The Experience of Living with Congestive Heart Failure: A Phenomenological Study

Lea Chiavaras

Carroll College, Helena, MT

Follow this and additional works at: https://scholars.carroll.edu/nursing_theses

Part of the Nursing Commons

Recommended Citation

Chiavaras, Lea, "The Experience of Living with Congestive Heart Failure: A Phenomenological Study" (2005). Nursing Undergraduate Theses. 53.

https://scholars.carroll.edu/nursing_theses/53

This Thesis is brought to you for free and open access by the Nursing at Carroll Scholars. It has been accepted for inclusion in Nursing Undergraduate Theses by an authorized administrator of Carroll Scholars. For more information, please contact tkratz@carroll.edu.
The Experience of Living with Congestive Heart Failure:

A Phenomenological Study

Lea Chiavaras

Carroll College
This thesis for honors recognition has been approved for the Department of Nursing.

Jocie Waldron, RN, MN
Professor of Nursing
Director

Dr. Joni Walton, APRN, BC
Professor of Nursing
Reader

Dr. Jeff Morris, Associate Professor of English
Reader

4/4/05
Date

4/4/05
Date

3/21/05
Date
Acknowledgements

First and foremost, I would like to thank Dr. Joni Walton for her endless support and guidance in helping me complete this project. She answered my constant line of questions and gave me support to keep working when I needed it the most. As one of my readers, Dr. Walton was extremely patient with me and spent numerous hours working through my paper. Without her, I would not have started this project, let alone finish it, and I am sincerely grateful for her insight, comments, and encouragement.

Second, I would like to thank my other two committee members, Jocie Waldron, director, and Dr. Jeff Morris, reader, who both spent many hours pouring through my paper and making invaluable corrections and comments. I thank them for their patience and support that greatly helped me through this process. Dr. John Ries, a professor of philosophy at Carroll College, deserves recognition as well for meeting with me to discuss my methodology. He also pointed me in the right direction to look for further research on phenomenology and gave me excellent references to borrow from his own collection. I thank him for his time as well as for explaining complicated philosophical topics in terms that I could comprehend.

Next, I would like to thank the four participants who graciously agreed to let me come into their lives and ask them about their experience with congestive heart failure. Each had an amazing, inspiring story to tell, and I will never forget how strong and brave each was. I thank them for their honesty and candidness with someone they had never met before. They were all incredible people and I am thankful to have met them.

I would also like to thank the several people who allowed me to come into their facilities and post flyers and make announcements in my search for volunteers for this
study. For confidentiality’s sake, I cannot name them, but I do appreciate all of the support and encouragement they gave me.

Finally, I would like to thank my family and friends because without their support I could not have accomplished what I have. I thank my parents for unconditional love and support that kept me going forward. I thank my friends for their patience and their willingness to listen and support me always. I would also like to thank the people who inspired me to research CHF in the first place, my grandparents, Brack and Ruth Stanley, and Marcella Chiavaras. Their own experience with this condition prompted me to learn more about CHF, and they always provided me with insight, ideas, love, and support.

Thank you all so much.
Abstract

Congestive heart failure (CHF) is a chronic, progressive disease with many symptoms and poor prognosis. Each year, millions of people must adjust to new physical limitations and make permanent changes in their lives affecting their diet, sleep, and medication regimen. Major factors that affect people with CHF that were researched and discussed in a review of literature include the following: fatigue, exercise, social support, and education. This phenomenological research project was designed to learn more about, and understand, the lived experience of people with CHF. Data were collected through interviews with four participants from Montana. The interviews were tape recorded and then transcribed. Colaizzi’s Method was used to analyze the data collected. Two of the four participants validated the results of their respective interviews. Six main themes arose among all of the participants. These themes were as follows: tolerating symptoms, losing independence, coping with life’s stressors, managing medications, worrying about money, and disregarding fluid and salt restrictions. The results of the data collected can help people better understand what patients with CHF experience, as well as identify how nurses can aid clients in maintaining/reaching a better quality of life.
# Table of Contents

Acknowledgements........................................................................................................... 4

Abstract............................................................................................................................... 6

Table of Contents................................................................................................................ 7

Chapter 1: Introduction........................................................................................................ 11

