



## ORIGINALES

### Comfort of Patients Hospitalized in Intermediate and Intensive Care Units

Comodidad de los pacientes hospitalizados en unidades de cuidado intensivo e intermedio

\*González Gómez, Ana \*\*Montalvo Prieto, Amparo \*\*\*Herrera Lian, Arleth

\*Masters in Nursing. Professor, Universidad de Cartagena. Nurse, Intensive Care Coordinator, MediHelp Services Health Care Clinic. \*\*Masters in Nursing. Professor, Universidad de Cartagena. E-mail: [amontalvop1@unicartagena.edu.co](mailto:amontalvop1@unicartagena.edu.co). \*\*\*Professor, Universidad de Cartagena. Colombia.

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#### ABSTRACT

**Objective:** Associate the sociodemographic factors to the dimensions of comfort (physical, social, psychospiritual, and environmental) of patients hospitalized in intensive and intermediate care units.

**Methodology:** Transversal analytic study with 160 patients hospitalized in the intensive and intermediate care units of four institutions in the city of Cartagena, from July to September 2014. Two instruments were used, the sociodemographic survey and Kolcaba's general questionnaire of comfort. Descriptive statistics and a logistic regression test for data management were used.

**Results:** A total of 57.5% of the participants were women with mean age of 51.7 years; 76.9% with stable partner; 43.4% with secondary schooling (incomplete and complete). The type of comfort transcendence in the social, psychospiritual, and physical dimensions prevailed in the patients and in the environmental dimension the type of comfort reached was tranquility. Association was found among the physical, social, and environmental dimensions with being from a socioeconomic level above two and having secondary or higher education. The psychospiritual dimension had no association with the sociodemographic factors.

**Conclusions:** Patients hospitalized in ICU or in IMCU with higher socioeconomic level had lower probability of feeling comfort during their hospitalization; in the social dimension, patients with more education had a higher probability of feeling comfortable. Belonging to a socioeconomic level above two, reduces the probability for hospitalized patients to feel comfortable in the environmental and physical dimensions.

**Keywords:** Intensive care; patients; relief; comfort. (Source: MeSH, NLM).

## RESUMEN

**Objetivo:** Asociar los factores sociodemográficos a las dimensiones de la comodidad (físico, social, psicoespiritual y ambiental) de los pacientes hospitalizados en las Unidades de Cuidado Intensivo e Intermedio.

**Metodología:** Estudio analítico transversal, realizado a 160 pacientes hospitalizados en las Unidades de Cuidado Intensivo e intermedio de cuatro instituciones de la ciudad de Cartagena, durante los meses de Julio a Septiembre del 2014. Se utilizaron dos instrumentos, la encuesta sociodemográfica y el cuestionario general de comodidad de Kolcaba. Se utilizaron la estadística descriptiva y una prueba de regresión logística para el manejo de los datos.

**Resultado:** El 57,5% de los participantes fueron mujeres con 51,7 años como edad promedio, con pareja estable el 76.9%, secundaria (incompleta y completa) el 43.4%. Predominó en los participantes, el tipo de confort trascendencia en las dimensiones social, psicoespiritual y física y en la dimensión ambiental el tipo de confort alcanzado fue la tranquilidad. Se encontró asociación entre las dimensiones física, social y ambiental con ser de un estrato socioeconómico mayor que 2 y contar con estudios de secundaria o superiores. La dimensión psicoespiritual no presentó asociación con los factores sociodemográficos.

**Conclusiones:** Los pacientes hospitalizados en la UCI o en la UCIN con un mayor estrato socioeconómico presentaron menor probabilidad de sentir comodidad durante su hospitalización; en la dimensión social, los pacientes con mayor educación tuvieron mayor probabilidad de sentirse cómodo. El pertenecer a un estrato socioeconómico mayor que 2, reduce la probabilidad de que el paciente hospitalizado se sienta cómodo en las dimensiones ambiental y física.

