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Predictors of Perception and Practice of Comfort Measures by Healthcare Providers in Meeting up Comfort Needs of Patients with Traumatic Injuries in Selected Hospitals within South West Region, Cameroon

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Abstract

This study sought to determine health care providers' perceptions of patients' comfort needs and describe the comfort measures practiced by health care providers' in providing comfort care to patients with traumatic injuries. Discomfort in patients with traumatic injuries may result from tissue damage, fractures, wounds, immobilization, invasive procedures, surgical interventions, and other aspects of trauma treatment. A descriptive cross sectional study was carried out. A total of 130 health care providers were selected by convenient sampling from Regional Hospital Limbe and Regional Hospital Annex Kumba. Data was collected with the use of a questionnaire and was analyzed using SPSS version 21.0. Associations between participants' characteristics and perception/practice outcomes were analyzed using multiple linear and logistic regression. The level of statistical significance was set at $p < 0.05$. Majority (85(65.4%)) of the participants were of age range 18-30 years with nurses dominating 85(65.4%). Also, 54(41.5%) had a bachelor's degree while 89(68.5%) of study participants had a working experience of 1-5 years. The highest perception was noticed with psychological comfort measures 118(90.6%) while the least was spiritual that is 80(61.7%) with an overall perception of 104(79.9%) positive and 26(21.1%) negative. Categorizing the practices, 57% had good practices of comfort measures with psychological and environmental comfort measures being the most practiced at 62.3% respectively while spiritual measures of comfort were the least practice at 51.6%. The analysis identified three positive and significant predictors of practice implementation: active listening and providing positive meaning demonstrated the strongest positive association (Unstandardized B = 1.685, Standardized Beta = 0.431, $p = 0.005$), indicating that providers who strongly endorse this interpersonal perception are significantly more likely to implement it in practice, followed by physical therapy, ambulation, positioning, and range of motion (B = 1.224, Beta = 0.345, $p = 0.011$), and respecting cultural practices (B = 0.903, Beta = 0.273, $p = 0.021$). Healthcare providers' demonstrated high agreement with recommended comfort measures across all dimensions, yet significant practice gaps existed with significant predictors to practice of comfort measures. Educational institutions should therefore integrate the six dimensions of comfort (physical, psychological, social, spiritual, cultural, and environmental) into curricula, ensuring students develop competencies in holistic comfort assessment and intervention.

Keywords: Perception, practice, comfort measures, traumatic injuries, comfort needs

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1.0 Introduction

Traumatic injuries are wounds to body tissues that has physical, psychological, emotional and cultural implications to an individual (WHO, 2024). Their occurrences are mostly sudden and are linked to external forces with increasing burden in recent times. According to findings by Nwanna et al., (2018) and Lundin et al., (2025), traumatic injuries account for about six million death and 52 million disability-adjusted life years (DALYs) annually. A systematic analysis across 195 countries and regions reveals that approximately 31.399 million deaths were attributable to trauma related injuries making it the sixth leading cause of death globally (Xia et al., 2024). The burden in low and middle income countries is of particular importance owing to poor health care systems, lack of standardized emergency and trauma care plans, and limited resources (human, material and financial) leading to worsening outcomes (Gosselin, 2022). In less developed nations (low and middle income countries) trauma injury related mortality account for 90% with prospects of increasing (Nwanna et al., 2018).

Traumatic injuries are mostly as a result of road traffic accidents, occupational accidents/hazards, domestic accidents including falls, physical assaults, burns and may occur as a results of gunshots injuries, explosions amongst others (WHO 2024). These injuries can lead to serious immediate life threatening conditions such as trauma-induced coagulopathy, systemic shock, and multiple organ failures amongst others (Dumovich and Singh, 2024). The consequences of trauma injuries are not just physical, there can be psychological and emotional making it more complicated. Those with traumatic injuries can experience anxiety, fear, impaired mobility, sleep and eating disturbance, psychological distress or even post-traumatic stress disorder (PTSD) Lathan et al., (2024), loss of independence, and prolonged hospitalization as a result of immobility leading to about 15% developing pressure sores during their hospitalization (Abdulkareem et al., 2025). These consequences interfere with the body function recovery and the quality of life necessitating implementation of comfort measures.