  * Etiology and Risk Factors............................................................................................ 12
  * Pathophysiology........................................................................................................... 12
  * Signs and symptoms.................................................................................................... 13
  * Impact on Patient......................................................................................................... 14
    * Social impact............................................................................................................. 14
    * Ethical impact........................................................................................................... 16
    * Economic impact..................................................................................................... 16

Chapter 2: Review of Literature........................................................................................ 17

  * Fatigue.......................................................................................................................... 17
  * Respiratory deficiencies............................................................................................... 18
  * Nutrition complications............................................................................................... 19
  * Impaired sleep............................................................................................................... 19
  * Nursing interventions related to fatigue..................................................................... 20
  * Exercise......................................................................................................................... 21
  * Exercise adherence....................................................................................................... 21
  * Nursing interventions related to exercise.................................................................. 23
  * Social Support.............................................................................................................. 24
  * Depression.................................................................................................................... 24
Chapter 3: Methodology

Phenomenology Method

Human philosophy

Pure experience

Phenomenological reduction

Bracketing

Intuiting

Selection of Participants

Data Collection

Data Analysis

Colazzi's method of analysis

Ethical Considerations

Limitations

Summary of Research Design

Chapter 4: Results

Tolerating Symptoms

Losing Independence

Coping with Life Stressors

Managing Medications
<table>
<thead>
<tr>
<th>Topic</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Congestive Heart Failure</td>
<td>9</td>
</tr>
<tr>
<td>Worrying About Money</td>
<td>40</td>
</tr>
<tr>
<td>Disregarding Fluid and Salt Restrictions</td>
<td>40</td>
</tr>
<tr>
<td>Chapter 5: Discussion</td>
<td>41</td>
</tr>
<tr>
<td>Tolerating Symptoms</td>
<td>42</td>
</tr>
<tr>
<td>Nurses’ role in ascertaining if patients are tolerating symptoms</td>
<td>43</td>
</tr>
<tr>
<td>Losing Independence</td>
<td>44</td>
</tr>
<tr>
<td>Moving to assisted living facilities</td>
<td>45</td>
</tr>
<tr>
<td>Inability to care for significant others</td>
<td>46</td>
</tr>
<tr>
<td>Oxygen dependency</td>
<td>46</td>
</tr>
<tr>
<td>Loss of driving capabilities</td>
<td>48</td>
</tr>
<tr>
<td>Decreased socialization with friends</td>
<td>49</td>
</tr>
<tr>
<td>Activity intolerance</td>
<td>50</td>
</tr>
<tr>
<td>Nurses’ role in helping patients regain independence</td>
<td>52</td>
</tr>
<tr>
<td>Coping with Life Stressors</td>
<td>55</td>
</tr>
<tr>
<td>Nurses’ role in helping patients cope</td>
<td>56</td>
</tr>
<tr>
<td>Managing Medications</td>
<td>58</td>
</tr>
<tr>
<td>Nurses’ role in helping patients manage medications</td>
<td>58</td>
</tr>
<tr>
<td>Worrying About Money</td>
<td>59</td>
</tr>
<tr>
<td>Nurses’ role in assessing patients’ financial concerns</td>
<td>60</td>
</tr>
<tr>
<td>Disregarding Fluid and Salt Restrictions</td>
<td>60</td>
</tr>
<tr>
<td>Nurses’ role in helping patients make diet changes</td>
<td>62</td>
</tr>
<tr>
<td>Gender Differences</td>
<td>63</td>
</tr>
<tr>
<td>Nurses’ role in completing a thorough assessment</td>
<td>65</td>
</tr>
</tbody>
</table>
Chapter 1: Introduction