**Palabras clave:** Cuidados intensivos; pacientes; alivio, comodidad. (Fuente: DeCS, Bireme).

## INTRODUCTION

Comfort in health refers to a sense of relief of discomfort, to a state of tranquility and satisfaction, or to any feeling, that makes life easy or pleasant. Kolcaba <sup>(1)</sup>, upon defining comfort, found three concepts (relief, tranquility, and transcendence), which are developed into four contexts (physical, psychospiritual, environmental, and social). In the last 20 years, Intensive Care Units (ICU) has become an essential part of almost all general hospitals. Their importance lies on the complexity of the treatment of the seriously ill and their early recovery from serious injuries <sup>(2, 3)</sup>, or for stable patients, who because of their clinical condition or diagnosis need monitoring or continuous interventions from nursing, without invasiveness, these are hospitalized in the intermediate care unit (IMCU).

It is common in patients hospitalized in ICU as in IMCU, due to some health alteration, to see in them and their families much discomfort that interrupts their family function. The individual assumes a passive role; often, the family is isolated and uninformed about their sick relative and their participation in caring for their relative is not considered <sup>(4)</sup>.

Patients hospitalized in ICU or in IMCU, because of their medical condition, depend 100% on the nursing staff to satisfy their basic needs. If patients are conscious and aware, they can manifest their needs, desires and discomforts, which would facilitate care and improve comfort. With patients who are unconscious, or with some degree of sedation or with neurological or mental alterations that make communication difficult by not being able to express their needs verbally, nursing must be mindful to satisfy them, as well as to interpret each variation in vital signs, given that these can be, at certain moments, manifestations of discomfort. It is important to offer nursing care that helps patients feel comfort during their hospitalization.

Being in ICU or IMCU is a difficult situation for patients because all the basic needs (physiological) must be satisfied and carried out in their unit (cubicle) and privacy is quite rare if non-existing. Doing so in the presence of people different from their families may keep patients from stating their real needs, which is why comfort can be altered. Patients in IMCU, by being stable and not under invasive measures – in some cases – may express their needs, which enable the nursing staff to provide care, but the patients' comfort is hindered by the alteration of their privacy.

Care provided to patients has evolved over time and these transformations have led to critical care services being currently considered a fundamental link within health systems, when caring for patients in critical state by, additionally, providing comfort <sup>(4)</sup>, but when offering nursing care it is aimed at improving the patient' health conditions, without bearing in mind their comfort. Nursing must consider that the hospitalization of a critically ill patient in an ICU causes discomfort to the whole family group and comfort is an important and relevant factor for the wellbeing of patients and their families <sup>(4)</sup>.

Caring is the essence of nursing and care is the paradigmatic element that makes the difference between this and other healthcare disciplines <sup>(5)</sup>. Patient care has been traditionally seen by the nursing staff and by common individuals as appertaining to the nursing profession. However, increased technology and specializations in different specific areas has contributed to the depersonalization of health care in current society. To mitigate this loss of identity, it is fundamental to conduct research that involves the components of care; among these, comfort as an indicator of its quality <sup>(6)</sup>.

In this study, the units that participated work in private institutions, provide care to adult patients affiliated to the Colombian General Social Security System during 2014, presented occupation of 86.75% with hospital stay of 5.32 days and average discharge of 28.55 patients per month.

This why Kolcaba <sup>(4)</sup> considered that nursing interventions should be aimed at increasing patient comfort, shifting away from the focus of biological care and moving on to an approach centered on patients and their families. This conception gives way to humane and warm hospitals where families and patients feel at home and the situation disease is not as noticeable. Comfort of patients hospitalized in an ICU is important for their physical, emotional, and spiritual recovery; nursing care provided with quality, security, and humanity favors the wellbeing of critical patients and improves the response to treatments and their quality of life.

