

EXPERIENCES OF WOMEN LIVING WITH HEART FAILURE

A RESEARCH PAPER

SUBMITTED TO THE GRADUATE SCHOOL

IN PARTIAL FULFILLMENT OF THE REQUIREMENTS

FOR THE DEGREE

MASTERS OF SCIENCE

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MUNCIE, IN

MAY 2012

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Abstract

RESEARCH PAPER: Experiences of Women Living with Heart Failure
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DATE: May, 2012

The majority of studies related to heart failure (HF) focus on men, or include only a limited number of women. There are differences in symptom manifestation and management between men and women related to incidence, age of diagnosis, risk factors, survival rate, and response to treatment of HF (Rhodes & Bowles, 2002). More information is needed about how women with HF perceive life experiences. The purpose of this qualitative study is to describe perceptions of women living with HF from a personal perspective. A phenomenological approach using Colaizzi's methodology will be used. This is a replication of Rhodes and Bowles' (2002) study. The anticipated purposeful sample will include 10 women ranging in age from 60-70. Women will have been diagnosed with Stage II HF by a cardiologist per New York Heart Association (NYHA) classification, living at home, and able to accomplish activities of daily living (ADL) independently. Open-ended interviews will be conducted with each woman by the researcher lasting about 2 hours. The question is: How do women with HF perceive life experiences? Understanding the daily lived experiences of women with heart failure will provide clinicians useful information in the development of plans of care that are specific to this population.

Chapter I

Introduction

During the past two decades, the prevalence of heart failure has tripled and affects millions of people worldwide (Riegel et al. 2010). It is estimated that nearly five million Americans exhibit some form of heart failure. The prevalence of heart failure approximately “doubles” with each decade of life (The San Diego Cardiac Center (2010). Retrieved from <http://www.heartfailure.org>).

Heart failure is a progressive, debilitating and chronic disease with frequent exacerbations of symptoms that result in hospitalizations, high mortality rates and impaired quality of life. Damage to the heart muscle and weakening of the entire cardiovascular system are two major consequences associated with heart failure. Fluid congestion and inadequate blood flow are two of the most prominent symptoms exhibited. Heart failure has been described as a syndrome rather than a disease, with a symptomatic and progressive deteriorating disease trajectory (Yu, Lee, Kwong, Thompson, & Woo, 2007).

Heart failure may develop after other conditions have damaged or weakened the heart muscle. Some conditions that may cause heart failure are: heart attack, coronary artery disease, hypertension, faulty heart valves, cardiomyopathy, myocarditis, congenital

heart defects, heart arrhythmias, diabetes, anemia and hyperthyroidism (Mayo Clinic staff, 2011. Hsich, 2010).

Heart failure can be caused by any disease or virus that attacks the heart muscle. This process happens over time and may be subtle. Heart failure eventually weakens the pumping action of the heart muscle and causes the ventricles to stretch. The heart is unable to keep up with the normal demands required to pump blood throughout the rest of the body. The effect heart failure has on daily living and quality of life for patients are important areas to consider when defining and developing quality of care models. Many studies related to heart failure have focused primarily on the pathophysiology of heart failure including treatments and medications, without a focus on the actual “lived experience” of the patient, (Albert M., Eastwood C., & Edwards, M., 2004; Agard, A., Hermeren, G., & Herlitz, J., 2004; Benatar, d., Bondmass, M., Ghitelman, J., Avitall, B., 2010). It is important for health care providers to have a clear understanding of the broad impact this disease has on patients when planning care models for the future.

Few studies have focused specifically on women and the effect heart failure has on the lived experience. Although some progress toward gender equity has been made, women diagnosed with heart failure continue to be understudied. Heart failure affects about 2.5 million women in the United States. Despite the fact that women account for nearly 50% of all hospital admission for heart failure, only 25% of women are involved in heart failure studies (Hsich, 2011).

In studies examining gender differences, women have been shown to carry a greater burden from heart failure. Women are hospitalized more often than men from disease complications and are more likely to be diabetic or hypertensive. A study by

Plach (2008) of 30 women (medium age 60 years) hospitalized due to heart failure, demonstrated that women had greater symptom severity, significantly lower quality of life and poorer perceptions of their health status than those with less severe heart failure symptoms. Continued study of gender differences related to heart failure is needed to validate Rhodes and Bowles' (2002) findings.

Background and Significance

Heart disease is the leading cause of death in women causing 1 in 3 deaths each year (American Heart Association 2012, retrieved from www.heart.org). More women die from heart disease than from the next three causes of death combined, including all forms of cancer. It has been noted that 64% of women who die suddenly of coronary heart disease had no previous symptoms (American Heart Association Go Red for Women, 2012, retrieved from, www.goredforwomen.org). Among chronic diseases, heart failure is the most common single cause of hospitalization in industrialized countries. Persons with heart failure experience frequent re-admissions to acute care setting, high costs and prolonged length of stay (Welstand, Carson, & Rutherford, 2009).

Causes of heart failure in women are often linked to high blood pressure, coronary artery disease, valvular disease and diabetes. This is not unlike the clinical picture demonstrated in men. Yet, women often present with atypical symptoms such as shortness of breath, unlike men who often have chest pain. Furthermore, women tend to be older with initial diagnosis.

Research has shown that women after a heart attack receive beta blockers, ACE inhibitors and aspirin less often than men (Hsich, 2011). These differences in treatment have been associated with a higher rate of complications and death. Coronary artery

disease and long-standing high blood pressure are two of the most common causes of heart failure, (Cannon & Vierck, 2009).

Women are the primary decisions makers in the home related to the use of health care services. Additionally women are responsible for the majority of their own care. A common belief is that women take better care of themselves than men (Lee, C., Riegel, B., Driscoll, A., Suwanno, J., Moser, D., Lennie, T., Worrall-Carter, L., 2009). Lee et al. found that women wait longer than men to seek emergency treatment when having heart related symptoms, additionally the authors found that physicians were slower to recognize the severity of illness in women.

The clinical and demographic differences in men and women are also demonstrated with the need for different health care services (Song, Moser, & Lennie, 2009). Women with heart failure and other cardiac conditions are more likely to have psychosocial distress and require more social support than men (Heo, Moser, Lennie, Riegel, & Chung, 2008).

The underrepresentation of women in heart failure research is not limited to drug trials. There is also a gap in the literature related to studies addressing the impact of the disease on quality of life (Allen, Arslanian-Engoren, & Lynch-Sauer, 2009). As a result, inadequate knowledge exists related to experiences of women living with heart failure. Paton, Backlund, Barnes, and Thirsk (2007) report that “women with heart failure experience social isolation, depression, sleep deprivation, malnutrition, fatigue and anxiety which are directly associated with non-compliance, inappropriate self-care, re-hospitalization and mortality” (p. 7). Women find it very difficult to accept lifestyle changes imposed on them by their disease, leading to an inability in performing simple

household tasks, supporting family and friends, and continuing work. Women begin to feel as if they are a burden to others (Paton et al.).

According to Rhodes and Bowles (2002), there is relatively little known about a women's response to heart failure and the challenge remains to evaluate the impact heart failure has on older women's lives. This study revealed the significance of understanding not only the impact heart failure has physically on a women's body and the impact heart failure has on the meaning of every aspect of daily life. The challenge for health care professionals is to provide a positive focus for heart failure patients and encourage these patients to take an active role in their life while coping with this disease. This approach may impact physical and mental health as well as providing an opportunity for an improved quality of life for each woman. Further study is needed specific to women in order to validate the results from this study.

Statement of Problem

Despite the fact that heart failure is heavily researched, there are only a limited number of studies specific to women and the effects heart failure may have on quality of life. Most methods used to evaluate a patient's symptoms limit themselves to measuring symptom occurrence and distress, failing to consider the meaning and importance these symptoms may have on activities of daily living. Rhodes and Bowles (2002), sought to examine and describe the experience of living with heart failure from the perspective of women actually living every day with this disease.

Purpose of Study

The purpose of this qualitative study is to explore and describe the lived experiences of women with heart failure from a personal perspective.

