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RESEARCH ARTICLE (ORIGINAL)

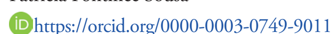
Comfort in the emergency service: The experience of families of critically ill patients

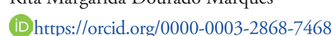
O conforto em contexto de urgência: A experiência da família da pessoa em situação crítica

El bienestar en el contexto de urgencias: La experiencia de la familia de la persona en estado crítico

Elsa Romeiros Crisanta Braga Lima[1, 2]

https://orcid.org/0000-0002-9788-7124

Patrícia Pontífice Sousa[1, 2]

https://orcid.org/0000-0003-0749-9011

Rita Margarida Dourado Marques[2, 3]

https://orcid.org/0000-0003-2868-7468

[1] Universidade Católica Portuguesa, Institute of Health Sciences, Lisbon, Portugal

[2] Centre for Interdisciplinary Research in Health (CIIS), Lisbon, Portugal

[3] Portuguese Red Cross Health School, Lisbon, Portugal

Corresponding author
Elsa Romeiros Crisanta Braga Lima
E-mail: elsalima@netcabo.pt

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Abstract
Background: When facing a critical illness, patients and their families need comfort.
Objective: To understand how families of critically ill patients experience comfort in emergency settings.
Methodology: This exploratory descriptive mixed-method study uses semi-structured interviews in a non-probability convenience sample of ten family members of critically ill patients in emergency services.
Results: Comfort was described as a state/perception of security, with emphasis on psychospiritual and physical dimensions. Comfort-promoting factors were related to nurses' positive attitudes/interactions and technical-scientific and relational skills, with emphasis on the psychospiritual dimension. Suggestions for comfort promotion focused on the development of relational and communication skills.
Conclusion: Comfort is associated with the situation/circumstance experienced and is transitory. In emergency services, comfort emerges as a dimension that nurses can adjust by harmonizing interests and performing specific actions that empower the families of critically ill patients.

Keywords: hospice care; family; patients; critical care; emergencies

Resumo
Enquadramento: Perante a vivência de uma doença crítica, o conforto enquanto necessidade acontece tanto na pessoa que vivencia a doença, como nos seus familiares.
Objetivo: Compreender a experiência do conforto da família da pessoa em situação crítica (PSC) em contexto de urgência.
Metodologia: Estudo exploratório descritivo misto recorrendo-se à entrevista semi-estruturada, numa amostragem não probabilística acidental de 10 familiares da pessoa em situação crítica num serviço de urgência.
Resultados: O significado de conforto expressou-se por um estado/perceção de segurança destacando-se a dimensão psico-espiritual e física. Os fatores promotores de conforto relacionaram-se com atitudes/interações positivas, competências técnico-científicas e relacionais dos enfermeiros, com enfoque na dimensão psico-espiritual. As sugestões para um cuidado confortador centraram-se no desenvolvimento de competências relacionais e de comunicação.
Conclusão: A perceção de conforto relaciona-se com a situação/circunstância vivida e assume um carácter transitório. No serviço de urgência, o conforto surge como uma dimensão que o enfermeiro pode ajustar, compatibilizando interesses e realizando determinadas atividades promotoras da capacitação da família da PSC.

Palavras-chave: cuidados de conforto; família; pessoa doente; cuidados críticos; urgência