Comfort is not the absence of physical pain but includes the patients' physical, psycho-spiritual, socio-cultural, and environmental experiences. Kolcaba's Comfort Theory conceptualizes comfort as the immediate experience of being strengthened when needs for relief, ease, or transcendence are addressed across these four contexts (Lin et al., 2024). Patients with traumatic injuries frequently experience complex and changing comfort needs due to physical, psychological, financial, social, cultural and environmental discomfort attributed to their conditions. Maximizing the comfort needs of these patients is not just a universal healthcare goal or fundamental human need but also a safety and security need according to Abraham Maslow. Consequently, comfort care for patients with traumatic injuries requires more than administering analgesics; it involves assessment of individual needs, positioning, and assistance with activities of daily living, maintenance of a conducive environment, communication, reassurance, emotional support, family involvement, and other individualized interventions (Lundin et al., 2025).

Evidence from trauma populations indicates that comfort care can substantially influence patients' experiences and satisfaction with care. For example, an analysis involving more than 112,000 trauma patients found that comfort-related factors were associated with patients' satisfaction with their hospital experience, emphasizing the contribution of comfort care to patient-centred trauma outcomes (Watts et al., 2021). In a study as reported by Clark (2021), it was seen that patients with traumatic injuries without comfort measures had about 17% and 20% higher chances of developing complications and being readmitted respectively. Similarly, studies of patients' experiences have

described comforting behaviours as including competent technical and physical care, attention to physical discomfort, positive communication, vigilance, and attention to patients' families (Hawley, 2000). These findings emphasize that health care professionals' perceptions and practices regarding comfort have important implications for how patients experience trauma. Health care professionals therefore are at the center to ensure comfort of the patients. When these comfort needs are met, the patient becomes hopeful, confident, recovers fast and can die peacefully (Lin et al., 2024).

In Cameroon, traumatic injuries represent an important component of emergency and hospital care. Research conducted in Cameroon has identified significant challenges in trauma care and demonstrated that patients with traumatic injuries may experience preventable morbidity and mortality within resource-limited healthcare environments (Christie et al., 2023). Nevertheless, existing research on trauma in Cameroon has largely concentrated on epidemiology, mortality, access to care, and clinical outcomes, while comparatively less attention has been given to the nursing dimension of trauma care and, specifically, the comfort needs of injured patients. There is limited empirical evidence describing how nurses perceive comfort, the comfort measures they routinely practice, and the challenges they encounter while attempting to meet the comfort needs of patients with traumatic injuries. This hinders the improvement of trauma care. To be able to adequately address this high burden of trauma associated injuries, the health care system must work towards preventing, curative and rehabilitative care including holistic treatment of the patient taking into consideration their psychological, physical, social, spiritual and cultural aspect of their care leading to a state of comfort hence a better quality of life for the traumatic patient (Nwanna et al., 2018).

1.1 Problem statement

The care traumatic patients received is a contributory factor to the mortality rate after traumatic injury. Trauma alone accounts for 10% burden of diseases worldwide and is the most common cause of deaths in adults under 40 in the UK (Nwanna et al., 2018). This can be as a result of road traffic accidents, gunshot injuries amongst others. The challenges on the use of comfort approach as part of the standard guide in the care of such patients has hampered on patients recovery and bring psychosocial challenges to patients. Despite the importance of comfort in nursing care, there remains a paucity of evidence concerning the provision of comfort care to patients with traumatic injuries in Cameroon, particularly within the South West Region.

1.2 Objective of the Study

The objective of this study is to determine the predictors of perception and practice of health care providers in meeting up comfort needs of patients with traumatic injuries in selected hospitals within southwest region of Cameroon.

2.0 Literature Review

The section present the literature review of the study.

2.1 Theoretical review

Kolcaba developed her theory based on the observations that comfort was an undervalued but essential outcome of care, distinct from purely biomedical measures such as vital signs or wound healing. Drawing from the works of Orlando, Henderson, and Paterson & Zderad, Kolcaba synthesized existing nursing knowledge with concepts from ergonomics, psychology, and

palliative care to create a structured framework. Initially, the theory focused on three forms of comfort that is relief, ease, and transcendence and four contexts physical, psycho-spiritual, environmental, and socio-cultural. Over time, the theory evolved to include institutional integrity, best practices, and best policies, extending its applicability from individual patient care to organizational and community-level interventions. Relief comfort usually comes in the form of pain management through medications. Ease comfort is focused more on the environment and psychological state of the patient (Dowd, 2017). Finally, transcendence comfort comes when a patient is able to rise above challenges that occur in care and recovery. Lin et al., 2024 mentioned that the theory has been cited in over 1,500 peer-reviewed articles, demonstrating its sustained relevance. It is further observe that the theory's middle-range status allows it to be operationalized in diverse settings without requiring wholesale paradigm shifts, making it particularly attractive for low-resource environments such as trauma care in Cameroon.