Research Question

How do women (65 years of age and older) with New York Heart Association (NYHA) Stage II heart failure perceive their own lives?

Theoretical Framework

A qualitative design based on Husserl's descriptive phenomenologic approach is used as the framework for this study. Husserl regarded the "experience" as the fundamental source of knowledge. His aim was to rigorously study events as they appear in order to arrive at an understanding of the human experience (Dowling, 2007). The purpose of phenomenology is to evaluate and then describe a specific phenomenon in relation to everyday experience. The ultimate goal is to find meaning and understanding (Balls, 2009). This framework is appropriate because this study seeks to explore, describe understand how a woman's personal experiences of living with heart failure affect daily life.

Definition of Terms

Heart Failure: Conceptual

Heart Failure, also known as congestive heart failure (CHF), is a term used when the heart is unable to pump enough blood to meet the body's needs. Over time, conditions such as narrowed arteries in the heart (coronary artery disease) or high blood pressure gradually leave the heart too weak or stiff to fill and pump efficiently (Katz & Konstam, 2009).

Lived Experiences: Conceptual.

The lived experience is used to describe firsthand accounts and impressions of a specific experience.

Gender Specific: Conceptual.

Gender describes a range of characteristics that are used to distinguish the differences between males and females including the masculine and feminine attributes assigned to each. Gender specific medicine is the study of how the normal function and the experience of disease differs between men and women or the comparison of the two sexes (Legato & Bilezikian, 2010)

Interviewing: Operational.

Interviewing is a process in which one person questions, consults and or evaluates another in regards to a specific topic.

Limitations

Due to the nature of qualitative studies, this study will be limited to a small convenient sample. All participants will be over the age of 60. There will be several interviews lasting from 30-60 minutes each. It cannot be assumed that all women with heart failure would have similar experiences.

Assumptions

1. Most aspects of a women's life are affected by heart failure.
2. Women with heart failure actively participate in the health care they receive.
3. Women with heart failure seek education about the disease.
4. Women with heart failure strive for control and management of their illness.

Summary

The lived experience of heart failure in women is understudied. Heart Failure affects approximately 2.5 million women in the United States. Despite the fact that women account for nearly 50% of all hospital admissions for heart failure, only 25% of women are involved in heart failure studies (Hsieh, 2011). Understanding the lived experience associated with women and heart failure will add to the body of knowledge that explores the impact on quality of life and care models that are needed and desired by patients.

The purpose of this qualitative study will be to examine and describe the experiences of women living with heart failure from a personal perspective. A phenomenological approach using Colaizzi's methodology will be used for this work.

This is a replication of Rhodes and Bowles' (2002) study. The findings will further provide information for health care providers in understanding the "lived" experience of women living with heart failure.

Chapter II

Review of Literature

Introduction

The prevalence of heart failure has nearly tripled over the past two decades; in the United States alone about 570,000 new cases are diagnosed each year (Riegel, B., Dickson, V., Cameron, J., Johnson, J., Bunker, S., Page, K., & Worrall-Carter, L., 2010). Heart failure is a debilitating chronic illness, which frequently is characterized by exacerbations in symptoms that frequently result in hospitalization, high mortality rates and impaired quality of life (QOL). The incidence of heart failure continues to increase each year around the world. Treatment is complex, intensive and expensive not only in health care resources but family life. Heart failure is heavily researched, Imes, C., Dougherty, C., Pyper, G., & Sullivan, M., 2011, as well as Lee, C., Riegel, B., Driscoll, A., Suwanno, J., Moser, D., Lennie, T., Worrall-Carter, L., 2009, and Rauh, R., Schwabauer, N., Enger, E., & Moran, J., 1999, provide studies focusing primarily on men, or include only a limited number of women without distinguishing gender differences. Women demonstrate clinical as well as demographic differences in comparison to men and require different care services. In women, heart disease remains the leading cause of death, in comparison with men, women present with very different symptoms and somewhat different risk factors. These differences identified by Rhodes

and Bowles (2002) lead to delayed presentation or less aggressive interventions. The purpose of this study is to examine the uniqueness of women's experiences in relation to living with heart failure.

Organization of the Literature

The literature review consists of selected research studies focusing on the experience of living with heart failure. The supportive literature review is divided into four categories: (a) organizing framework, (b) living with heart failure (c) outcomes for persons living with heart failure and (d) experiences of women living with heart failure.

Organizing Framework

The organizing framework for this study is the experience of women living with heart failure, based on Husserl's descriptive phenomenology approach. Husserl regarded the "experience" as the fundamental source of knowledge. His aim was to rigorously study events as they appear in order to arrive at an understanding of the human experience (Dowling, 2007). The goal of the phenomenological approach is to understand the essential features of a phenomenon; providing the study is as free as possible from cultural influence. The purpose of phenomenology is to evaluate and then describe a specific phenomenon in relation to an everyday experience; the ultimate goal is to find meaning and understanding. This study explores, describes and seeks to understand how a woman's personal experiences of living with heart failure affect daily life.

Living with Heart Failure

There is an expectation that patients will assume responsibility for their day to day care. This is especially evident in the acute care setting with the decreased length of stay and the emphasis on outpatient care. There have been numerous studies conducted

related to services provided for patients but few have concentrated on self-management. Welstand et al. (2009) conducted an integrative review exploring the experiences and perceptions of patients living with heart failure, “find any commonality that might enhance care for this patient population and areas for future research” (p 1374). The purpose of this integrative review was to provide a clearer understanding of self care behaviors through the summarization of past empirical or theoretical studies.

Welstand et al. (2009) using integrative methodology set out to answer the research question, “Do patients share any common concerns, perceptions and themes about their experiences of living with heart failure that might enhance care giving?” (p. 1375). Inclusion criteria included studies specifically related to patient’s experience. Exclusion criteria were studies not published in English, and review and discussion papers. A total of 2588 papers were identified. Further exclusion criteria implied studies that focused on the disease process and/or did not included information about the lived experience for the patient.

Eighteen studies were selected. The studies clearly reflected a focus of the patient’s experience of living with heart failure. The settings for all 18 studies reviewed were worldwide with Sweden (n= 7), USA (n=6), UK (n=3), and Canada (n=2) (Welstand et al., 2009). The total sample size included 245 patients and 32 relatives/caregivers. The gender mix included 73 women, and 156 men, with three studies inclusive of male only (n=47), and three women only (n=24). The age range within the sample was 29-90.

The studies identified as appropriate were examined with a more formal analytical process in order to alleviate any subjective influence. According to Welstand et al.

(2009), “the data gathered should be allowed to speak for itself in keeping with the open methodology of the review” (p. 1376).

A constant comparative method of data analysis was used. This was done to prevent any methodological/theoretical issues to influence results. Each study was treated as transcribed data, and initial themes and categories were all identified. The use of a constant comparative process was repeated throughout the review to ensure that any emerging and final categories were clearly grounded in data, as well as resolving any discrepancies about the data. This process ensured that results did not fit into more than one category. Welstand et al. (2009), stated in the discussion that having two members of the review team validate the information provided an additional element of trustworthiness to the final categories that emerged.

Five conceptual categories were identified from the analysis of 18 studies: “diagnosis and manifestations of heart failure”, “perceptions of day-to-day life”, “coping behaviors”, “role of others”, and “concept of self”. Each category appeared to influence the other and revolved around the “concept of self,” ultimately each patient living the experience of heart failure had to redefine self, and then determine how this “new self” would function in day to day life, (Welstand et al., p. 1376).

The authors concluded from this review that there was limited literature available which examined the patient’s lived experience with heart failure. The exploration of the 18 studies generated some important conceptual categories about the lived experiences of patients with heart failure. The categories represent both positive and negative experiences that are neither predictable nor sequential but form a significant part of all

patients' experience of heart failure. This appears to imply the notion of supporting individuals on a journey of accepting a new self as described by Welstand (2009).