Resumen
Marco contextual: Ante la experiencia de una enfermedad crítica, el bienestar como necesidad se da tanto en la persona que experimenta la enfermedad como en sus familiares.
Objetivo: Comprender la experiencia de bienestar de la familia de la persona en situación crítica (PSC) en el contexto de urgencias.
Metodología: Estudio exploratorio descriptivo mixto, para el que se utilizaron entrevistas semiestructuradas en una muestra accidental no probabilística de 10 familiares del enfermo crítico en un servicio de urgencias.
Resultados: El significado de bienestar se expresó mediante un estado/percepción de seguridad y se centró en las dimensiones psicoespiritual y física. Los factores que promovieron el bienestar estaban relacionados con las actitudes/interacciones positivas, las competencias técnico-científicas y las relacionales de los enfermeros, con especial énfasis en la dimensión psicoespiritual. Las sugerencias para una atención reconfortante se centraron en el desarrollo de las competencias relacionales y comunicativas.
Conclusión: La percepción del bienestar está relacionada con la situación/circunstancia vivida y tiene un carácter transitorio. En el servicio de urgencias, el bienestar emerge como una dimensión que los enfermeros pueden ajustar, al coincidir con los intereses y realizar ciertas actividades que promueven el empoderamiento de la familia del PSC.

Palabras clave: cuidado de la comodidad; familia; persona enferma; cuidados críticos, emergencias

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Introduction

Considered a focus of nurses' attention, comfort constitutes a unique, subjective, multidimensional, and positive experience. As it relates to a situational context, its meaning is immediate and dynamic. It results from the circumstances experienced, the intrinsic factors in the relationship with oneself, and one's interactions with others, the environment, or society (Ponte et al., 2019; Sousa, 2020). The state of comfort results from satisfying the needs for relief, tranquility, and transcendence, present in the different physical, psychospiritual, sociocultural, and environmental contexts resulting from the lived experience (Sousa, 2020).

Considering the experience of critical illness, it is worth noting that critically ill patients are not the only ones needing comfort. Their families also seek comfort, as the hospitalization and the uncertainty of their experiences affect the patient-family dyad.

The process of comfort care results from a context-specific environment and the characteristics and actions of the group of actors involved (Sousa & Marques, 2021). The emergency service, characterized by its immediate, efficient, and technically complex assistance, focuses primarily on treating patients. Most of the time, it does not have the best conditions for welcoming patients and families, privacy, individuality, therapeutic interactions, and the timely and appropriate provision of information. These aspects are essential for delivering humanized and comforting care to hospitalized patients (Kalocsai et al., 2018; Ocak & Avsarogullari, 2019).

In the complex emergency service setting, comfort is a necessity and should be an objective and planned nursing intervention aimed at patients and their families. Hence, this study seeks to understand how families of critically ill patients experience comfort in emergency settings.

Background

In caring for families of critically ill patients, addressing the family members' comfort is crucial and demands personalized and adjusted attention to their needs. Health professionals often undervalue these needs as they focus primarily on the patients under their care (Marques et al., 2016; Sousa & Marques, 2021).

In the context of critical illness, patients and their families seek emergency services for health care to relieve physical and psychological discomfort, such as pain and fear.

In this service, nursing care is seen from an emergency and more technical perspective and is associated with the performance of complex and efficient procedures. These frequently involve life-threatening risks and the constant presence of death, causing anxiety in critically ill patients and their families (Valente et al., 2017). As having a critical illness creates a situational crisis, going to a critical care service constitutes a complex, uncomfortable, and dramatic event that families experience as one of the most stressful situations. To handle such situations, families need to mobilize internal skills and resources (Galinha de Sá et al., 2015). Due to their proximity to patients and families, nurses play a vital role in this process by facilitating measures that promote patients' and family members' comfort and well-being.

Comfort is considered an immediate and desirable state associated with the subjective experience of feeling helped, strengthened, and encouraged to acquire or enhance individual capacities to respond to multiple needs (Kolcaba, 2003). The state of comfort is more than the relief of discomfort. It is a positive phenomenon, an immediate state promoted through nursing interventions that go beyond physical care (Kolcaba, 2003). Comfort is endowed with meaning and achieved through comforting interventions. These are a multi-contextual, continuous, inclusive, and planned process, which is an integral part of the care process and aims at achieving a better and higher state of comfort (Sousa, 2020).