Based on the theory and on the instrument by Kolcaba <sup>(7)</sup> to measure the comfort of patients hospitalized in ICU and IMCU, no studies were found on the theme researched. Diverse studies have identified factors that can inconvenience patients hospitalized in these units <sup>(8, 9, 10)</sup>. Gutiérrez <sup>(11)</sup>, in a systematic review of qualitative studies of patients hospitalized in ICU, showed that patients display fear of death when they sense it is near, ignorance of the consequences of the disease and of everything taking place around them, and of a future that completely changes their lives, turning them into handicapped patients or into family burdens. Another fundamental concern for patients is their family's wellbeing, that of their partner's and how they are experiencing their hospitalization.

According to Achury <sup>(8)</sup>, critical patients sense that communication is limited and becomes an emotional and situational element that influences upon the experience of pain because patients who are unable to verbalize their pain or cannot make

themselves understood endure states of anxiety, agitation, depression, sadness, and fear. Likewise, another study <sup>(9)</sup> stated that the presence of precipitating and predisposing factors in the ICU leads to sleep deprivation and originates in patients physiological, social, and emotional complications that increase their mortality and their stay in these units.

According to the researcher's observations in healthcare institutions, the administrative and care organization, the infrastructure, technology, and scientific support of the ICU and IMCU services is different from the provisions in other services offering care to institutionalized patients. A permanent and main concern of nurses in these units (ICU and IMCU) is that of conserving biomedical equipment, supplies, and devices that permit guaranteeing timely care to patients hospitalized and monitoring of vital signs in patients under their responsibility. Here, nurses provide timely care and try to make patients understand that of the multiple interventions performed, some can be uncomfortable and even painful, but which improve and preserve their health. Due to the aforementioned, providing comfort to patients hospitalized in an ICU is an unknown condition for the nursing staff in this setting. It is as of this assumption that the need emerges to see how a patient feels when admitted to ICU and IMCU and, thus, intervene these situations, tracing care plans that are more interventionist, individualized, and real with the experiences of patients.

The comfort phenomenon and the relation established with individuals in need of care in ICU and IMCU is something positive, accomplished as consequence of the care provided by nurses to improve the health situation of hospitalized patients <sup>(12)</sup>.

With these patients, contact with their relatives or caretakers are quite limited and in some units, it only lasts a few minutes during the day. Different researchers have studied the health situation of patients hospitalized in ICU and IMCU nationally and internationally, as well as aspects related to noise, pain, sleep onset of the hospitalized patient, and the patient's communication in situations of invasive ventilator support, but information is yet to be found about the evaluation of comfort of patients in this service.

For the researcher, patients hospitalized in ICU and IMCU need to have their basic needs satisfied by the nursing staff, have comfort measures that must be offered homogeneously, with respect, quality, security, and humanization throughout their hospitalization; this must be provided in each of the shifts. The purpose of this study was to determine the association between the sociodemographic factors and the dimensions of comfort (physical, social, psychospiritual, and environmental) present in patients hospitalized in the intensive and intermediate care units of four hospital institutions.

## **MATERIALS AND METHODS**

Cross-sectional analytic association study, conducted on a sample taken with 95% confidence index and 5% error, from 50 to 70% of those hospitalized during one semester in four of the ICU and IMCU, for 160 patients. The study was classified as minimum risk for the volunteer participants, who had to be over 20 years of age <sup>(13, 14)</sup>. Once the participants understood the objectives and signed the informed consent – they were aware of the possibility of withdrawing and revoking their participation, the information was gathered. Permission was obtained from the scientific directors at the health institutions.

A sociodemographic survey was used along with the general questionnaire for nursing "Comfort in patients hospitalized" designed and authorized for use by Kolcaba <sup>(9)</sup>. The questionnaire has 28 items in a 1 to 4 Likert-type scale. It assesses comfort in four dimensions: physical (six items), social (four items), physical-spiritual (12 items), and environmental (6 items); these dimensions circumscribed to the types of relief, tranquility, and transcendence. The questionnaire has been used in oncology, medical-surgical, psychiatric, and community patients; it was validated in Colombia and obtained a Cronbach's alpha of 0.9 <sup>(1)</sup>. The Cronbach's alpha obtained in this study was 0.74.

