the theory regarding the physical context, Kolcaba described comfort as being related to bodily sensations and homeostasis, and it may also be associated with the control of symptoms resulting from possible diagnoses.²⁴

In this way, the statements showed partial convergence with the literature, since comfort measures in the physical dimension also predominated. However, these measures were mostly concentrated on actions addressing the basic daily needs of older adults receiving PC, as the professionals did not identify differentiated comfort measures for residents receiving palliative care, but rather focused on basic care, such as repositioning, hygiene, and the use of air mattresses.

It should also be noted that, although some professionals mentioned the use of pain medication, there was no reference to the systematic assessment and management of other symptoms, a fundamental aspect of the palliative approach that, in the findings, appeared only sporadically and without evidence of monitoring the therapeutic response.

This scenario can be understood in light of the literature, which indicates that comfort assessments and interventions are complex, dynamic, and highly individualized, being influenced by factors such as the patient's experience, the role of the family, team actions, and the clinical environment itself. In addition, some studies have indicated that Nursing professionals reported difficulties in systematically assessing comfort needs, which directly affects the planning of interventions and their effectiveness in care practice.²³

However, when considering the domains of the Theory of Comfort, it can be inferred that the physical comfort measures reported may promote the state of relief, indicating an immediate reduction in discomfort and some degree of effectiveness in patient comfort.

Furthermore, Kolcaba emphasized that promoting comfort should go beyond merely positioning the patient correctly, relieving pain, and ensuring nutrition and hygiene. It refers to the experience of providing assistance and encouragement, addressing the patient's needs in all their multidimensionality, and alleviating suffering.⁸ From this perspective, when faced with the diagnosis of a life-threatening illness, patients experience various feelings associated with loss, vulnerability, and the perception of their own inability to cope with the situation.²⁵

Regarding the relevance of this subject, the psychospiritual context proposed by Kolcaba emphasized the meaning of the individual's existence and self-awareness, encompassing self-esteem, self-concept, sexuality, and spirituality.¹⁰ Furthermore, the author emphasized the importance of providing security, attentive listening, and recalling memories.²⁶ Some participants in this study also expressed perceptions that align with these elements, particularly concerning spirituality, attentive listening, and recalling memories.

From this perspective, spirituality can be understood as a person's ability to establish a relationship with oneself, with other individuals, and with a higher being, as well as the ability to achieve self-transcendence in time and space.²⁷

In this regard, addressing spiritual needs in the context of PC may contribute to decision-making processes, since spiritual beliefs and values influence choices related to healthcare. Moreover, higher levels of spiritual well-being are associated with reduced decisional conflict, greater perceived support, and a better quality of life throughout the course of illness.²⁸

Thus, the crucial role of the care professional in the context of comfort and the possibility of addressing the domain of transcendence described by Kolcaba can be understood. Religiosity, in this context, represents a specific way of experiencing spirituality and may facilitate the process of transcendence. For many people, religious

practices provide tools that help sustain inner strength and overcome the material discomforts imposed by illness.

This aspect was also evidenced in the statements, as in the account of a participant who highlighted the suffering of an older woman who had been separated from her religious practice, which was alleviated when she was able to resume this connection, reinforcing the relevance of religiosity to comfort and the reframing of suffering in the process of finitude.

However, it was not clear whether attention is given to the spiritual dimension of older adults who do not have a religion. This reflection is relevant, since the literature indicates that spirituality and religiosity are not equivalent concepts, although they are often treated as synonyms in the context of healthcare.²⁷

Regarding the environmental context, this encompasses external factors that influence the older person's experience of comfort. Thus, adapting the care environment to the needs of older adults constitutes an important strategy for promoting comfort.¹⁰

In this sense, the participants' statements showed that aspects such as room organization, the use of clean clothing, appropriate lighting and temperature, as well as access to television, music, and the garden, constitute environmental strategies that may promote feelings of welcome, familiarity, and well-being.

The continuous presence of positive environmental factors in the routine of the LTCF favors the state of ease among resident older adults, providing greater satisfaction as their needs are consistently met.

Although the environmental context constitutes one of the domains proposed by the Theory of Comfort, this dimension was the least evident in the participants' statements. A similar finding was identified in a scoping review on the application of the Theory of Comfort, in which the environmental context was among the least explored aspects in the studies analyzed.²³

This result suggests that, despite their theoretical relevance, environmental aspects tend to be less valued or less explicitly addressed in care practice, which may indicate a greater emphasis on other dimensions of care to the detriment of the institutional environment.

In light of the findings and the literature, it is evident that the implementation of PC in the context of LTCF requires continuous investment in professional training and in the structuring of comfort practices grounded in theoretical frameworks, so that interventions are systematized and oriented toward promoting the quality of life of institutionalized older adults.

It should be noted that this study's limitations are related to its scope, which was conducted in a single LTCF and with a limited number of participating professionals. Therefore, the findings cannot be generalized to other PC contexts. In addition, the limited population may not fully reflect the diversity of professional knowledge and practices, reinforcing the need for future research in different institutions.

The study also highlights important contributions to practice, emphasizing the relevance of PC education and the development of actions that prioritize comfort in all its dimensions. The use of the Theory of Comfort as a framework that allows professional interventions to be organized and guided is emphasized, enhancing their effectiveness and promoting humanized care centered on the needs of older adults.

Conclusion

This study's findings made it possible to understand that there is a limited understanding of what PC actually entails, often associated only with the finitude of life. The scarcity of technical and scientific knowledge, combined with the predominance of common sense, directly affects how this care is provided, revealing difficulties in formally understanding the relief of suffering and symptom control as foundations of the palliative approach, as well as the absence of tools to validate the initiation of this care for institutionalized older adults.

Regarding comfort practices, partial convergence with Kolcaba's Theory of Comfort was observed. However, the reported actions focused on basic care provided as part of routine care, without specific differentiation for residents receiving palliative care and without evidence of systematic assessment and monitoring of symptoms. Nevertheless, sensitivity was observed in interpersonal and spiritual aspects, such as attentive listening, affective bonds, encouragement of religiosity, appreciation of

memories, and attention to the environment, elements that are consistent with the pillars of the theory and reveal potential for more comprehensive care.

It is reaffirmed that all comfort measures prioritized by professionals working at the LTCF are considered relevant to the well-being of older adults. However, it is essential to recognize the existing obstacles in practice, as well as the need to expand care, so that care is grounded in a holistic view of the human being, consistent with the actual needs of each individual, to provide comfort across the entire human dimension and ensure the best possible experiences throughout the course of illness and until the end of life.

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