Thus, nurses should understand the phenomenon of comfort by identifying needs and planning and assessing interventions to understand to what extent comfort care outcomes are achieved (Kolcaba, 2003; Marques et al., 2016; Sousa, 2020). It is essential to allow families to express their wishes and desires and understand their needs, bearing in mind their uniqueness, considering them in a comprehensive way, and valuing their experience in the time and circumstance, in their relationship with the environment and context. Thus, comfort care must be planned, considered, responsible, and individual according to the unique characteristics of each family (Sousa, 2020).

Research question

How do families of critically ill patients experience comfort in emergency settings?

Methodology

This exploratory descriptive mixed-method study (a research approach that combines qualitative and quantitative elements) seeks to understand how families of critically ill patients experience comfort in emergency settings. It aims to (i) understand the meaning of comfort for families of critically ill patients; (ii) identify factors promoting the comfort of families of critically ill patients in everyday life and at the emergency service; (iii) identify the level of comfort of families of critically ill patients, and (iv) identify nursing interventions promoting the comfort of families of critically ill patients. The target population consisted of family members of critically ill patients who attended the central emergency service of a public hospital in the Lisbon region. This study used the non-probability convenience sampling method (Fortin, 2009) and had the following inclusion criterion: to be a Portuguese-speaking adult family member of a critically ill patient in outpatient settings or hospitalized for up to 24 hours in the emergency service. During the analysis process, the final sample size and composition were determined by data saturation according to Bogdan and Biklen's (1994)

guidelines, which recommend capturing the richness of individual experience and achieving redundancy without adding new data.
In accordance with this study's research question and objectives, the semi-structured interview was selected as the data collection method based on a script the authors developed. It contained the thematic blocks responding to this study's objectives and was organized into three parts. The script's first part addressed family members' sociodemographic variables, namely age, gender, family relationship, and level of education, as well as the emergency service sector where they received care. The second part consisted of two open questions addressing the meaning of comfort and what promotes comfort for family members in their daily lives. The third part was composed of three questions. The first was a closed question referring to family members' comfort level using a Likert scale from 0 to 10, where zero corresponded to *no comfort* and 10 to *maximum comfort*. The other two were open questions asking for the aspects contributing to more and better comfort and their suggestions for comfort-promoting nursing interventions.
The script was discussed informally with some nurses and formally with two judges to ensure its validity. It was pre-tested with individuals from the target population who were not part of the study to guarantee that the questions were understood and determine the mean length of the interview. The researcher selected the family members, always confirming their availability through an initial conversation. The approach to family members was carried out after the critically ill patient's admission and care while they were waiting to do exams or receive results. The interviews took place in a private room of the emergency service, with only the interviewer and the interviewee. Before starting the interview, the interviewer explained the objective, and all study participants signed informed consent forms. The data anonymity and confidentiality were ensured.
Participants were allowed to speak freely and express their ideas to avoid conditioning their answers. The interview was conducted in a way that allowed ideas to flow spontaneously. Nevertheless, sometimes it was necessary to ask some questions to refocus the interviewee. Each interview had a duration of 15 to 30 minutes. The verbal answers were fully registered in writing, and the information was validated with the family members at the end.
Regarding formal and ethical procedures, before data collection began, some steps were required to conduct the study in the chosen institution. Authorization was requested from the institution's Board of Directors and the Head Nurse of the emergency service, where the study was carried out. This study also received the favorable opinion of the institution's Ethics Committee (Reference: 141/20) on May 13, 2021.
After data collection, the interviews were transcribed in full. Following Bardin's guidelines (2018), a qualitative data/content analysis was carried out with a deductive approach, i.e., using the *physical*, *psychospiritual*, *sociocultural*, and *environmental* dimensions pre-defined by Kolcaba (2003). To treat quantitative data, descriptive statistics, this study used the *Statistical Package for the Social Sciences* (SPSS) software, version 23.0 for Windows.