Patients received explanations on how to fill out the instruments; the information was gathered through supervision of a nurse trained in its management. The general questionnaire on comfort has a minimum score of 28 points and a maximum score of 112. The statistical analysis established cutoff points for each of the dimensions in the types of relief, tranquility, and transcendence, shown in Table I.

**Table I. Distribution of items and cutoff points for each dimension of comfort**

Types Dimension	Relief	Tranquility	Transcendence	Items
Physical	0-7	8-14	>14	2, 9, 12, 13, 17, 18
Social	0-5	6-10	>10	1, 3, 10, 22
Psychospiritual	0-13	14-26	>26	4, 5, 6, 8, 15, 16, 21, 23, 24, 26, 27, 28
Environmental	0-7	8-14	>14	7, 11, 14, 19, 20, 25

Adaptation by the authors of the instrument General questionnaire of comfort of the taxonomic structure of the theory of comfort proposed by Kolcaba

The study used the Stata 17.0 statistical software; descriptive statistics were generated on the characteristics of the patients hospitalized in ICU, using absolute frequencies and percentages <sup>(15)</sup>. To express information on the levels of comfort found, frequency and prevalence measurements were used, as well as measurements of central tendency, variance, and typical deviation, with 95% confidence intervals.

## RESULTS

The mean age of the patients participating in this study was 51.7 years, of which 57.5% (92) were female. Regarding marital status, 46.3% (74) were married, followed by common-law marriage with 30.6% (49) and those who were single with 11.9% (19). Regarding the level of schooling of the participants, 22.5% (36) reported incomplete secondary, followed by 21.9% (35) with complete secondary; 10% (16) had technical and university studies, respectively.

With relation to the socioeconomic level, those in level 1 prevailed with 41.3% (66), followed by levels 2 and 3 with 26.9% (43) and 26.3% (42), respectively. Reportedly, 36.3% (58) of the patients participating in the study were affiliated to the General

Health Social Security System (SGSSS, for the term in Spanish) in the subsidized regime and 35% (56) of them in the contributive regime. The most prevalent religion was Catholicism with 79.4% (127), followed by Evangelicals with 8.8% (14) (Table II).

**Table II. Distribution according to gender, marital status, schooling, socioeconomic level, and social security of patients hospitalized in ICU and IMCU, Cartagena.**

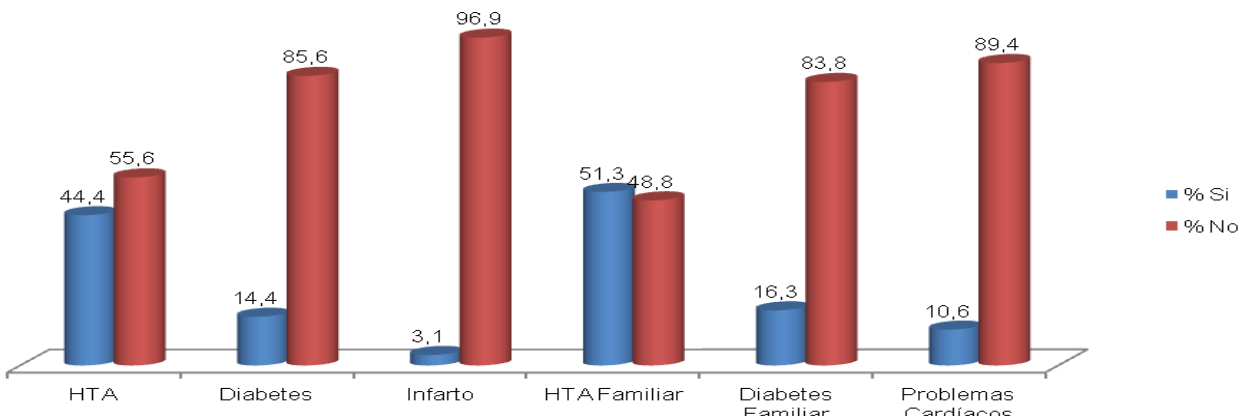
<b>GENDER</b>	<b>N</b>	<b>%</b>
Female	92	57.50
Male	68	42.50
<b>MARITAL STATUS</b>	<b>N</b>	<b>%</b>
Does not know/NR	3	1.9
Married	74	46.3
Divorced	3	1.9
Single	19	11.9
Common-law marriage	49	30.6
Widow(er)	12	7.5
<b>SCHOOLING</b>	<b>N</b>	<b>%</b>
None	8	5.0
Incomplete primary	31	19.4
Complete primary	16	10.0
Incomplete secondary	36	22.5
Complete secondary	35	21.9
Technician or Technologist	16	10.0
University	16	10.0
Graduate	2	1.3
<b>SOCIOECONOMIC LEVEL</b>	<b>N</b>	<b>%</b>
1	66	41.3
2	43	26.9
3	42	26.3
4	2	1.3
6	7	4.4
<b>SOCIAL SECURITY</b>	<b>N</b>	<b>%</b>
Contributive	56	35.0
Exceptional Regime	28	17.5
Without affiliation	3	1.9
Subsidized	58	36.3