Educational information and specific programming provided to persons suffering from an illness have been shown to improve well being and compliance with medical regimens. Adequately informed patients are able to make decisions concerning medical interventions, treatment regimens, and end of life care. Agard et al. (2004) proposed that patients with heart failure do not have an adequate knowledge base concerning their medical condition and treatment options. The authors sought to explore the patients' knowledge of heart failure and attitude toward medical information, and to assess different patient-related factors that might hamper the improvement of patients' knowledge. The research question was: What effect does adequately informing heart failure patients have on their life experience? This study is a conceptual analysis of what constitutes adequate information in the context of heart failure as seen from the perspective of the patient. The authors included a component of ethical consideration in regards to a patients' right to participate in the decision-making process and influence outcomes in care

Sahlgren's University Hospital in Gothenburg, Sweden provided the setting for this study. A sample of 40 patients (25 men and 15 women) participated; the mean age was 73, with a range of 60-80 years. The inclusion criteria were a verified chronic heart failure diagnosis, mentally competent, and undergoing treatment. This diagnosis was considered to be the main cause of symptoms. This sample was designed to provide representation from patients of different ages, and at various stages of heart failure. The

interviews were conducted in an outpatient clinic, and varied in length from 20 to 40 minutes (Agard et al., 2004).

Semi-structured interviews were conducted with four open-ended questions (interview guide) to collect data. The interviews were not tape recorded. The authors tested with pilot interviews conducted by the primary investigator. The primary investigator was not the primary physician providing care for patients. The questions were the following:

1. What is your opinion about the medical information that you have been given?
2. What kind of information is lacking?
3. What information have you been given about heart failure?
4. What is your attitude toward receiving prognostic information? (Agard et al., 2004, p. 220).

Several themes were identified from the interviews. Units of meaning such as different levels of comprehension, various reasons, wishes, experiences and points of view were then identified and classified according to similarities in content (Agard et al., 2004). From this information, the authors agreed that the interpretation of the data and categories were satisfactorily related to their original context.

The findings resulted in four categories. The first category presented involved the level of knowledge the patients had about heart failure. The majority of the patients (n=34) had a vague understanding of the disease, other patients (n=25) did not seem to be aware that taking medication daily would be lifelong. Findings demonstrated that patients did not view this as a life altering illness. There were nine participants that had an adequate knowledge base about heart disease and heart failure (Agard et al., 2004).

The second category “opinions on basic information” revealed that the majority of participants did have enough information to make decisions about their health and treatment. There were two participants that were very critical and did not feel they had been informed (Agard et al., 2004).

The third category finding “attitudes toward receiving or not prognostic information” provided the researchers with insight into the patient’s feelings about prognosis. Did having more information about heart failure lead to negative feelings or did this allow for a more hopeful affect of thought processes? Several of the participants agreed that yes the patient had the right to be informed and be able allowed to take care of the practical aspects of life (Agard et. al., 2004). The fourth and final category involved the perceptions of the prognosis. Some of the patients were overoptimistic and remained hopeful that death could not be predicted while others felt that life ends because of advanced age.

According to Agard et al., (2004) “embedded in the qualitative approach is the opportunity for questions to be raised about the subjectivity of the interpretation of the interviews, the interviewer’s influence on the respondents’ answers and the researchers’ credibility” (p. 224). The results yielded three main conclusions. First the authors noted that there was a discrepancy between the patient’s actual knowledge of heart failure and apprehension of being satisfactorily informed about heart failure. Second, the authors surmised that the participants were unaware of a knowledge deficit and may not have wanted to improve the level of knowledge, and finally, there were a number of patients that simply did not want to receive information. It was noted that only a few of the

participants sought additional information or were interested in information about their prognosis (Agard et al., 2004).

Additional conclusions noted that many participants were satisfied even though they had limited information about heart failure, some participants did not view heart failure as a deadly disease, and several were indifferent to receiving specific information. Agard et al. (2004) “claimed that adequate information is the kind of information that needs to be provided to manage a patient securely and effectively, information that is not requested or cannot be understood does not make a difference to the patient or affect his or her choice is redundant” (p. 225).

Heo et al. (2008) found in this study that there are three major concerns regarding gender differences in relation to self-care behavior, lack of self-care in patients resulting in high hospitalizations rates, psychological factors, knowledge and functional status relating to a patient’s ability to care for themselves and gender differences affecting psychosocial and functional status in heart failure patients. The purpose of the Heo et al., (2008) study was to identify gender related correlates to self-care behaviors in heart failure patients and to determine whether there were gender differences involved in these correlates. The research question was: Are there gender differences in relation to self-care behaviors in heart failure patients?

The sample for this study was recruited from outpatient clinics of one academic medical center, and two community hospitals in a US Midwestern city. Participants were recruited during routine follow up visits to the cardiologist based on the following inclusion criteria: primary diagnosis of heart failure confirmed by clinical, signs, symptoms and radiographic evidence, ability to read and speak English, no diagnosis of

psychiatric or cognitive problems as determined by medical record review and patient interview, and 18 years of age and older (Heo et al., 2008).

The sample size was determined by a calculation based on prior studies considering an α of .05, power = 80%, 6 predictors, and a total expected $R^2 = .25$, (Heo et al., 2008). Eligibility was confirmed by the research associates through medical record review. There were one hundred twenty-two participants who met the inclusion criteria, 77 men and 45 women.

Recruitment and data collection occurred between 2004 and 2006 using a cross-sectional, correlational study design. Seven instruments were used to assess differences in gender correlates (Heo et al., 2008). These were:

1. Self-Care of Heart Failure Index (SCHFI)
2. Beck Depression Inventory (BDI-II)
3. Control Attitudes Scale-Revised
4. SCHFI sub-scale
5. HF knowledge and barriers to Adherence Scale
6. Duke Activity Status Index
7. Multidimensional Scale of Perceived Social Support

Descriptive and clinical data were also collected and analyzed using standard statistical measures such as: means, standard deviations and percentages, Chi-square test, Mann-Whitney U and independent t -test for interval variables to assess gender differences.

Findings from Heo et al., (2008) revealed that both men and women exhibited self-care behavior scores that were less than 70% of the standardized score, indicating the majority of men and women with heart failure did not consistently engage in self-care

behaviors. Results indicated that men had better functional status than women. It was also noted that higher self-care confidence, better perceived control over heart failure and symptom management, and knowledge of how to manage heart failure were related to better self-care behaviors ($F [3,116] = 13.16, R2 = .25, p < .001$). Data analysis related to age showed that older participants demonstrated better self-care behaviors ($F [4,115] = 12.85, R2 = .31, p < .001$). Depressive symptoms, social support and functional statuses were not significantly related in regards to age.

Multiple regression analysis related to gender indicated that positive perceived control and heart failure management knowledge were related to better self-care behavior in men ($F [2,73] = 7.90, R2 = .18, p = .001$). Further analysis demonstrated that when age was entered into the evaluation older age related better to self-care behaviors in men, ($F [3, 72] = 8.36, R2 = .26, p < .001$) (Heo et al., 2008).

Higher self-care confidence and poor functional status were related to better self-care behaviors in women ($F [2, 41] = 10.82, R2 = .35, p < .002$). Depressive symptoms and social support were not related to either men or women's self-care behaviors in relation to confidence and functional status (Heo et al., 2008).

Heo et al., (2008) have indicated that the results of this study provide insights into self-care behaviors in patients with heart failure. Self-care confidence was the strongest factor affecting self-care behaviors, with perceived control and heart failure knowledge influencing the patients' involvement in self-care behavior.

The authors concluded that self-care behaviors were poor, however several modifiable factors affecting patients' self-care behaviors were identified that could be targeted. In order to provide effective interventions for heart failure patients, the

uniqueness of men and women should be considered. The authors further concluded that when working with heart failure patients, clinicians need to address the self-care status unique to gender, and focus interventions on modifiable factors specific to men and women (Heo et al., 2008).

Outcomes for persons living with heart failure

Outcomes for heart failure remain poor inspite of advances in medical treatments. The treatment for heart failure is complex and requires a comprehensive individualized plan of care for each patient. A study by Benatar et al. (2003), hypothesized that the method by which outpatient care is delivered may affect outcomes in this patient population (p. 347). The purpose of this study was to compare the outcomes of patients receiving home health care from a Nurse Telemanagement (NTM) approach to actual home nursing visits (HNV). The method of delivering the home care was the focus of the study. The outcomes were length of stay (LOS), heart failure hospitalization charges, readmissions and preintervention, and post intervention quality of life (QOL) measurements.