2.2. Empirical Review

In a study by Silva et al. (2018) in Portugal, titled "Comfort Needs and Measures of Patients Admitted to Intensive Care Units," the objective was to identify comfort needs and corresponding comfort measures delivered by nursing staff to intensive care unit (ICU) patients, based on Kolcaba's Comfort Theory. The methods involved qualitative content analysis of nursing care records, which yielded 55 registration units. These were categorized into comfort needs (28 units) and comfort measures (27 units). Detailed results showed that among comfort needs, 28% were physical, 14% environmental, 56% psycho-spiritual, and 14% social. Among comfort measures, 18% concerned suffering relief, 56% peaceful atmosphere, and 26% transcendence. The study concluded that ICU patients' comfort needs are predominantly psycho-spiritual and physical, while nurses most frequently adopt measures aimed at relieving suffering and creating a peaceful environment, with less emphasis on transcendence. The implication for the present study on healthcare personnel's views on comfort measures is that nurses intuitively prioritize psycho-spiritual needs and immediate suffering relief over environmental or social aspects. However, the gap between high psycho-spiritual needs and only moderate use of transcendence measures suggests that healthcare personnel may require further training to address holistic comfort fully, especially in high-acuity settings where physical needs often dominate attention.

Reichman et al. (2023) conducted a study titled "Healthcare Professionals' Perceptions of Integrated Psychosocial Care in Orthopedic Settings," aiming to explore health professionals' views on integrating psychosocial services into orthopedic trauma care, given that 50% of orthopedic patients experience psychosocial distress impacting recovery. Methods comprised 18 semi-structured focus groups with 79 orthopedic professionals (surgeons, residents, nurses) across three Level-I Trauma Centers, using the Rainbow Model of Integrated Care for hybrid inductive-deductive qualitative analysis. Detailed results revealed that professionals identified benefits across all six integration dimensions (clinical, professional, organizational, system, functional, normative), including increased patient satisfaction, reduced provider burden, and lower healthcare costs. Barriers included fast-paced clinic flow and mental health stigma, with recommendations tailored to each dimension. The study concluded that integrated psychosocial care can improve recovery and long-term outcomes, but implementation requires addressing organizational and attitudinal barriers. The implication for the present study on healthcare personnel's views on comfort measures is that professionals recognize comfort as extending beyond physical pain relief to include psychosocial support. Yet, barriers such as time constraints and stigma may prevent

personnel from routinely offering psychosocial comfort measures, highlighting the need for systemic changes to embed holistic comfort into standard protocols.

3.0 Methodology

The study adopted a quantitative descriptive cross-sectional design and was conducted at Regional Hospital Limbe and Regional Hospital Kumba in the South West Region of Cameroon. The study population comprised healthcare providers, including nurses, midwives, medical doctors, pharmacists, laboratory scientists, and other professionals involved in caring for patients with traumatic injuries. Eligible participants had worked in the selected facilities for at least one year and were involved in trauma care, while those who declined consent were excluded. A total of 130 healthcare providers were recruited using convenience sampling. Data were collected using a structured questionnaire assessing socio-demographic characteristics, perceptions of comfort measures, and comfort care practices across physical and physiological, psychological and emotional, social, cultural, spiritual, and environmental dimensions. Perceptions were measured using a four-point Likert scale, while practices were assessed using a five-point frequency scale. The questionnaire was reviewed by nursing experts and pretested among ten healthcare providers at Regional Hospital Buea, with Cronbach's alpha coefficients ranging from 0.605 to 0.981. Participation was voluntary, confidentiality was maintained, and completed questionnaires were checked for completeness. Data were coded and analysed using SPSS version 21.0. Descriptive statistics included frequencies, percentages, and appropriate measures of central tendency and dispersion, while associations between participant characteristics and perception or practice outcomes were examined using chi-square tests and logistic regression at a statistical significance level of $p < 0.05$.