Congestive heart failure (CHF) is a chronic disease that completely alters the lives of those who suffer from this condition. Heart failure is a chronic, progressive disease with many symptoms and poor prognosis resulting in patients diagnosed with heart failure frequently being hospitalized. According to the American Heart Association’s (AHA) website (2003), “Nearly 5 million Americans are living with heart failure, and 550,000 new cases are diagnosed each year” (¶ 3). Cardiovascular diseases, such as congestive heart failure, heart diseases, and hypertension, are “the number one killer of women, according to the American Heart Association. It kills half a million American women each year” (as cited in Skarnulis, WebMD website, 2004, ¶ 1). Heart failure is one of the most common causes of hospitalization for elderly adults and treatment for this disease costs billions of dollars per year (Ignatavicius & Workman, 2002). People suffering from congestive heart failure typically experience major lifestyle changes, including changes in their diet, their medication regimen, their sleep pattern, and especially their activity levels. According to Duncan and Pozehl (2003), “heart failure is associated with decreased exercise tolerance that is believed to result from reduced cardiac output and muscle atrophy that is associated with left ventricular dysfunction, neurohormonal activation, and pulmonary and systemic venous congestion” (¶ 3). Millions of people each year must learn to adjust to new physical limitations and make permanent changes in their lives. The purpose of this thesis is to understand the lived experience of people with CHF and to identify how nurses can aid clients in maintaining/reaching a better quality of life.
Etiology and Risk Factors

There are several associated factors that cause and/or contribute to the development of congestive heart failure. Behaviors that put one at risk include, “smoking, being overweight, eating foods high in fat and cholesterol, and not exercising” (AHA website, 2004, ¶ 1). There are also several predisposing physical conditions that place people at risk for developing CHF that include: history of “high blood pressure, angina, myocardial infarction, rheumatic heart disease, valvular disorders, endocarditis, and pericarditis” (Ignatavicius & Workman, 2002, p. 701). One can even contract a virus that damages the heart muscles that can eventually lead to heart failure (AHA website, 2004). Increasing age is one of the main risk factors of developing this disease. Ignatavicius and Workman (2002) state, “heart failure occurs most commonly in older adults; 50% of clients with heart failure are older than 70 years of age” (p. 700). CHF is diagnosed by several tests that include: chest X-rays, electrocardiograms, angiograms, exercise stress tests, blood tests, and others. These tests show if the heart is enlarged, if the heart and/or lungs are congested, if there are any blocked arteries, if the person suffered a heart attack in the past, the activity level that the heart can sustain, and many more signs that congestive heart failure is occurring (AHA website, 2004).

Pathophysiology

Congestive heart failure affects the whole person and develops into a systemic disease. Minter (2000) states, “In congestive heart failure . . . the heart begins to fail in its ability to efficiently pump enough blood to meet the needs of the body. Blood and other fluids back up in the lungs and in the lower extremities” (WebMD website, 2000, ¶ 1). The main type of CHF is categorized as left heart failure with either systolic or diastolic
dysfunction. Systolic dysfunction occurs when the left ventricle is unable to pump adequate amounts of blood into the body because of its inability to contract effectively during systole. Diastolic dysfunction happens when the left ventricle does not relax, or open up enough, during diastole, which prevents adequate amounts of blood from filling the ventricle. This results in an inadequate amount of blood entering circulation (Ignatavicius & Workman, 2002). With the left ventricle being unable to meet the blood needs of the body, several compensatory changes occur in the body. These include: “increased heart rate, improved stroke volume, arterial vasoconstriction, sodium and water retention, and myocardial hypertrophy” (Ignatavicius & Workman, 2002, p. 699). These mechanisms only temporarily improve the person’s condition, and changes such as the enlargement of the heart, sodium and water retention, and arterial vasoconstriction quickly begin causing other physical problems in the patient. In order to keep blood pressure up, the blood vessels constrict and blood is shunted to the heart and brain and away from less vital organs (AHA website, 2004). As the disease progresses, the body begins to develop “impaired tissue perfusion, pulmonary congestion, and edema” (Ignatavicius & Workman, 2002, p. 700). Eventually the heart will not be able to keep up with the body’s demand for blood and will eventually cease functioning, causing death.

**Signs and symptoms.** There are many signs and symptoms that are related to congestive heart failure. According the AHA website (2004) the main symptoms include: “shortness of breath, persistent coughing or wheezing, edema, tiredness, fatigue, lack of appetite, nausea, confusion, impaired thinking, and increased heart rate” (¶ 11). McCance and Huether (2002) state, “The clinical manifestations of left heart failure are the result of pulmonary vascular congestion and inadequate perfusion of the systemic circulation.
Individuals experience dyspnea, orthopnea, cough of frothy sputum, fatigue, decreased urine output, and edema” (p. 1032). The pulmonary congestion that develops also causes the person to have an irritating, nonproductive cough (Ignatavicius & Workman, 2002).