Study participants were enrolled from two medical centers using a prospective randomized design. These criteria were: documented diagnosis of heart failure as determined by means of radiographic evidence of pulmonary congestion, documented New York Heart Association (NYHA) functional classification III or IV, conventional clinical heart failure symptoms of dyspnea and edema that responded to diuresis and echocardiographic evidence suggestive of heart failure. The sample consisted of 216 patients (63.9% female and 36.1% male, average age 63). All patients were randomized

to either the NTM group or the HNV group to allow for attrition (N=108) (Benatar et al., 2003).

It was found that all patients completed at least 3 months of the study. Although short, this period allowed for a rapid turnover of Nurse Telemanagement and Home Nurse Visit methods in an attempt to decrease overall costs while still accomplishing the heart failure teaching goals (Benatar et al., 2003). Additional outcomes were measured at 6 and 12 months. Sex and race were representative of the ethnic and sex composition of the population that received services at two medical centers.

A prospective randomized design was used in this study to compare heart failure outcomes. Four Quality of Life (QOL) measurement instruments were included and completed both before and after the intervention: Minnesota Living with heart failure Questionnaire, Quality of Life Index – Cardiac Version, Hospital Anxiety and Depression Scale, and Heart Failure Self-efficacy Scale. The hospital charges were calculated according to the discharge summary. The Diagnosis Related Group (DRG) and Length of Stay (LOS) per hospital days' data were also included. The researchers utilized the following methods in presenting the analysis. The Shapiro-Wilks test was used to test for normal distribution, a 2-group repeated-measure analysis of variance was used to compare the continuous variables preintervention and postintervention. The χ^2 evaluated the discrete variables and the Mann-Whitney and Wilcoxon rank sum tests were used for the nonnormally distributed variables, (Benatar et al., 2003).

The results indicated that after 3 months of outpatient care, the patients in the nurse telemanagement group had fewer heart failure readmissions and shorter LOS compared with the home nurse visit group. The results continued at the six and twelve

month mark. The QOL measurements improved in both groups after intervention as compared to baseline data.

Hospital charges at 3 months were smaller for the nurse telemanagement group compared the home nurse visit group. The findings were reinforced with similar findings at 6 and 12 months.

In conclusion, the authors suggested that a telemonitoring service was more efficacious than home nurse visit in decreasing readmission rates and costs. It was found that QOL measurements were significantly improved in both groups. Benatar et al., (2003), suggest that these findings reinforce the importance of outpatient support for all patients.

The transition for older adults from a hospital setting to home is known to be a vulnerable period. Naylor, Brooten, Campbell, Maislin, McCauley and Schwartz (2004), “examined the effectiveness of using transitional care interventions delivered by advanced practice nurses [APNs] to elders hospitalized with heart failure” (p. 675). Elders with heart failure have a very high incidence of rehospitalization among adult patient groups. This growing segment of the population is living longer with chronic health problems. These chronic health problems are complicated by breakdowns in care during patient transition from hospital to the home setting. This breakdown of care between hospital and home negatively affects quality of life (QOL) and consumes a large amount of health care resources.

System factors have been identified as contributing to a breakdown in care. The leading causes identified are lack of communication between caregivers, inadequate education to both the patient and caregivers in regards to heart failure as well as limited

access to resources. The purpose of this study was to examine the effect structured APN intervention on postdischarge planning and home follow up will have on elders hospitalized with heart failure. The research question was: Did the re-hospitalization rate decrease following the completion of the comprehensive intervention program as directed by the APN (Naylor et al., 2004)?

The setting for this study included six hospitals. There were 239 patients age 65 and older enrolled in the study. Patients were divided into a control group and intervention group using a computer-generated, institution-specific block 1:1 randomization algorithm. Research assistants obtained baseline health status data and other demographic information from the participants. Other demographic information included mean age (76 vs. 77, $p = .089$), race (64% vs 69% white, $p = .20$), and gender (57% vs. 59% female, $p = .804$). Inclusion criteria included a diagnosis of heart failure, English speaking, and alert and oriented, reachable by phone after discharge and residing within a 60-mile radius of the admitting hospitals (Naylor et al., 2004).

Telephone interviews were conducted at 2, 6, 12, 26, and 52 weeks after discharge to gain information about any rehospitalization and/or unscheduled visits to physicians, emergency departments, or clinics. The following instruments were used to assess information about rehospitalization and unscheduled visits to physicians. Quality of life was assessed using the Minnesota Living with Heart Failure Questionnaire. Functional status was measured using the Enforced Social Dependency Scale, patient satisfaction was assessed using an investigator-developed instrument at 2 and 6 weeks post index hospitalization (Naylor et al., 2004). During hospitalization, a comprehensive patient assessment using valid and reliable instruments was conducted that addressed,

“patients’ and caregivers’ goals; nature, duration and severity of heart failure and comorbid conditions, physical cognitive and emotional health status, general health behaviors and skills and availability and adequacy of social support” (Naylor et al., 2004, p. 677).

Positive outcomes in this study are defined as decreased readmission rates, lower instance of death, increased QOL, patient satisfaction and lowered healthcare costs. Findings demonstrated the length of time to first readmission or death was greater in the intervention group. The patients receiving intervention demonstrated greater patient’s satisfaction, but only short-term improvements were demonstrated in overall QOL. The number of visits and projected costs for home visits was higher for the intervention group during the 52 weeks post discharge, the costs were balanced by reductions in heart failure and co-morbidity related readmission within the first six months post discharge (Naylor et al., 2004). The study confirms earlier results about the short-term effectiveness of such interventions in improving heart failure related outcomes in older adults.

Naylor et al. (2004) related that findings support a transitional care program substantially enhances patient management strategies needed to improve clinical outcomes for this growing population of elders that are living longer with multiple, debilitating conditions while at the same time reducing costs.

Experiences of Women and Heart Failure

Women are increasingly identified as a risk for heart failure and Myocardial Infarction (MI). Women have a longer life-span than men, and risk factors are different for women (Rhodes & Bowles, 2002). Women view heart failure as beyond personal control and experience a sense of loss including anger, depression and powerlessness. It

is important to understand the perceptions of women in relation to heart failure in order to treat women holistically. The purpose of this phenomenological study was to examine and describe experiences of women living with heart failure. The research question was: “How do older women with Stage II heart failure perceive their own lives?”(Rhodes & Bowles, 2002, p. 442) A descriptive phenomenology approach was used to describe the meaning of this experience from the women’s perspective. Inclusion criteria for participants included women ranging in age from 60-90 and diagnosed with New York Heart Association (NYHA) Stage II HF. Five Caucasian were chosen for this study and had lived with heart failure between two and 10 years.

The setting for the interviews was determined by each participant, with the majority held in homes, although one participant chose a senior center location that was comfortable. One hour semi-structured interviews were conducted. Colaizzi’s steps were used to analyze the verbatim transcripts. The interviews continued until a saturation point was reached, in other words no new information emerged with additional time together. Two questions were used; (a) “Is this description of heart failure accurate about your life experience? (b) Is there any important aspect of living with heart failure which has not been described here based on your experience?” (Rhodes & Bowles 2002, p.7). If additional questions were asked they were used to keep the interview on track and or to clarify information that had already been given. For this study, the researcher bracketed beliefs and assumptions derived from experience and the literature and recorded these in a log before interviews began (Rhodes & Bowles, 2002).

With analysis of transcribed narratives, four themes emerged, the themes were:

Acknowledging Losses – all five women described physical and social losses and expressed concern with maintaining control of their lives. They had all suffered some level of depression and emotional control was at times difficult. The five women acknowledged their losses and found ways to accept and go on.

Accepting losses – not only did the women have to learn to accept physical limitations, change their mental outlook and shift their emotions in order to accept the losses heart failure had brought but also a major shift for all five was to allow tasks to be unfinished or at least for tasks to require far longer time than they would have liked.