4.0 Results and Findings

This section presents the findings obtained from the 130 healthcare providers who participated in the study. The results are organized into seven subsections covering the socio demographic characteristics of participants, healthcare providers' perceptions of comfort care measures, the association between perception and demographic characteristics, practices of comfort care measures, overall practice across the six dimensions of comfort, the relationship between providers' perceptions and their practices, and multivariable factors associated with perceived comfort. To enhance clarity and avoid excessively lengthy presentation, the findings are summarized in tables showing the major patterns and statistically relevant results, followed by brief interpretations of the findings.

4.1 Socio Demographic Characteristics of Healthcare Providers

The socio demographic and professional characteristics of the 130 healthcare providers were examined to describe the profile of the participants included in the study. Table 1 summarizes the predominant characteristics.

Table 1: Summary of Socio Demographic Characteristics of Healthcare Providers

Characteristic	Predominant Category	n (%)
Age	18 to 30 years	85 (65.4)
Sex	Female	93 (71.5)
Level of training	Diploma	60 (46.2)
Profession	Nurse	85 (65.4)
Professional experience	1 to 5 years	89 (68.5)
Hospital	Regional Hospital Limbe	88 (67.7)
Previous trauma training	Yes	77 (59.2)
Desire for trauma training	Yes	122 (93.8)

The findings indicate that the study population was predominantly young, female, and nursing based. Healthcare providers aged 18 to 30 years constituted 65.4% of the sample, while females accounted for 71.5%. Nurses formed the largest professional group at 65.4%, followed by laboratory scientists, medical doctors, midwives, and pharmacists. Regarding educational preparation, diploma holders represented 46.2%, while 41.5% had bachelor's degrees. Most participants also had relatively limited professional experience, with 68.5% having worked for between one and five years.

Regional Hospital Limbe contributed 67.7% of the participants compared with 32.3% from Regional Hospital Kumba. Although 59.2% of the healthcare providers reported having received previous training in traumatic injuries, 93.8% expressed a desire to receive further training. This substantial demand for additional training suggests that previous exposure to trauma related education may not have fully addressed providers' perceived learning and competency needs. It further supports the importance of continuing professional development in comprehensive trauma and comfort care.

4.2 Healthcare Providers' Perception of Comfort Care Measures

Healthcare providers' perceptions were assessed across physical and physiological, psychological and emotional, social, cultural, spiritual, and environmental dimensions of comfort. Table 2 summarizes selected measures reflecting the strongest and comparatively lower levels of agreement within each dimension.

Table 2: Summary of Healthcare Providers' Perceptions of Comfort Measures

Comfort Dimension	Highly Endorsed Measure	Agreement %	Comparatively Lower Endorsed Measure	Agreement %
Physical and physiological	Medication and oxygen or non-invasive ventilation	95.4	Acupuncture or acupressure	50.8
Psychological and emotional	Therapeutic touch	94.6	Attention focusing	80.0
Social	Patient communication staff	91.6	Financial resources and paperwork support	66.9
Cultural	Respecting cultural practices	83.0	Same dimension measure	83.0
Spiritual	Providing spiritual care	75.3	Supporting personal rituals for dying patients	48.5
Environmental	Calm, soothing, quiet and peaceful environment	95.4	Family lounge and beds in the room	51.6

The results demonstrate generally favourable perceptions of comfort measures across the six dimensions. The highest agreement was reported for creating a calm, soothing, quiet, and peaceful environment and for medication and oxygen or non-invasive ventilation, both at 95.4%. Psychological and emotional measures were also strongly endorsed, including therapeutic touch, encouragement, reassurance, respect for privacy, patient education, and active listening. Social measures such as patient staff communication and positive body language were similarly viewed favourably, indicating that participants recognized comfort as extending beyond the management of physical pain. Overall, 104 healthcare providers, representing 79.9%, had a positive perception of comfort measures, while 26 had a negative perception. Psychological comfort recorded the highest categorical perception at 90.6%, whereas spiritual comfort recorded the lowest at 61.7%. The pattern is consistent with the multidimensional understanding of comfort presented in Kolcaba's Comfort Theory, whereby effective comfort care incorporates physical, psychospiritual, sociocultural, and environmental needs. Nevertheless, the relatively lower endorsement of some spiritual and environmental interventions indicates areas where awareness of holistic comfort care could be strengthened.

4.3 Association Between Perception of Comfort Measures and Demographic Characteristics

Chi square analysis was conducted to determine whether healthcare providers' perceptions of comfort measures differed according to their demographic and professional characteristics. Table 3 summarizes the association results.