Results

The sample consisted of ten family members of critically ill patients, Caucasian (100%), women (100%), aged between 37 and 79 years (mean = 56 years), and living in the district where the hospital is located. Considering the degree of relationship with the critically ill patient, six were *daughters* (60%), two were *cousins* (20%), and two were *wives* (20%). Regarding education, four family members had higher education levels, namely bachelor's degree (40%) and master's degree (20%), two had basic education levels (20%), one had a secondary education level (10%), and one had a first cycle basic education level (10%). The emergency service spaces where family members were welcomed and approached were the critical care room (70%), the patient observation room (20%), and the emergency care room (10%). The participants' transcribed accounts were identified by the letter "I" (Interviewee) followed by a number referring to the order in which the participants were interviewed.
After the verbatim transcription, the information treatment allowed breaking down, organizing, systematizing, and analyzing the accounts to select, group, simplify, and transform the data. This process resulted in four thematic areas that meet the objectives:

(i) The meaning of comfort for families of critically ill patients
The meaning of comfort included how family members grasped the concept, which allowed understanding the idea of comfort in relation to the elements that gave significance to its experience. The analysis resulted in characteristics included within the *psychospiritual dimension* and connected to a positive and comprehensive meaning, bound to families' individual desires/needs, as exemplified in the family members' accounts: "comfort is well-being" (I5, I7); "security" (I7); "protection (I8); "feeling that you are not alone" (I3); "sharing" (I9); "to love" (I9); "peace of mind" (I6); "without worries" (I5); "having the patience to care for mother" (I8); and "feeling that mother is well" (I8).
This study also observed that the concept of comfort gained meaning in the *physical dimension* when referring to normal body functioning, for example: "being well" (I1; I2; I8; I10); "not feeling sick" (I6); "not feeling pain" (I5; I6); "feeling well" (I4); and "being healthy (E9)".
The concept was also closely related to the *social dimension*, for example, "being accompanied" (I3), "getting along with everyone," and "socializing" (I1), and the *environmental dimension*, for example, "being surrounded by a comfortable environment that transmits well-being" (I2; I4).

(ii) Factors promoting the comfort of families of critically ill patients in everyday life and at the emergency service

To understand how critically ill patients' families experience comfort, this study sought to identify comfort-promoting factors in everyday life (daily setting) and the moment lived (emergency service setting).

In the daily setting, the results obtained were included in the (i) *psychospiritual dimension* and the (ii) *sociocultural dimension* (Kolcaba, 2003).

Regarding the *psychospiritual dimension*, the participants made significant statements such as: "to be with God" (I1); "to know that family and friends are all well" (I3); "to know that there are people who like me" (I4); "that my family and I are safe, without illness" (I6); "peace" (I6); "to be with my children and granddaughter and that they are well, that mother is well" (I8); and "the family to be well" (I10).

The *sociocultural dimension* was identified in participants' statements such as "helping others" (I1; I9); "getting along with everyone" (I1); "being friends of each other" (I2); "talking with others" (I1); "being together as a family, socializing" (I2); "being with [my] children and granddaughter.... "(I8); "having those I love close to me, family and friends" (I9); "doing well at work" (I10); "going for a walk and being outdoors" (I1); "silence" (I5); and "being at home" (I7).

In the emergency service setting, comfort-promoting factors for family members, particularly during the welcoming and the moments of interaction with health professionals, were also included in the (i) *psychospiritual* and (ii) *sociocultural* dimensions.

The subcategory "emotional security/confidence" of the *psychospiritual dimension* stood out in statements such as: "feeling hope" (I1); "professionals' competence" (I1; I2; I3; I4; I5; I6; I7; I8; I9; I10); "knowing what is going on" (I2); "seeing my family member's health/illness situation resolved" (I8); "being looked after with attention" (I9); "the professionals' smile when they welcome us" (I9); "already has some idea of the diagnosis" (I5); "to have updated information on the situation to be able to organize personally and professionally" (I6); and "being able to buy the medicines" (I7). Results were also observed in the sociocultural domain in examples such as: "talking to the doctors and nurses" (I2), "the professionals are friendly" (I8), and "being entitled to days of family care leave" (I8).