Changing their lives – accepting their losses was one thing, but moving on required the women to change their lives. The women focused on what they could do, not what they could no longer accomplish on their own. All five women refocused their mental energy as well to a more productive method.

Deepening relationships – this theme revealed that the women began to deepen relationships with those close to them and whom they interacted with consistently. The women had also deepened their relationships with their God, making strong efforts to demonstrate their beliefs in their lives, to treat others, well and to strengthen their faith (Rhodes & Bowles, 2002).

The findings of this study are similar to findings of prior studies in regards to participants considering alternative approaches to activities of daily living (ADL), maintaining control of life, depression, and a decrease in social activity however; there are very few studies specific to women so comparison of findings is difficult (Rhodes & Bowles, 2002) .

Implications for practice identified by Rhodes and Bowels (2002) are that nursing can and does play a pivotal role in assisting the heart failure patient in developing a positive plan and encouraging each individual patient to take charge of their own lives. Education also fosters a positive course, as the women in this study wanted to know about their disease and were willing to make changes in their daily lives to delay progression of the disease. The final conclusions indicate that more research is needed but that even though every aspect of a women's life is affected by heart failure, these women drew on inner strength to create a meaningful life inspite of this disease.

It is known that men comprise the majority of heart failure research subjects, and few qualitative studies are done that specifically examine women. Men and women are nearly equal in the prevalence of heart failure yet women with heart failure are more likely to succumb to the disease. Allen et al. (2009) described the purpose of this pilot study to seek a better understanding of the "lived" experiences of women with New York Heart Association (NYHA) class III heart failure.

Descriptive phenomenology provided the theoretical framework for this (Allen et al., 2009) study based on the premise that a deeper understanding of this identified phenomena can be obtained by the exploration of the lived experiences. It is projected by the authors that heart failure has a profound impact on women's lives, affecting physical, social, emotional, mental, spiritual and economic functioning for everyday life.

Potential participants for this study were screened with the following inclusion criteria; female; diagnosed with NYHA class III heart failure; 21 years of age; capable of verbally articulating their experiences with heart failure; and willing to participate in recorded telephone interview (Allen et al., 2009). The sample consisted of four women.

The participants ranged in age from 49-64 years. Additional demographic data related to marital status, years with heart failure, employment status, and reported co-morbidities were collected. Telephone interviews were selected in order to avoid travel for the participants and were completed in one conversation.

Participants were asked to describe what it was like living with heart failure; interviews were audio-recorded and transcribed verbatim. The interviewer used techniques of active listening. At the close of each interview a summary was presented to the participants for clarification and feedback. Interviews were considered complete with participant agreement. Data were analyzed using the Giorgi 5 step method. This method includes:

- Researcher reads the data multiple times and the transcriptions as compared with oral to ensure accuracy
- Data is read a second time in slow purposeful manner, investigators dwell on the data in order to understand the women who live it, identifying individual units of meaning
- Develop themes from individual units of meaning
- Develop concepts captured from the meaning of each thematic category, identify focal meanings
- Focal meanings integrated and synthesized into a structural description of the meaning of the lives experience (Allen et al., 2009)

The findings revealed five themes: developing a new conception of self, conceding physical limitations, enduring emotional heartache, accepting support, and rejuvenating through rest. Allen et al., (2009) summarized the findings by comparing two similar

studies conducted specific to women. It was found in this study that women welcomed the care and support received, whereas in contrast to previous work women believed they were a burden. The women in this study were somewhat younger than in previous work (49-64) as compared to 60-90. The women in this study expressed a desire to participate in order to maintain professional activity which was not reported in the older group from previous studies. Both in previous work and in this study, participants developed a new self-image as a result of drastic limitations imposed by heart failure. Allen et al. (2009) found three of the four women reported depression which does coincide with previous finding of 35% to 64% depression among women with heart failure.

The authors identified the nurses role with women and how the involvement of a nurse could be a catalyst for strengthening relationships as women adapt to a new lifestyle and live a more purposeful and meaningful life.

Allen et al. (2009) concluded that living with NYHA class III heart failure is a complex phenomenon for women. It requires women to develop a new conception of self as a consequence their physical limitation and emotional heartache induced by the disease and because of the need for rest and to accept support. Due to the small sample size, this study is only a beginning and the authors encourage researchers to explore more in-depth the life of women living with heart failure.

The understanding of symptoms for those living with an illness is often measured by the number of occurrences and or level of distress but fail to consider the importance these symptoms have on a person's life. Fatigue is reported in both quantitative and qualitative studies to be one of the most common and distressing symptoms among people with chronic heart failure (Hagglund, Boman, & Lundman, 2008). Fatigue is a

chronic symptom for heart failure patients, and affects all aspects of a patient's life. The purpose of this study was to examine the lived experience of elderly female heart failure patients in regards to fatigue. An explorative, descriptive design was used.

The setting for this study was each patient's home with narrative interviews conducted by the researcher. Women were recruited from an outpatient clinic at the local hospital. The inclusion criteria were: women age 70 years or older, diagnosed with heart failure confirmed by the criteria of the European Society of Cardiology, and the ability to communicate in Swedish (Hagglund et al., 2008). There were 19 patients who qualified of the study, and 10 women agreed to participate. Demographic data showed the age of the participants between 75-89 years, with mean age 83, regarding marital status, one woman lived with her husband, the other 9 lived alone, and all ten women lived in apartments experienced other co-morbidities.

Each narrative interview lasted approximately an hour with the opening question the same with each woman "please tell me about what it is like to live with heart failure and in particular how you experience fatigue"(Hagglund et al., 2008, p. 291). Follow up questions were asked for clarification and for conversation. Each interview was audio recorded and transcribed verbatim. The transcriptions were then reviewed for accuracy. The researcher was involved in this process. The analytical process was guided by qualitative content analysis as described by Graneheim and Lundman (Hagglund et al., 2008). During the process of analysis movements were made between the whole and parts of the interview text, in order to confirm the interpretations made at a higher level of abstraction (Hagglund et al., 2008).

Findings from Hagglund et al., (2008) identified two themes and five subthemes. The themes were labeled “living with the loss of physical energy” and “striving for independence while being aware of deteriorating health”. The women identified three subthemes in relation to “living with the loss of physical energy” to include experiencing a substantial presence of feebleness, and “unfamiliar bodily sensations”, “experiencing unpredictable variations in physical ability” and “needing help from others in daily life”. Two subthemes were identified in relation to “striving for independence” while being aware of deteriorating health: acknowledging one’s remaining abilities, and being forced to adjust and struggle for independence.

The authors concluded that the women living with heart failure experience an unpredictable variation in physical ability. This leads to limitations in what woman want to do vs. what woman are really able to perform. However the women continued to find joy in life within the constraints of their illness. This experience of fatigue, as narrated by 10 elderly women with heart failure, appeared as a power which engulfed the whole body, with substantial consequences for everyday life (Hagglund et al., 2008). The authors further concluded that fatigue, similar to pain must be considered a subjective experience. Nurses caring for elderly heart failure patients must engage in dialogue with the patient to ascertain the patient’s level of fatigue and how this will influence the plan of care and ability to improve the patient’s daily life.

Heart failure has a significant impact on the everyday life of those living with the disease and there is minimal research on this impact especially with women. Paton et al. (2007) conducted a study regarding the day-to-day challenges faced by women with heart failure. The purpose of this interpretive study was to highlight the everyday challenges

women living in the community with heart failure experience, and how to make sense of the experience and work through challenges. This important information will provide the clinical nurse a knowledge base that would be helpful and supportive during discharge planning for women with heart failure. The framework for this study was based on this interpretive phenomenological approach. The research question was: “What are the day-to-day challenges encountered by woman living in the community, medically diagnosed with heart failure?”

Seven women, all living in a large urban community, met the following inclusion criteria: medical diagnosis of heart failure, no current need for support from either the acute care setting or the outpatient heart failure clinic, the primary investigator contacted each participant to review the purpose of the study and process involved. Demographic data collected related to age (47-75), marital status (3 married, 2 widowed, 2 divorced), and economic status (4 stable, 3 on public assistance) (Paton et al., 2007).