Table 3: Association Between Perception of Comfort Measures and Demographic Characteristics

Characteristic	χ^2	p Value	Interpretation
Age	1.218	0.544	Not significant
Sex	3.907	0.048	Significant
Level of training	2.188	0.701	Not significant
Profession	1.693	0.794	Not significant
Years of experience	0.390	0.942	Not significant
Previous trauma training	0.016	0.898	Not significant
Hospital	0.977	0.323	Not significant

Statistical significance was determined at $p < 0.05$.

Sex was the only demographic characteristic significantly associated with healthcare providers' perceptions of comfort measures, with $\chi^2 = 3.907$ and $p = 0.048$. Female healthcare providers demonstrated a higher proportion of positive perception at 89.2% compared with 75.7% among male healthcare providers. The finding suggests that perception of the importance of comfort measures differed according to sex within the study population. Age, educational level, profession, years of professional experience, previous trauma training, and hospital were not significantly

associated with perception because their p values exceeded 0.05. Positive perceptions were therefore evident across different professional and demographic categories rather than being concentrated among providers with a specific level of training, experience, or professional background. These results indicate that demographic characteristics alone provide limited explanation for differences in how healthcare providers perceive comfort care.

4.4 Practice of Comfort Care Measures by Healthcare Providers

Healthcare providers reported how frequently they implemented comfort measures in their routine care of patients with traumatic injuries. Table 4 presents a concise summary of representative frequently practiced measures across the six dimensions.

Table 4: Summary of Self-Reported Practice of Comfort Measures

Comfort Dimension	Representative Measure	Frequently Practiced	Often or Almost Always (%)
Physical and physiological	Assessing patients' pain and comfort level		78.4
Psychological and emotional	Calling patient by name and giving full attention		71.5
Social	Facilitating communication between patient and care team		61.5
Cultural	Respecting patients' sociocultural background		55.4
Spiritual	Respecting beliefs and religious affiliation		65.4
Environmental	Providing a comfortable and clean environment		70.0

Physical comfort assessment was among the most consistently implemented practices, with 78.4% of providers reporting that they assessed patients' pain and comfort levels often or almost always. Similarly, 73.8% frequently ensured relief from pain or physical discomfort. Within psychological and emotional care, 71.5% reported frequently calling patients by name and giving them full attention, while 70.0% regularly provided explanations and education concerning care plans and procedures. Taking time to talk and listen to patients was also frequently practiced by 69.2% of providers. Environmental comfort measures were also relatively well implemented. Seventy percent frequently provided a comfortable and clean environment, while comfortable beds and chairs were reported as routinely provided by 71.5%. Implementation was comparatively less consistent for several social, cultural, and spiritual interventions. The findings therefore demonstrate that healthcare providers practiced several important comfort measures, but the frequency of implementation varied considerably according to the nature and dimension of the intervention.

4.5 Overall Practice of Comfort Measures

The individual practice items were categorized to determine the overall level of comfort care practice within each of the six dimensions. The findings are summarized in Table 5.

Table 5: Overall Practice of Comfort Measures by Dimension

Dimension of Comfort	Poor Practice n (%)	Average Practice n (%)	Good Practice n (%)
Physical and physiological	26 (19.6)	27 (20.8)	77 (59.6)
Psychological and emotional	27 (20.8)	22 (16.9)	81 (62.3)
Social	32 (24.6)	27 (20.8)	71 (54.6)
Cultural	34 (26.1)	28 (21.5)	68 (52.4)
Spiritual	34 (26.1)	29 (22.3)	67 (51.6)
Environmental	27 (20.8)	22 (16.9)	81 (62.3)
Overall	30 (23.0)	26 (20.0)	74 (57.0)

Overall, 57.0% of healthcare providers demonstrated good practice of comfort measures, while 20.0% had average practice and 23.0% had poor practice. Psychological and emotional comfort and environmental comfort recorded the highest levels of good practice at 62.3% each, followed by physical and physiological comfort at 59.6%. Social comfort recorded 54.6% good practice, while cultural and spiritual comfort recorded lower levels of 52.4% and 51.6%, respectively. The results reveal an important difference between perceived importance and actual implementation of comfort measures. For example, physical comfort measures had a perceived importance level of 85.2%, compared with an implementation level of 68.2%, producing a practice gap of 17.0%. The original findings similarly identified substantial gaps across other comfort contexts. Thus, although healthcare providers generally recognized the importance of holistic comfort care, this recognition did not consistently translate into routine practice. The lower implementation of sociocultural and spiritual measures highlights areas requiring greater attention in training and clinical practice.