Other	3	1.9
Does not know/NR	12	7.5
<b>Total</b>	<b>160</b>	<b>100.0</b>

**Source:** Study data.

Regarding the personal and family pathological antecedents, it was found that 44.4% (71) had hypertension and 14.4% (23) had diabetes; as per family-type antecedents, 51.3% (82) had antecedents of family high blood pressure, background of family diabetes with 16.3% (26), and heart problems with 10.6% (17) (Graphic 1).

**Graphic 1. Personal and family pathological antecedents in patients hospitalized in ICU and IMCU, Cartagena.**

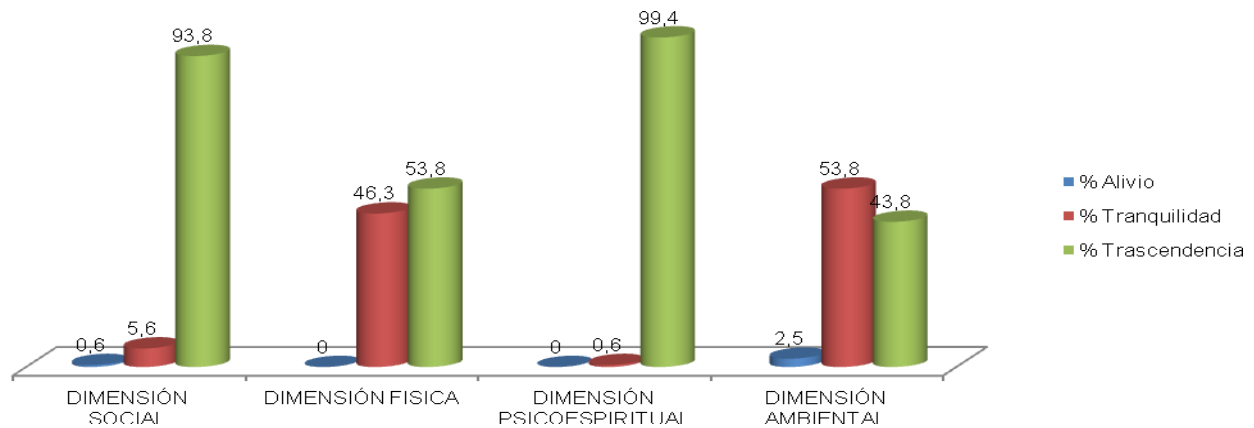


HTA = HBP Diabetes = Diabetes Infarto = Heart attack HTA Familiar = Family HBP Diabetes familiar = Family diabetes Problemas Cardiacos = Cardiac Problems Si = Yes

**Source:** Study data.

Comfort was experienced by patients, according to the three types stipulated by Kolcaba (relief, tranquility, and transcendence), in the social, physical, and psychospiritual dimensions in 93.8% (150), 53.8% (86), and 99.4% (159), respectively. In the environmental dimension, the type of comfort that prevailed was tranquility with 53.8% (86) (Graphic 2).