Each participant was individually interviewed by the primary investigator and co-investigator in the participants own home. Interviews were unstructured. The researchers started the interview with a grand tour question, “Could you describe an average day and some of the challenges that you have encountered?” (p. 9). Probes included “How did this affect your plans?” and “How did you respond or resolve the challenge?”(Paton et al., 2007, p. 9). All interviews were audiotaped and took approximately 1 to 1 ½ hours. The interviews were transcribed verbatim. The participants were provided an opportunity for a second interview during the data collection phase, but none of the women accepted.

Findings resulted in the identification of three themes: recalibrating time and space, balancing wishing and hoping, and acknowledging loss, persevering through

personal, social and practical uncertainties (Paton et al. 2007). It was noted that the women in this study voiced frustration in the process of reaching the diagnosis of heart failure, as all received a different diagnosis initially. Also co-morbid conditions played a role prior to the diagnosis of heart failure and these conditions affected the entire process of establishing diagnosis and treatment. The frustration surrounding length of time for diagnosis was evident from the findings.

Findings also revealed that women need to attain a level of psychosocial stability. Paton et al. (2007) stated that the three themes could be used to create a “discharge planning framework, in which the registered nurse could be central in guiding women through the process of recalibrating, balancing and acknowledging loss” (p. 12). The nursing observation provides information about what the patients expect from themselves and what is expected from others.

Paton et al. (2007) concluded that findings from the three themes, encompassing the core element of uncertainty could offer a starting point for women in similar situations. The women could describe to the nurse how each one envisaged an activity level, a vision for the future, and the disparity between what ‘is’ and what ‘was’. This information provides a positive opportunity for the clinical nurse to establish a relationship with the patient to not only meet the physical needs but also to partner with the patient in establishing a realistic plan for living at home with heart failure.

Heart failure in relation to women continues to be an issue with underrepresentation in clinical trials and misunderstanding of the differences in presentation and symptoms between women and men. The purpose of this study is to “compare functional status between women and men with heart failure, determine

whether sex-based differences exist for factors that influence functional status and examine whether depressive symptoms mediate the link between physical symptoms and functional status in women and men” (Song et al. 2009, p. 2). The theoretical framework for this study was based on the middle-range theory by Lenz, which specifically includes the concept of the symptom experience.

The setting for this study was on three cardiology units at Yonsei University Medical Center, Severance Hospital in Seoul, South Korea. Inclusion criteria included: 20 years of age or older, heart failure diagnosed by two cardiologists and confirmed per the Framingham criteria and American Heart Association stage C (current or previous symptoms of heart failure associated with underlying structural myocardial change) or stage D (symptomatic at rest or with minimal activity despite optimal medical therapies) heart failure (Song et al., 2009). There were 244 eligible patients, eight patients refused, and five withdrew, which left 231 for the final sample. The mean age of the sample was 63. Demographic data related to: functional status, comorbid diseases, medications, situational factors, psychological symptoms and physical symptoms.

Questionnaires were given to the participants. The primary investigator and a trained researcher assisted the patients with completion of the questionnaire. Six variables were measured.

1. Functional Status was measured using the Korean Activity Scale/Index
2. HF Symptoms were measured using the Symptom Status Questionnaire
3. Depressive symptoms were measured using the Beck Depression Inventory
4. Living status – alone or not
5. Socioeconomic Status – education, occupation, income range

6. Clinical Characteristics – disease state and demographic information (Song et al., 2009).

The functional status of patients reflects the progression of the disease; women with heart failure have higher rehospitalization rates than men, and a worse quality of life than men, (Song et al., and 2009). Results provided evidence that women in this study had worse functional status than men with heart failure. Women also demonstrated depressive symptoms more often than men. Severe depressive symptoms were associated with worse functional status in women, but not in men. Physical symptoms appeared to play a significant role with women due largely to the fact that symptoms of dyspnea on exertion, fatigue, and ankle swelling affected a woman's ability to care for her family and perform domestic responsibilities. These physical symptoms for women appeared to be increased by the level of depressive symptoms, which in turn affected the overall functional status for each woman. Men on the other hand did not seem as affected by depressive symptoms. The authors recommend further research on sex-specific interventions. Interventions designed for each gender should be developed to improve functional status (Song et al., 2009).

Song et al., (2009) concluded that depressive symptoms were the most influential factors associated with functional status in women. Depressive symptoms mediated the relationship between physical symptoms and functional status. More research is needed to explore these variables associated with functional status depression and heart failure.

The feeling of security is considered to be a basic human need for women with heart failure. Security is often impacted by the physical symptoms of heart failure such as breathlessness, fatigue, loss of body function and loneliness. Few studies have been done

to evaluate this problem, Burstrom, Brannstrom, Boman, and Strandberg (2011), recognized this problem and conducted a study to address the gap in understanding. The purpose of their study was to describe women's experiences of living with heart failure with a focus on feelings of security and insecurity. A descriptive qualitative design was used.

Eight women were selected with the following inclusion criteria: female gender, diagnosis of heart failure according to criteria of the European Society of Cardiology, and classification in the NYHA functional classes II to III, (Burstrom et al., 2011).

Demographic data showed mean age of the women was 82 with a range of 76-88. Four of the participants were married and four women lived alone.

The data were collected during two separate meetings. An initial group meeting was arranged to facilitate familiarity among the participants. The phone interview process was conducted by the investigator. An experienced group leader facilitated the focus group session, focusing on participant opportunity for sharing experiences and feelings. Separate phone interviews were conducted after the initial focus group meeting (Burstrom et al., 2011).

The interviews were audio recorded and transcribed verbatim. A structured interview guide was provided for participants. The guide included four broad questions related to perceived participant security in order to facilitate understanding. The principal researcher also used gentle probing questions throughout the interview process to illicit further responses (Burstrom et al., 2011).

Participant interviews were read several times in order to derive meaning and identify a sense of the whole. Subthemes were extracted using a qualitative content

analysis. The four themes identified, best described the feelings of security/insecurity for these eight women. To increase rigor and trustworthiness results were continuously discussed among the authors, and themes and subthemes were revised to clarify content until agreement was achieved (Burstrom et al., 2011).

Findings among the women provided four themes for feeling secure and four themes of feeling insecure (Burstrom et al., 2011). The first theme reflected on the past, everyday life and the future. There was an identified feeling of peace and gratitude for past lives and gratitude for each day. One woman related, “after all, I can take care of myself, and you can only do what you can do” (p. 4). The second theme centered on trusting the body despite the disease. The women related feelings of happiness knowing that despite heart failure the body continued to function and took pride in the ability to live with the disease.

The third theme, ‘not having to deal with the disease process alone’, included the perception that, health care providers were close by to care for physical needs. The fourth theme provided insight into the participant’s faith in caregivers and the treatments received. These women believed in physicians and nurses stating the Home Care staff were wonderful and the doctors provided thorough medical exams and worked to help them feel stronger by trying different types of medications (Burstrom et al., 2011).

The findings regarding insecurity were divided into four themes as well. The themes were: self-blame for smoking and other factors, fear of living with a frail body, anxiety and loneliness related to dependency on others, and lack of faith in their care providers, (Burstrom et al., 2011). The authors stated that the findings were consistent with other studies where both men and women adjust their lives to their day-to-day

condition in a life view that involves “living life as it has become” (Burstrom et al., 2011, p. 6).

Nursing staff provide an integral role as a source of support for this population. Burstrom et al., (2011) concluded that it is to provide a sense of security for the patient that persons involved understand the woman’s outlook on life and perceptions of living with heart failure. The authors encourage further research interventions related to women’s personal interpretations of living with heart failure and anxiety related to security issues (Burstrom et al., 2011).

Living with a chronic illness is a challenging experience due to vulnerability, loneliness and loss of independence. Support has been defined as plain help, i.e., information, education, economic support, auxiliary and external service, research shows that people with chronic diseases find support important (Sundin, Bruce, & Barremo, 2010). The purpose of this study was to provide insight into the meaning of support by elderly women living with heart failure. A phenomenological method of interpretation was used as the authors evaluate and describe the lived experience of support.