**Impact on Patient**

With so many physical symptoms, patients suffering from congestive heart failure experience major changes in their lives. They must make substantial changes in their diet, exercise routine, rest habits, medication regimen, and much more. One of the main changes that these patients must adjust to is their activity intolerance. Most patients suffering from CHF experience fatigue and shortness of breath due to the inadequate tissue perfusion, the inadequate blood flow to their vital organs and tissues, and because of their congested lungs and heart. Most patients are instructed to join a cardiac rehabilitation program and/or develop their own exercise routine. Because these are typically significant changes that people must make, many have difficulties complying with all of the doctor’s orders. Changes might need to be made gradually overtime, if possible, to help the patients adjust to their new lifestyles. If changes must be made immediately, as is often the case, patients must have a great deal of support and encouragement from members of the health care team.

**Social impact.** Patients with CHF experience many changes in their social lives. Most are unable to do the activities that they once enjoyed. They cannot physically keep up with some of their peers, which might cause social isolation such as not being able to play 18 holes of golf with friends every weekend. On the other hand, many are instructed to enter an organized cardiac rehabilitation program where they exercise with other patients suffering from CHF, and this can improve a patient’s social life and help him/her
feel more connected to others. Exercise is generally very tiring and difficult for these patients, which can be extremely frustrating and depressing and this “increases the likelihood that patients with heart failure will stop exercising before the benefits are realized” (Duncan & Pozehl, 2002, ¶ 5). Duncan and Pozehl (2003) state, “Loss of physical ability contributes to a decline in functional ability and to a decreased quality of life” (¶ 5). If patients become depressed, they will withdraw from friends and family and will need to receive support and possibly counseling to help them work through their feelings.

Other social impacts that CHF has on patients are that patients might develop cognitive impairment due to inadequate blood flow to the brain and other physical problems that develop with this disease. A study completed by Ekman, Fagerberg, and Skoog (2001) found that “moderate-severe cognitive impairment was relatively common in elderly patients with chronic heart failure” (¶ 20). This can cause social isolation, difficulties and hardships for friends and family members, and frustration for the patients themselves. Patients, their families, and their friends will need support to learn how to adjust to any mental changes that the patients experience.

Patients might also need support from family and friends in relation to their spirituality. Many patients diagnosed with CHF question and/or explore their spirituality. Westlake and Dracup (2001) found that “[CHF] may threaten the individual’s sense of self and lead to questions related to spirituality” (¶ 1). This might cause the patient to begin attending a church or spirituality group, or it might push the patient away from his/her own spirituality and possibly the support that a church community may provide.
Ethical impact. Patients, and their families, have to begin to prepare for the end of the patient’s life because CHF is a chronic, progressive disease and the patient will eventually die from it. Patients will have to consider making out a will and other provisions for the end of their life. They will need nonjudgmental, open-minded, and unobtrusive counseling, guidance, and support to help them make the decisions that they need to make. Members of the healthcare team should not try to influence the patient’s decision in any way. Patients might also consider getting a do not resuscitate order, in which case the patient, family, and health care team must be counseled as to what this order means and the order must be followed.

Economic impact. Billions of dollars are used every year to treat the millions of people who suffer from congestive heart failure. Not only are the medical treatments, such as surgeries and medications, extremely expensive, but most patients need to be hospitalized and also have some form of rehabilitation. Cardiac rehabilitation programs cost a great deal of money to maintain, and are very expensive for patients to participate in. According to the AHA (1998), “hospitalizations for heart failure cost $3.4 billion in 1995, or $5,153 per hospital discharge” (as cited in Ignatavicius & Workman, 2002, p. 700). Patients have to pay a great deal of money to receive treatment and to try to maintain adequate quality of life. Patients with CHF, their insurance companies, and the government must typically pay for multiple medications, hospital and physician visits, other medical treatments, rehabilitation programs, and much more. Evangelista, Doering, Dracup, Westlake, et al (2003) state, “The most common reasons cited for difficulty following this prescribed activity were lack of transportation, distance from clinic, time, and costs” (¶ 19). These are a few reasons why patients do not comply with exercise
regimens prescribed by physicians. Treating patients with congestive heart failure is going to continue costing the patients, insurance companies, and the government billions of dollars because “the incidence and prevalence of heart failure are increasing, placing a growing burden on the health care system” (Westlake & Dracup, 2001, ¶ 2).