(iii) The level of comfort of families of critically ill patients

When asked about their comfort level (in a Likert Scale format from 0 to 10 points) during welcoming and subsequent moments of interaction, the answers of family members of critically ill patients ranged from 0 to 10, with a mean of 5 points.

(iv) Nursing interventions promoting the comfort of families of critically ill patients

Considering nurses' actions, the participants reported that the comfort provided at the emergency service focused on the (i) *psychospiritual* and (ii) *environmental* dimensions.

Within the *psychospiritual dimension*, the results obtained were included in the subcategory "emotional security/confidence", particularly regarding a more significant nurse/family interaction and care humanization, as exemplified in the statements: "professionals contact more" (I2); "talking more with her about the situation" (I2); "talking to people" (I5); "knowing how she is, even if she is the same" (I6); "being humane with patients and family members" (I10); and "being competent, the technical part is important, but the human part is essential" (I10). Grouped in the subcategory "presence/relational approach to the individual," it was possible to identify aspects regarding the presence near the patient, for example, "to allow being next to the husband" (I2). The subcategory "positive attitudes/interaction" included the health professionals' attention, patience, sensitivity, and availability, described in the following accounts: the professional "is patient" (I1); "pays attention" (I1, I5); "does not act too quickly" (I4); "spends time helping people" (I4); is "available" (I5); "is sensitive" (I10); "gives information" (I1, I5, I6); "provides information about the existing religious services" (I1); "provides as soon as possible information that she is well" (I3); provides "guidance about the environment" (I3); and "guidance about social assistance [services]" (I8).

Regarding the *environmental dimension*, this study's participants mentioned aspects such as the improvement of the structure and functioning of the emergency service, namely the right to food (I7), the physical conditions of the waiting rooms (I3), the health professionals' attitude towards the person/family member regarding the proximity and interaction between them in the emergency service spaces (I5), and also the need for people capable of providing guidance in the unknown environment of the emergency service (I3).

Discussion

In a person-centered care approach, describing the phenomenon requires identifying its essential structure, meaning, and significance, as well as the nursing interventions aimed at this population. Person-centered care requires health organizations and their professionals to respect people's experiences and values, recognizing them as whole and unique individuals. From this perspective, it is crucial to understand patients as partners and co-designers of care (Edgman-Levitan & Schoenbaum, 2021).

(i) The meaning of comfort for families of critically ill patients

In the several meanings found regarding the comfort of critically ill patients' family members, some of the results are included in the four categories of Kolcaba's theory (2003), with different perceptions for each family member. The results show a similarity between the phenomenon's multidimensional meaning and a positive and comprehensive nature adjusted to the family's needs and wishes.

The experience of comfort relates to a feeling of well-being. Vaz and Amor (2018) define it as a state of contentment responding to physical and/or spiritual demands and a

sense of comfort and tranquility. The concept is also described as a state of well-being characterized by the absence of various discomforts, such as illness and physical, psychological, and social problems (Sousa, 2020). Nevertheless, it is more expressed physically and associated with pain and other symptoms that cause suffering (Kolcaba, 2003). From a social factor perspective, the results show that interpersonal, family and social relationships positively and favorably influence and generate comfort (Kolcaba, 2003). Also, there seems to be a link between the environment and the concept of comfort through a mutual influence, hence the need for a reassuring environment and privacy.

ii) Factors promoting the comfort of families of critically ill patients in everyday life and at the emergency service

In daily life, comfort-promoting factors are related to the *psychospiritual dimension* and one's internal self-awareness, in which one's meaning, the meaning of life, and the relationship with a higher being are included. Importance is also given to self-esteem, to feeling useful as a form of empowerment that promotes more and better comfort, combining mental, emotional, and spiritual components (Kolcaba, 2003; Sousa, 2020).