The setting for this study was a heart failure clinic in a middle-sized Swedish hospital. Inclusion criteria were: women over age 65, and class III-IV heart failure according to the NYHA scale for 2 years. A nurse at the clinic was asked to choose women to participate, five agreed. Demographic data: age: 67-88, marital status, participants had children, grandchildren, great-grandchildren and first cousins nearby (Sundin et al., 2010).

Narrative interviews were conducted by the authors. Three interviews were conducted in the women’s homes, one at a short-term living facility, and one in the

hospital. All interviews were recorded and lasted 40-90 minutes. The women were encouraged to reflect and share experiences of support, gestures were noted. Open ended questions were used to elicit further responses. The interview text was interpreted using a phenomenological hermeneutic three step approach: “ naïve readings, structural analysis, and the comprehensive understanding,” (Sundin et al., 2010, p. 3).

The authors related findings from the structural analysis, providing two themes and five sub-themes. The first theme: feeling confident means support: sub-themes, “enjoying freedom, independence” and “being confirmed mediates safety”. The second theme: feeling abandoned, demonstrated subthemes of, “suffering from dependency of others” “longing for sharing” and “feeling neglected in care” (Sundin et al., 2010, p.4). Findings in this study also revealed women living in a supportive relationship with their family and care providers have more confidence in themselves to handle the challenges of heart failure.

Sundin et al. (2010) concluded that care givers should consider each person’s individual needs and provide support. According to the authors, a supportive relationship is a relationship that provides women independence, bridges a woman’s feeling of being a burden, and allows women to keep their dignity. The authors further concluded that women manage their daily lives independently for as long as possible, and want their caregivers to consider their “whole” lives, and be seen as participants in decisions affecting their health.

Summary

The literature review presents published studies on the life experiences of person's living with heart failure, specific information in relation to women, and describing the differences and at times misunderstandings associated with the care of women vs. men.

Welstand et al. (2009) concluded from the review of 18 studies that there appears to be a common process across all patients in accepting heart failure into daily life and learning to live with a *new self*.

Benatar et al. (2003) concluded that there are significant improvements in outcomes for heart failure patients by including the use of telemonitoring vs. traditional home nursing visits. This was evident in results by demonstrating a decrease in length of stay, few heart failure readmissions, and decrease in hospital charges and improvement in quality of life.

Naylor et al. (2004) provided information in regards to the vulnerable period patients experience between hospital and home. The authors shared evidence to support a transitional care program facilitated by advance practice nurses for postdischarge planning for both men and women.

The Agard et al. (2004) study proposed that patients do not have an adequate knowledge base concerning their medical condition and treatment. The knowledge base affects the ability of the medical team to manage the patients securely, effectively, enhance and or maintain quality of life.

The Heo et al. (2008) study identified correlates related to self-care behaviors in heart failure patients and whether there were gender differences involved in these correlates.

Rhodes and Bowles (2002) concluded that there is no aspect of a women's life that is not affected by heart failure and that health care personnel play a vital role in fostering a positive focus and encourage patients to take charge of their lives and illness.

The Allen et al. (2009) study compared findings with two similar studies specific to women. The outcomes revealed that women with heart failure developed a new self-image as a result of the drastic limitations imposed by the disease.

The work of the Hagglund et al. (2008) study dealt specifically with the symptom of fatigue and the effects fatigue has on the life of women with heart failure. The authors concluded that fatigue similar to pain must be considered a subjective experience and nurses caring for these patients need to ascertain the level of fatigue individually.

Paton et al. (2007) provided evidence that the clinical nurse's role in establishing a relationship with women living with heart failure is not to only meet the physical needs experienced but also to partner with the patient to establish a realistic plan for living at home.

Song et al. (2009) concluded that depressive symptoms were the most influential factors associated with functional status in women. They further added that depressive symptoms influenced the relationship between physical symptoms and functional status.

Burstrom et al. (2011) demonstrated that it is essential to provide as sense of security not only for the women living with heart failure but to all persons involved in care.

Sundin et al. (2010) concluded that care givers should consider each person's individual needs while providing support. Women especially value a supportive relationship and want caregivers to consider whole lives.

Chapter III

Methodology and Procedures

Introduction

Heart disease is a leading cause of death for women. Research has shown that heart failure affects about 2.5 million women in the United States, despite the fact that women account for nearly 50% of all hospital admissions for heart failure. It has been noted that women present with very different symptoms and different risk factors when compared to men. Additionally only 25% of women are involved in heart failure studies (Hsich, 2011). Heart disease is anticipated to reach critical proportions as the population ages. With this, the incidence of heart failure will continue to rise.

There are differences in symptom manifestation and management between men and women related to incidence, age of diagnosis, risk factors, survival rate, and response to treatment of heart failure (Rhodes & Bowles, 2002). Sadly, these differences, lead women to delay seeking treatment for heart failure, including less aggressive interventions that may be beneficial. This study is a replication of the Rhodes and Bowles (2002) qualitative study. This chapter contains a description of the research question, settings, population, sample, methods and procedures used for this study. Human subjects' protection is also addressed.

Purpose

The purpose of this qualitative study is to examine and describe the experiences of women living with heart failure from a personal perspective. This is a replication of Rhodes and Bowles' (2002) qualitative study of the lived experiences of women with heart failure using a phenomenologic method. Husserl's (1970) descriptive phenomenology approach served as the philosophical basis for the study.

Research Question

How do older women with New York Heart Association (NYHA) Stage II heart failure perceive their own lives?

Population, Sample, and Setting

The population for the study will include women ranging in age from 60-90 and diagnosed with NYHA Stage II heart failure. Ten women 60- 90 years of age will be identified for this study and will be invited to participate by health professionals working on an outpatient cardiology unit. Women diagnosed with heart failure during the last ten years will qualify to participate. The setting for the interviews will be determined by each individual participant with the option of conducting the interviews in the participant's home or on the outpatient cardiology unit. This allows for a level of comfort as the participant discusses their experience with heart failure.

Protection of Human Subjects

The study will be submitted for approval to the Ball State University Institutional Review Board (IRB). Following approval by Ball State IRB, the study will be submitted to St. Vincent Hospital IRB as well as the Saint John's Health System Research Committee for final approval prior to study initiation. Approval to conduct the study will

also be obtained from the section Chief for Cardiology at Saint John's Health System, and the Chief Nursing Officer (CNO).

Each potential participant will be verbally informed of the purpose of the study prior to enrollment. Participants will be provided a copy of the study consent. The consent will be read verbatim to the participants prior to consenting. Time will be provided for any questions or concerns before consent is signed. The procedure for withdrawal from the study with no penalty will also be explained. Participants will be assured of the confidentiality of responses and that no change in treatment will be altered due to their participation.

Procedures

After a brief initial introduction, a presentation of the study and its protocols will be provided for nursing leadership and nursing staff on the outpatient cardiology unit where potential participants will be recruited. Copies of the study protocols will be provided. Ample time will be provided at the end of the presentation for staff to discuss questions or concerns. The population site targeted for recruitment is one where outpatient and in-patient cardiac patients are cared for, thus it will be important to include the inpatient staff in this presentation. This informational meeting will include details of the study, purpose of the work and interview process. The staff will be informed of the paperwork and space where interviews will be conducted on the outpatient unit. This will allow for confidentiality and lack of interruption.

Methodology of Data Collection

The researcher will conduct face-to-face interviews with each consenting participant lasting no more than one hour. Participants will be interviewed individually in

a private setting of their choice. Each interview will be audio-recorded and notations will be made on behaviors and reactions during the interview process. Interviews will be semi-structured, with questions that will guide and promote open-ended conversation.

Examples of specific open-ended questions include:

- In what ways has experiencing heart failure affected your life?
- Describe any specific feelings or thoughts you have regarding heart failure?
- Is there anything else you would like for us to know about your life regarding living with heart failure?

Further questioning will be used to elicit additional information, bring focus to the discussion on heart failure or clarify information. Each interview will last no more than one hour. Narrative interviews will be conducted until no new information emerges and saturation has been achieved.