Chapter 2: Review of Literature

Congestive heart failure is an extensively researched topic in the nursing literature. With the numerous symptoms and complications of CHF, there is much about the condition to be studied. There are also millions of people diagnosed with CHF who make up a large portion of health care clients. Many of these people suffer from activity intolerance. Activity intolerance is a major complication of CHF and is caused by many factors, both physiological and psychological. Major factors that affect CHF clients’ activity intolerance that have been researched and will be discussed are: fatigue, exercise, social support, and education. All of these factors are interrelated and nurses play a key role in helping clients work within aspects of these factors to improve their activity tolerance, which in turn improves their quality of life.

*Fatigue*

Fatigue is a major aspect of activity intolerance in patients with CHF. There are many physiological symptoms of this condition that cause patients to feel exhausted, weak, and overwhelmed by physical exertion. Because people suffering from fatigue have very little energy to do activities that they once enjoyed, and even activities of daily living such as showering and preparing meals, many do not have a satisfactory quality of life (Ekman & Ehrenberg, 2002).
Respiratory deficiencies. Congestive heart failure causes respiratory problems and deficiencies that have been researched in several studies. These studies explore the impact that respiratory problems and deficiencies have on a person’s activity tolerance level. Lung diffusion impairment is thought to be one of the factors that decreases activity tolerance and occurs as a result of increased pulmonary venous pressure and pulmonary congestion (Ignatavicius & Workman, 2002). A study completed by Agostoni, Bussotti, Palermo, and Guazzi (2002) researched the effect that lung diffusion had on 40 patients with CHF and their exercise abilities and compared those results with 40 participants who did not have CHF. The researchers found that the lung diffusion impairment in CHF participants caused decreased lung transfer capacity for carbon monoxide (TLCO) and increased hypoxia compared to the control group. The researchers believe that the decreased TLCO and increased hypoxia were two main reasons for lower exercise capacities in the CHF group in relation to the control group.

Lung diffusion impairment is also related to dyspnea, another major complication of CHF. Dyspnea can be caused by both impaired lung diffusion and inadequate cardiac output (Ignatavicius & Workman, 2002). Van den Berg-Emons, Bussman, Balk, Keijzer-Oster, and Stam (2001) used an “activity monitor” to assess the difference in everyday mobility between participants with CHF and relatively healthy control group participants (¶ 1). They found that dyspnea and fatigue were two of the main symptoms in the CHF group that restricted everyday activities the most. The CHF group was overall much less active than the control group. The researchers concluded “that people with CHF may decrease their physical activity to minimize the occurrence of symptoms such as dyspnea.
and fatigue" (Van den Berg-Emons et al., 2001, ¶ 23). A major limitation to this study was that there were no female participants.

**Nutrition complications.** A study completed by Keuhneman, Saulsbury, Splett, and Chapman (2002) explored the effects of a full-time dietician working with patients enrolled in a cardiac rehabilitation program and found that participants who learned to maintain a low sodium, adequate fluid diet reported decreased fatigue and a higher quality of life than participants who continued to consume a high intake of sodium and fluids. Patients diagnosed with CHF typically have to make major changes in their diets that often include decreased sodium and fluid intake. This can be a difficult adjustment to make and serious problems arise when people with CHF do not follow diet guidelines. High sodium and fluid volumes in patients with CHF exacerbate their health problems, placing higher demand on the heart, lungs, and other vital organs, and is one of the most frequent reasons for hospitalizations in people with CHF.