**Graphic 2. Types de comfort according to each of the dimensions that measure comfort in patients hospitalized in ICU and IMCU, Cartagena.**



Dimensión Social = Social Dimension Dimensión Física = Physical Dimension  
 Dimensión Psicoespiritual = Psychospiritual Dimension Dimensión Ambiental = Environmental Dimension  
 Alivio = relief Tranquilidad = Tranquility Trascendencia = Transcendence

**Source:** Study data.

Upon establishing the associations through the logistic regression test between the sociodemographic factors and the physical, social, psychospiritual, and environmental dimensions, association was found in the physical, social, and environmental dimensions. The psychospiritual dimension presented no association with the sociodemographic factors.

In the physical dimension, being in a socioeconomic level above two diminishes the probability of having greater comfort when hospitalized in an ICU or in IMCU (Table III).

The social dimension was associated negatively with belonging to a socioeconomic level above two (OR = 0.09 0.01 – 0.76), that is, by belonging to a higher socioeconomic level there is lower probability of patients considering they have greater comfort. Having complete secondary or higher studies (OR = 13.99 1.60 – 122.15), was associated positively given that more education is related to higher probability of feeling comfortable (Table III).

The association between the environmental dimension and belonging to a socioeconomic level above two (OR = 0.34 0.13 -0.88) is negative, as well as having complete secondary education or higher (OR = 1.542 0.668 – 3.563). These results show that for the environmental dimension, by belonging to a socioeconomic level above two and having completed secondary studies or more patients hospitalized in ICU or in IMCU have lower probability of having greater comfort (Table III).



**Table III. Logistics regressions of comfort in the physical, social, and environmental dimensions in patients hospitalized in intensive and/or intermediate care units, Cartagena.**

Variables	Physical dimension	Social dimension	Environmental dimension
	OR 95%CI	OR 95%CI	OR 95%CI
Being a woman	1.29 (0.61 - 2.69)	3.17 (0.68 - 14.74)	0.62 (0.30 - 1.30)
Being from socio-economic level above two	0.31 (0.12 - 0.78)	0.09 (0.01 - 0.76)	0.34 (0.13 - 0.88)
Having a partner	1.12 (0.49 - 2.54)	1.46 (0.30 - 7.00)	1.27 (0.56 - 2.86)
Having completed secondary education or more	1.06 (0.46 - 2.41)	13.99 (1.60 - 122.15)	1.54 (0.66 - 3.56)
Being in the contributive or special health regime	0.60 (0.27 - 1.30)	1.05 (0.17 - 6.38)	0.68 (0.32 - 1.46)
Having HBP	1.44 (0.66 - 3.10)	2.54 (0.48 - 13.33)	1.16 (0.55 - 2.46)
Having Diabetes	1.00 (0.33 - 3.06)	1.72 (0.17 - 17.08)	0.54 (0.17 - 1.69)
Having Heart attack	0.21 (0.02 - 2.38)	0.00 (0.00 - 0.00)	0.00 (0.00 - 0.00)
Having a relative with Hypertension	1.89 (0.90 - 3.94)	0.82 (0.18 - 3.63)	1.69 (0.81 - 3.53)
Having a relative with Diabetes	1.95 (0.68 - 5.57)	0.45 (0.06 - 3.42)	1.99 (0.72 - 5.52)
Having a relative con Heart problems	0.45 (0.14 - 1.42)	1.17 (0.11 - 11.66)	0.32 (0.10 - 1.04)

**Source:** Study data.

## DISCUSSION

When applying the logistic regression test to the data obtained in this study and associating the four dimensions proposed by Kolcaba in her Theory of Comfort and the sociodemographic factors, association was found between being from a socioeconomic level above two and having completed secondary studies or above, in the physical, social, and environmental dimensions. No association appeared between the psychospiritual dimension and the sociodemographic factors.