4.6 Relationship Between Provider Perception and Practice of Comfort Measures

The relationship between healthcare providers' perceptions and implementation of comfort measures was examined to identify perception related factors that significantly predicted practice. Table 6 presents the significant positive and negative associations.

Table 6: Significant Predictors of Practice Implementation

Provider Perception or Measure	B	Standardized β	p Value
Active listening and providing positive meaning	1.685	0.431	0.005
Physical therapy, ambulation, positioning and range of motion	1.224	0.345	0.011
Respecting cultural practices	0.903	0.273	0.021
Education, information and answering questions	-1.641	-0.406	0.013
Applying heat or cold	-1.109	-0.314	0.032
Psychosocial support	-0.773	-0.231	0.049
Sharing stories and communicating with families	-1.047	-0.282	0.049

Active listening and providing positive meaning demonstrated the strongest positive association with practice implementation, with $B = 1.685$, $\beta = 0.431$, and $p = 0.005$. This was followed by

physical therapy, ambulation, positioning and range of motion with $B = 1.224$, $\beta = 0.345$, and $p = 0.011$. Respecting cultural practices was also positively associated with implementation at $B = 0.903$, $\beta = 0.273$, and $p = 0.021$. These results emphasize the importance of interpersonal communication, physical rehabilitation, and culturally responsive care in translating perceptions of comfort into clinical practice. Conversely, education and information, heat or cold application, psychosocial support, and communication with families produced statistically significant negative coefficients. These inverse relationships are comparatively counterintuitive and should not be interpreted as evidence that the interventions themselves reduce comfort. Rather, they indicate the direction of association within the fitted multivariable model. The positive contribution of cultural respect remains compatible with culturally congruent approaches to care reflected in Leininger's Culture Care Theory, while the strong contribution of active listening demonstrates the importance of relational aspects of holistic comfort care.

4.7 Multivariable Factors Associated with Perceived Comfort

A multivariable linear regression model was fitted to examine the combined contribution of demographic characteristics and selected comfort related variables to perceived comfort. Table 7 provides a summary of the principal model statistics and predictor results.

Table 7: Summary of Multivariable Regression Analysis of Factors Associated with Perceived Comfort

Model Component	Result
Multiple R	0.701
R^2	0.492
Adjusted R^2	0.102
F statistic	1.262
Overall model p value	0.174
Durbin Watson statistic	1.598

The model yielded $R = 0.701$ and $R^2 = 0.492$, indicating that the combined variables accounted for 49.2% of the observed variation in perceived comfort. However, the adjusted R^2 declined substantially to 0.102 and the overall regression model was not statistically significant, $F = 1.262$, $p = 0.174$. This difference between R^2 and adjusted R^2 suggests that the model contained a relatively large number of predictors in relation to the sample size and may therefore have been over fitted. Consequently, although several individual coefficients attained statistical significance, these associations should be interpreted cautiously because the overall model was not statistically significant.

None of the demographic factors, including age, sex, level of training, profession, years of experience, hospital, previous trauma training, and desire for additional training, independently predicted perceived comfort in the multivariable model. The Durbin Watson statistic of 1.598 did not indicate a major autocorrelation concern. Collectively, the results suggest that specific care behaviours may be more relevant to comfort implementation than general provider characteristics. This supports the need to strengthen practical competencies in active listening, culturally responsive care, physical comfort interventions, psychosocial support, and holistic assessment rather than relying solely on professional experience or qualification.

5.0 Conclusion

Healthcare providers' demonstrated high agreement with recommended comfort measures across all dimensions, yet significant practice gaps existed: physical, psycho-spiritual, socio-cultural, and environmental, revealing that providers recognize the importance of comfort interventions but face systemic barriers to implementation. The regression analysis revealed that active listening was the strongest positive predictor of both practice implementation and patient comfort, while education and psychosocial support showed negative associations, suggesting that interventions must be carefully tailored rather than applied generically.

6.0 Recommendations

Educational institutions should integrate the six dimensions of comfort (physical, psychological, social, spiritual, cultural, and environmental) into curricula, ensuring students develop competencies in holistic comfort assessment and intervention. Clinical placements should provide supervised practice in pain management, active listening, and family communication, preparing graduates to implement adaptable, resource-sensitive care in diverse healthcare settings across Cameroon. Further study should be conducted to identify the factors affecting the implementation of comfort measures

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