**Impaired sleep.** People suffering from CHF have many contributing factors that negatively effect their sleep patterns, and poor sleep easily leads to fatigue. Parker and Dunbar (2002) did a study to determine the importance for cardiovascular nurses in recognizing patients suffering from sleep problems. They found that patients who had problems sleeping presented fatigued, had difficulties concentrating, had tempers, daytime sleepiness, and a desire to be alone. The researchers concluded that nurses should consider, and assess for, sleep problems such as “paroxysmal nocturnal dyspnea, orthopnea, insomnia, frequent awakenings, and daytime sleepiness” because lack of sleep was found to decrease a patient’s quality of life and limit the ability to perform activities of daily living (Parker & Dunbar, 2002, ¶ 5).
Nursing interventions related to fatigue. Nurses play a major role in aiding CHF patients in dealing with fatigue. Decreased fatigue and increased energy have been shown to improve the patient’s quality of life and allow them to perform activities of daily living and live an active life. First, nurses need to be aware of the characteristics and complications of fatigue. Nurses must be able to recognize fatigue in their patients and act accordingly to formulate a plan of care that will attempt to alleviate their symptoms. Ekman and Ehrenberg (2002) state, “Nurses need to develop skills in analyzing data from patients concerning fatigue and to tailor interventions that enable patients to adhere to treatment” (¶ 28).

Not only do nurses need to be able to recognize and help the patient cope with fatigue, but nurses must also educate their patients about the importance of exercise and adhering to diet guidelines, as well as help patients develop strategies to improve their sleep. Van den Berg-Emons et al. (2001) found that patients with CHF decrease their activity to avoid the symptoms of dyspnea and fatigue, but that this became a negative cycle projected as “hypoactivity→reduced fitness→early fatigue→further hypoactivity” (¶ 2). Keuhneman et al. (2002) showed the importance of teaching clients to adhere to sodium and fluid restrictions in their study. This same study suggests that to improve adherence, nurses should incorporate the patient’s own goals, use continual and progressive education, and develop a strong, trusting relationship with the patient. Nurses can also play an important educational role in helping people develop methods to improve their sleep. Parker and Dunbar (2002) express the importance of getting a thorough sleep history from both the patient and family members. Once a sleep deficit is noted, nurses can work with other members of the healthcare team to develop strategies...
Congestive Heart Failure

Exercise

Exercise is a very important factor in maintaining and improving patients’ activity tolerance. Many people diagnosed with CHF are referred to, or advised to join, a cardiac rehabilitation program because of the benefits of exercise. As discussed earlier, fatigue and dyspnea are a couple of the main symptoms of this condition, so adhering to an exercise routine can be extremely difficult for people. Routinely exercising eventually decreases fatigue and dyspnea and increases activity tolerance, but many people stop exercising due to the fatigue and dyspnea before they begin to benefit from the exercise (Akosah, Schaper, Havlik, Barnhart, & Devine, 2002).

Exercise adherence. Many studies have been aimed at determining factors that affect patients’ adherence to prescribed exercise regimens. Studies have been completed determining better ways to keep people who are enrolled in cardiac rehabilitation programs motivated, as well as how to help people maintain an exercise routine at home. Duncan & Pozehl (2003) followed 16 patients over 24 weeks to study the effects of an exercise adherence intervention on patients with CHF. All of the participants exercised under supervision at a rehabilitation center for the first 12 weeks, and the last 12 weeks the participants were monitored at home to determine adherence rates away from a rehabilitation center. Half of the group was only required to exercise, and the other half had to exercise, set goals, make graphics of their status, and they received guidance and support from care providers. The results showed that the intervention group adhered significantly better than the non-intervention group to the exercise program, both at the
rehabilitation center and at home. The intervention group also reported decreased symptoms of dyspnea and fatigue and a higher quality of life than the non-intervention group. Limitations of this study include the small sample size, there was only one female in each group and the rest were male, and the participants volunteered for the study, which might indicate that they were more motivated than the general population with CHF (Duncan & Pozehl, 2003). This study shows that the intervention worked well to help participants adhere to an exercise routine, and also that exercise can be very beneficial to CHF patients.