No studies were found to enable the discussion with the results from this research. According to the OR obtained, association was evidenced between socioeconomic level and education, conditions that can allow patients better communication with the

health staff, at the same time that they express their needs and concerns and accept care more naturally, valuing each of the activities conducted. In the physical dimension, being from a socioeconomic level above two diminishes the probability of feeling comfort during hospitalization in ICU or in IMCU; in the social dimension, by belonging to a higher socioeconomic level there is lower probability for patients to feel greater comfort. Having completed secondary or higher studies is associated positively with the probability of feeling comfortable. For the environmental dimension, patients belonging to a socioeconomic level above two are less likely to feel major comfort in this dimension, an aspect that can be attributed to these patients living in better conditions and with economic independence, which is why the limitations of the pathology and the hospitalization may displease them.

With relation to the sociodemographic characteristics, the mean age of patients hospitalized, participating in this study, was 51.7 years. Da Silva <sup>(16)</sup> reported similar results in a descriptive exploratory study with patients with principal diagnosis of acute myocardial infarction admitted to intensive therapy unit, where the mean age interval was between 44 and 54 years. Fernandes <sup>(17)</sup> reported that the mean age of the participants in the research 'Stress of patients in ICU' was 50 years; Marosti <sup>(18)</sup> found similar information in a study, where the mean age was 58.2 years. Given that the ICU and IMCU provide optimal care to patients with serious compromise – real or potential, patients over 50 years of age are more frequently affected in their vital functions and require health care in units that guarantee sufficient material resources and teams of specialized professionals (physicians and nurses, fundamentally) to provide security in the type of care received and guarantee their wellbeing.

With relation to marital status, in this study 76.9% of the patients have a partner. In this regard, Da Silva <sup>(16)</sup> reports that 60% of the patients were married; Marosti <sup>(18)</sup> provides similar information when stating that 55.8% of the patients were married. Contrary to this information, Fernandes <sup>(17)</sup> reports only 25% of the patients with a partner. For individuals hospitalized in an ICU, their condition makes them vulnerable, and having a partner, relatives, or a group of friends lets them have better social support than other patients who do not have this resource.

Regarding schooling, in this study, 21.9% of the participants have completed secondary studies secondary. To this effect, Jiménez <sup>(19)</sup> found that 29.5% have completed secondary studies and reported that no significant difference exists between the capacity to cope and adaptation and the schooling of relatives and patients in ICU.

In this study, 53.2% of the participants belonged to socioeconomic levels 2 and 3, similar to information presented by Bohórquez <sup>(20)</sup> and Zambrano <sup>(21)</sup> who reported that participants in their studies that the participants belonged to these socioeconomic levels. Patients in these socioeconomic levels are subjected to different social and economic pressures that place them at risk of enduring critical health situations that can require hospitalization in critical care units. Due to their many socioeconomic pressures, Bohórquez <sup>(20)</sup> highlights the interest patients have in emerging from that situation to continue with their daily activities, especially work and daily life.

Hugh blood pressure (HBP) ranks first as a pathological antecedent (44.4%) and as family antecedent in 51.3% of the participants and 16.3% of diabetes. Padrón <sup>(22)</sup> reported HBP as the principal personal antecedent in 60.45% of the participants.

Grillé<sup>(23)</sup> describes HBP as risk factor for developing subarachnoid hemorrhage and reports it as personal antecedent in 55% of the patients.