In an intentional search for the uniqueness/particularity of each family member, this study's participants mentioned as factors that promote comfort in their daily lives being close to and socializing with family members and friends, having help, sharing and mutual support, and having job stability, which is in line with Santos et al. (2016). Maintaining positive relationships with family and friends makes people feel cared for, loved, esteemed, valued, supported, and with a sense of belonging (Sousa, 2020). The same dimensions appeared in the emergency service, where trust and security, which are positive and therapeutic on their own, were highlighted as comfort instruments and prerequisites for experiencing comfort. Financial stability and education-related factors are fundamental for the state of comfort due to the recognition, stability, and autonomy one wishes to obtain, as well as the supportive attitudes, involvement in care, and decision-making.

The communicational process intervenes in the promotion of comfort, playing a key role in the interaction and development of the therapeutic relationship. Thus, the participants valued health professionals' positive attitudes/interactions, such as friendliness, smiling, and attention, which are included in the *psychospiritual dimension* (Kolcaba, 2003). Such attitudes/interactions are comforting communication skills, understood as care providers' structuring patterns. They facilitate the adaptation to the situation experienced and attribute meaning to the health professional/patient/family relationship, as when transmitting information regarding the patient's condition (Ocak & Avsarogullari, 2019; Sousa, 2020).

Establishing an authentic relationship that promotes the understanding of the situation is a humanized and adjusted response to the experience, which nurses can mobilize through the network of social and emotional support and information to family members (Freitas et al., 2012).

(iii) The level of comfort of families of critically ill patients

Assessing the comfort level is crucial for nurses' actions. According to family members, the welcoming and subsequent moments of interaction were perceived as moderately comfortable. It is worth noting that welcoming is a significant moment of care delivery that must be planned considering comfort promotion. Otherwise, it will generate anguish and stress.

In this initial meeting, comfort needs are high, so the purpose should focus on increasing potential comfort. However, this intention is hardly ever fully achieved (Kolcaba, 2003; Sousa, 2020). Hospitalized patients' family members experience uncertainty, fear, and anxiety regarding the severity of the clinical condition (Galinha de Sá et al., 2015). Therefore, assessing the family members' comfort level is essential to implement comforting, planned, considered, adjusted, and individualized nursing interventions, which can be validated (Sousa, 2020).

(iv) Nursing interventions promoting the comfort of families of critically ill patients

In the care relationship, several strategies related to health professionals' attitudes and behaviors are adopted and assumed as human qualities of the comforting relationship, being included in the (i) *psychospiritual*, (ii) *sociocultural*, and (iii) *environmental dimensions*.

The nurses' behaviors are determinants of the comfort level, contributing to families' greater empowerment and encouragement. Attitudes and postures based on a positive and favorable relationship influence the establishment of bonds of trust.

Developing interpersonal skills combines gestures, postures, and words, in which the way of being in a relationship stands out as an approach strategy. Information and clarification about the patient's clinical condition in an accurate and up-to-date manner, the religious and social assistance services, and the surrounding environment are highlighted as forms of comforting that promote more significant control over one's health care (Ocak & Avsarogullari, 2019; Ponte et al., 2019).

In the structure of comfort, the interaction with the health team proves vital as it allows for communicating concerns, fears, and worries and sharing knowledge (Mendes, 2018). Verbal and non-verbal communication emerges as a key instrument of comfort care, implying the need for nurses to be empathic and close to interact and establish a partnership with critically ill patients and their family members. Promoting family members' close and unique presence is a strategy of interaction and comfort care for families of critically ill patients (Galinha de Sá et al., 2015; Sousa & Marques, 2021). Family members feel the need to maintain close contact with the patient to the extent that they can observe, verify, follow the situation and clinical evolution, as demonstrated in other studies (Freitas et al., 2012; Fortunatti, 2018; Ocak & Avsarogullari, 2019).