Methods of Data Analysis

The application of Colaizzi's phenomenological method will be used as the framework for this study. Colaizzi identified seven stages of analysis to guide the researcher. The seven stages provide a framework to discuss and analyze the processes used to interpret and make sense of the research material (Valle & King, 1978).

- Acquiring a sense of each transcript
- Extracting significant statements
- Formulation of meanings
- Organizing formulated meanings into clusters of themes
- Exhaustively describing the investigated phenomenon

- Describing the fundamental structure of the phenomenon
- Returning to the participants

As Colaizzi (1978) stated: “The researcher must realize that each participant is more than merely a source of data...he must listen with the totality of his being and the entirety of his personality” (Balls, 2009). The Colaizzi method emphasizes the importance of reading and rereading the interviews in order to gain a sense of the lived experience. This process includes identifying the significance of each statement, to frame meaning through “bracketing”, formulating themes from the information, defining a description of the lived experience, and develop a structure of the phenomenon. The results of this process are returned to the participants ensuring that the information is representative of the experience rather than structure. This process ensures rigor.

Research Design

A descriptive phenomenological method will be used to answer the research question. Descriptive phenomenology serves to put into words or describe the meaning of an experience from the view of those who have had that experience (Balls, 2009). The researcher seeks to discover the essences of meaning of the phenomenon and attempts to describe them as faithfully as possible.

Descriptive phenomenology, which is attributed to Husserl (1963; original work 1913), attempts to make phenomenology a rigorous science within the tradition of its time, and uses the concept of bracketing to maintain objectivity. Bracketing involves putting aside what the researcher already knows about the experience being investigated and approaching the data with no preconceptions about the phenomenon (Balls, 2009). This bracketing process continues throughout with a self-examination and identification

any previously held beliefs concerning women and heart failure. Credibility will be further established by allowing each participant to review a copy of the results. With this review each participant will be able to ask questions,

- Is this description of heart failure accurate about my own life experience?
- Is there any important aspect of living with heart failure based on my own experience that has not been described? (Rhodes & Bowles, 2002).

Summary

The purpose of this study is to describe the experience of living with heart failure from the perspective of women living each day with this disease. A qualitative design using descriptive phenomenology will be used for this study. Interpretation and analysis of the finding using Colaizzi and phenomenological methodology will provide a method of demonstrating rigor and trustworthiness in analyzing data obtained through qualitative methodology. The findings from this study may assist health care providers in the development of educational programs and individualized plans of care specific for women living with heart failure. This is a replication of Rhodes and Bowles (2002) study.

References

- Agard, A., Hermeren, G., & Herlitz, J. (2004). When is a patient with heart failure adequately informed? A study of patients; knowledge of and attitudes toward medical information. *Heart & Lung, 33*(4), 219-226.
- Albert, N., Eastwood, C., & Edwards, M. (2004). Evidence-Based practice for acute decompensated heart failure. *Critical Care Nurse, 24*(6), 1-17.
- Allen, J., Arslanian-Engoren, C., & Lynch-Sauer, J. (2009). The lived experience of middle-aged women with New York heart association class III heart failure: a pilot study. *Progress in Cardiovascular Nursing, 24*(3), 96-101.
- American Heart Association (2012). Heart Disease. Retrieved from www.heart.org
- American Heart Association (2012). Go Red for Women. Retrieved from www.goredforwomen.org
- Balls, P. (2009). Phenomenology in nursing research: Methodology, interviewing and transcribing. *Nursing Times, 105*(31), 1-9.
- Benatar, D., Bondmass, M., Ghitelman, J., & Avitall, B. (2003). Outcomes of chronic heart failure. *Archives of Intern Medical, 163*(3), 347-352.
- Burstrom, M., Brannstrom, M., Boman, K., & Strandberg, G. (2011). Life experiences of security and insecurity among women with chronic heart failure. *Journal of Advanced Nursing*. doi: 10.1111/j.1365-2648.2011.05782.x .
- Cannon, C. Vierck, E. (2009). *The New Heart Disease Handbook* (1st Ed.). Beverly, MA: Fair Winds Press.

- Dowling, M. (2007). From Husserl to Van Manen. A review of different phenomenological approaches. *International Journal of Nursing Studies*, 4(1), 131-142.
- Hagglund, L., Boman, K., & Lundman, B. (2008). The experience of fatigue among elderly women with chronic heart failure. *European Journal of Cardiovascular Nursing*, 7(4), 290-295.
- Heo, S., Moser, D., Lennie, T., Riegel, B., & Chung, M. (2008). Gender differences in and factors related to self-care behaviors: A cross-sectional, correlational study of patients with heart failure. *International Journal of Nursing Studies*, 45(12), 1807-1815.
- Hsieh, E. (2011, August 23). Heart failure and women. Retrieved August 23, 2011, from <http://my.clevelandclinic.org/heart/disorders/heartfailure/hfwome/women.aspx>.
- Imes, C., Dougherty, C., Pyper, G., & Sullivan, M. (2011). Descriptive study of partners' experiences of living with severe heart failure. *Heart & Lung*, 40(3), 208-216.
- Katz, A., & Konstam, M. (2009). *Heart Failure - Pathophysiology, Molecular Biology, and Clinical Management* (2nd ed.). Baltimore, MA: Lippincott Williams and Wilkins.
- Legato, M., & Bilezikian, J. (2010). *Principles of gender-specific medicine* (2nd ed.) Amsterdam, Holland: Elsevier Academic Press.
- Lee, C., Riegel, B., Driscoll, A., Suwanno, J., Moser, D., Lennie, T., Worrall-Carter, L. (2009). Gender differences in heart failure self-care: A multinational cross-sectional Study. *International Journal Nursing Studies*, 46(11), 1485-1495.

- Mayo Clinic Staff (2011). Heart Failure. Retrieved from www.mayoclinic.com/health/heart-failure
- Naylor, M., Brooten, D., Campbell, R., Maislin, G., McCauley, K., & Schwartz, J. (2004). Transitional care of older adults hospitalized with heart failure: A randomized, controlled trial. *Journal of American Geriatrics Society, 52*(5), 675-684.
- Paton, B., Backlund, J., Barnes, M., & Thirsk, L. (2007). Recalibrating time and space: women's challenges of living with heart failure. *Canadian Journal for Cardiovascular Nursing, 17*(1), 7-14.
- Plach, S. (2008). Psychological well-being in women with heart failure: Can social roles make a difference? *Health Care for Women International, 29*(1), 54-75.
- Rauh, R., Schwabauer, N., Enger, E., & Moran, J. (1999). A community hospital-based congestive heart failure program: Impact on length of stay, admission and readmission rates and cost. *The American Journal of Managed Care, 5*(1), 37-43.
- Rhodes, D., & Bowles, C. (2002). Heart failure and its impact on older women's lives. *Blackwell Science Ltd., 39*(5), 441-449.
- Riegel, B., Dickson, V., Cameron, J., Johnson, J., Bunker, S., Page, K., & Worrall-Carter, L. (2010). Symptom recognition in elders with heart failure. *Journal of Nursing Scholarship 42*(1), 92-100.
- Song, E., Moser, D., & Lennie, T. (2009). Relationship of depressive symptoms to functional status in women with heart failure. *American Journal Critical Care, 18*(4), 348-356.

- Sundin, K., Bruce, E., & Barremo, A. (2010). Elderly women's experiences of support when living with congestive heart failure. *International Journal Qualitative Studies Health Well-being*, 5(2), 5064-5074.
- The San Diego Cardiac Center (2010). Heart Failure Online. Retrieved from <http://www.heartfailure.org>
- Valle, R., King, M., (1978). *Existential – Phenomenological alternatives for psychology*. New York: Oxford University Press.
- Welstand, J., Carson, A., & Rutherford, P. (2009). Living with heart failure: An integrative review. *International Journal of Nursing Studies*, 46(10), 1374-1385.
- Yu, D., Lee, D., Kwong, A., Thompson, D., & Woo, J. (2007). Living with chronic heart failure: a review of qualitative studies of older people. *Journal of Advanced Nursing*, 61(5), 474-483.