In spite of the exhaustive bibliographic search conducted in different databases and of consulting with the author of the instrument about studies on comfort in patients hospitalized in ICU and IMCU, no reports were found in this respect. In this study, patients hospitalized in ICU and IMCU evaluated the type of comfort on the transcendence level in the social dimension in the sense in which they are above problems or their own pain<sup>(24)</sup>. A different score is reported by Montalvo<sup>(10)</sup> and Uribe<sup>(25)</sup> in their studies, where the type of comfort presented by the patients was of tranquility referred as a state of satisfaction or one that makes life easy or pleasant<sup>(1)</sup>. The type of support received by the patients from their partner, family, and group of friends against this condition of adversity (being hospitalized in an ICU or an IMCU), makes them feel strengthened and diminishes the tensions of being in this situation.

With regards to the physical and psychospiritual dimensions, the data in this study reports that the type of comfort reached by patients was transcendence, with this level of comfort corresponding to the state in which patients are above problems or their own pain. Similar information is reported by Montalvo<sup>(10)</sup> and Gómez<sup>(26)</sup> with relation to the level of comfort reached by patients in these dimensions. Uribe<sup>(25)</sup> reports in the psychospiritual dimension the level of transcendence and relief in the physical dimension referring to this level as the satisfaction of specific needs, which allows patients to transmit and communicate their different needs when requiring care.

This study obtained a level of tranquility in the environmental dimension. Uribe<sup>(25)</sup> and Montalvo<sup>(10)</sup> obtained similar results referring to the state of satisfaction or that of making life easy or pleasant<sup>(1)</sup>. Within the environmental dimension, 59.4% (132) stated that noise does not let them rest. Achury<sup>(27)</sup> expresses that environmental factors are the set of everything surrounding the individual in the ICU. Hence, it includes the biomedical equipment and conditions of service (lighting or noise). Noise is generated by different causes, like conversations of the health staff (nursing), doors being opened, visits from relatives, and the sound generated by telephones, radios, televisions, and monitoring equipment used. These situations described by the researcher coincide with the study results in the environmental dimension where the type of comfort, according to the scale by Kolcaba<sup>(7)</sup>, was tranquility; patients participating do not feel comfortable in this dimension and the item that generates the most discomfort in them is noise.

The data obtained in the four dimensions contradict the researcher's perception about the experience of being hospitalized in ICU, being that it is quite stressful for the patient and it is considered that the results obtained could be due to the reduced number of participants, an aspect that became a limitation of the study. It is worth noting that a condition that must be kept in mind is that patients can easily adapt to the new condition arising.

## CONCLUSIONS

The patients participating in the study were catholic married women with mean age of 51.7 years, secondary education, belonging to socioeconomic level 2, and affiliated to the subsidized regime of the Health Social Security System.

The type of comfort that prevailed was transcendence in the social physical and psychospiritual dimensions, referring to patients being able to be above the problems, a condition that can favor patients hospitalized in a stressful service, like ICU and IMCU.

In the environmental dimension, the type of comfort that prevailed was tranquility that would offer patients satisfaction and comfort against their experiences during their hospitalization. Within the environmental dimension, noise was the biggest discomfort reported by the patients.

For patients hospitalized in an ICU or in IMCU, in the social dimension of comfort, belonging to a higher socioeconomic level indicates lower probability of being considered with greater comfort during their hospitalization; having a higher level of education relates to a higher probability of feeling comfortable.

For the physical dimension of comfort, patients with a socioeconomic level above two reduce the probability of having greater comfort when hospitalized.

In the environmental dimension of comfort, patients with a socioeconomic level above two have a lower probability of having greater comfort.

## Recommendations

Motivate the nursing staff, as leaders in patient care, to conduct education programs on noise management. Develop protocols in management of biomedical equipment – manage alarms. Promote a culture of silence to improve patient comfort.

Carry out patient-care plans, bearing in mind education on the pathology and the antecedents; evaluate the characteristics of the environment and their relation with it. Conduct research with patients hospitalized in ICU and IMCU who show aspects as important as comfort, which they perceive during hospitalization, being such a specialized service, it cannot be separated from humanization in care; comfort must be of transcendence in all dimensions.

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