In family members' opinion, information/clarification reduces uncertainty, making it easier to manage situations, considering each family member's individuality. This

constitutes a comforting attitude. The complexity of having a critical condition generates feelings of anguish and concern due to the uncertainty of recovery. It also causes suffering, leading family members to develop specific needs focused on the search for maintaining proximity with the critically ill patient and other family members and reorganizing social and professional life and their expectations regarding future life projects (Freitas et al., 2012, Valente et al., 2017; Fortunatti, 2018; Sousa, 2020).
In the studied microculture, the hospital's physical environment, described as humanizing, positively influenced the patient's therapeutic process and the family's comfort.
The results allowed gathering knowledge about the meaning and significance of the phenomenon of comfort for families of critically ill patients and comfort-promoting interventions. However, a study with a larger number of participants using other research methods, namely observation, is recommended. This study has limitations regarding the number of participants who could be interviewed, and the decision not to record the interviews may have limited the recording of information or even conditioned the participants' answers.

Conclusion

The issues regarding comfort play a significant role in nursing, as it is desirable in each individual's life. Nurses' actions focused on supporting, helping, and empowering families are determinants of care and allow these professionals to be recognized as privileged actors of comfort. Within the logic of quality care, comfort emerges as a dimension partially controllable through actions of support, protection, or environment adjustment aimed at families of critically ill patients.
The nurses' emotional support to families is a determinant of care and allows nurses to be recognized as privileged actors of comfort. For critically ill patients' family members, comfort in their daily life is associated with strategies that nurture relationships and create greater proximity, aspects included primarily in the *psychospiritual* and *social dimensions*. In the emergency service setting, family members reported feeling comfortable (mean=5; 0-10). As comfort-promoting factors, the participants highlighted the feelings of security and confidence about the health professionals' technical-scientific and relational skills, the friendliness, smiles, and attention received, the updated information on critically ill patients' conditions, their financial stability, and the right to care for their family and reorganize their personal and professional life.
Regarding comforting nursing interventions in the emergency service setting, the families of critically ill patients suggested strategies to humanize relationships aimed at searching for harmony and information management. A highlight is given to nurses' development of relational and communication skills demonstrating attention, sensitivity, availability, humanization, and concern for providing and updating information on the patient's clinical condition. This development can empower families to improve the reorganization of their life projects. Participants also suggested improving the emergency services' structure and functioning, searching for a physically comfortable environment that facilitates the interaction and proximity between the patient/family/health professionals. It was possible to observe differences in the aspects that comforted families of critically ill patients during the welcoming and moments of interaction in the emergency service setting and everyday life. Comfort was perceived as an individual transitory experience that varies according to the situation, the moment, and the situational context. These aspects align with studies on this phenomenon.
In situations of increased vulnerability, the relevance of individualization guides comforting actions. Through communication skills, it is possible to build a partnership relationship with critically ill patients' families, allowing for the identification of individual needs and promoting nursing interventions capable of improving and enhancing comfort.
In care practice, planning should be the basis of nurses' actions. Nurses must focus on the meaning and significance of comfort to minimize the suffering and discomfort experienced by the families of critically ill patients in emergency settings. The reality of this setting highlighted the importance of individualizing care, considering the uniqueness of the family unit, and tailoring comfort care based on people's actual needs, expectations, preferences, and values.
This study recommends exploring the phenomenon of comfort as a concept inherent to people's satisfaction in different contexts and populations and as a structuring element for the humanization of health care.

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Author contributions
Conceptualization: Lima, E. R.
Data curation: Lima, E. R.
Formal Analysis: Lima, E. R., Sousa, P. P., & Marques, R. M.
Validation: Sousa, P. P., & Marques, R. M.
Writing – original draft: Lima, E. R., Sousa, P. P., & Marques, R. M.
Writing – review & editing: Lima, E. R., Sousa, P. P., & Marques, R. M.

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