Duncan and Pozehl (2002) used the same adherence intervention theory to study another CHF population where the participants in the intervention group also rated higher satisfaction with their exercise routine and greater confidence in being able to continue their routine than the exercise only group. This population included 13 patients, six in an exercise only group and seven in an exercise intervention group, who had completed a supervised exercise program. Participants were only monitored on whether or not the intervention use of goal setting, graphing their status, and care provider guidance and support helped patients adhere to an exercise routine at home, and did not follow their progress during the supervised exercise program. Duncan and Pozehl (2002) had similar results in this study and found that the intervention group maintained better adherence to their exercise program than the exercise only group. The researchers believed that progress graphing and care provider guidance and support were especially effective interventions for people who might have had difficulties remembering exercise recommendations and instructions. A small sample size was a limitation in this study.
Other studies have found that both elderly and young people have poor compliance with prescribed diet and exercise. Evangelista et al. (2003) recently completed a study that looked at an aspect of exercise adherence other than exercise intervention programs. These researchers studied the compliance behaviors of 140 patients, half over 65 years and half under 65 years, and also determined factors that affected their compliance. Participants filled out a questionnaire measuring compliance of six activities, including exercising regularly. The results showed that both the elderly and the young groups had poor compliance with prescribed diet and exercise. Reasons given for poor compliance to exercise included “physical symptoms (pain, dizziness), lack of energy (weakness, fatigue), and poor motivation” (Evangelista et al., 2003, ¶12). Limitations of this study included that volunteer participation, which might mean that they are more motivated than the general CHF population, and self-reporting, which can overestimate compliance levels.

_Nursing interventions related to exercise._ Nurses can play an integral role in helping patients adhere to their exercise programs. As shown in the two studies by Duncan and Pozehl (2002, 2003), one of the main factors that made the intervention successful was care provider guidance and support. Nurses can educate patients on how to safely and correctly perform exercises and reassure patients that exercising will eventually ease their symptoms of fatigue and dyspnea rather than exacerbate them. These two studies also showed that nurses can implement an intervention program with their patients that includes incorporating patient’s individual goals and graphing their progress. This gives the patient visual incentive to keep working and getting even better.
Nurses should work hard to keep CHF patients exercising at least until the patients start to experience the benefits, with less fatigue and dyspnea.

Social Support

People suffering from congestive heart failure experience many changes in their lives that can be difficult to adjust to. One of the major changes that a person is likely to encounter is that of activity intolerance. People with CHF typically cannot be as active as they once might have been. Activity intolerance affects one’s ability to perform activities of daily living and their ability to do favorite hobbies/activities. This major change in lifestyle can be a contributing factor to the development of depression in CHF patients, while others might react by questioning or exploring their spirituality. During this time, patients benefit from strong social support from family, friends, and health care providers (Westlake & Dracup, 2001).

Depression. Depression and lack of social support have been shown to have serious adverse effects on patient outcomes with CHF. Richardson (2003) recently studied the effects of depression on patients with CHF and found that those “who are depressed or who lack social support have been shown to have increased morbidity and hospital readmission rates, to be less adherent to their medical regimen, and to have an overall increase in cost of care” (¶ 1). Social support can have a positive effect on decreasing the incidence of depression in CHF patients. Patients also report a higher rating of quality of life when they have strong social support through family, friends, and/or community. Social activity is considered by some to be as good for a person with CHF as physical exercise is.
**Spirituality.** Major changes, such as activity intolerance and the realization that they will die from this condition, can cause people with CHF to begin questioning and/or exploring their spirituality. In a phenomenological study conducted by Westlake and Dracup (2001), 87 participants answered questions about their spirituality and factors that helped them adjust to the CHF. Westlake and Dracup (2001) found that the participants found hope in their spiritual beliefs, medical treatment, and/or family and friends, and many found peace in those areas as well. "Many patients cited the importance of family and friends . . ." (Westlake & Dracup, 2001, ¶ 20). Social support played a major role in helping these patients find hope, feel at peace, and feel comfortable questioning/exploring their spirituality.

**Nursing interventions related to social support.** Nurses need to be aware of the important role social support plays in the health of CHF patients. Nurses should screen for depression during assessments, especially in those who are noncompliant with prescribed regimens (Richardson, 2003). Nurses can also be a support person for patients by encouraging them, providing unconditional compassionate care, reinforcing complaint behavior, and being a consistent figure in their lives through appointments, phone check-ups, and possibly in-home care. Helping patients find social support in their lives through churches, community groups, support groups, and/or family involvement is also an important nursing intervention (Westlake & Dracup, 2001).

**Education**

"Education of the patient is a main component of cardiac rehabilitation" (Goodwin, 1999, ¶ 14). Many of the nursing interventions and nursing roles involve educating patients. As stated earlier, nurses need to educate CHF patients about the
importance of adhering to prescribed exercise programs, maintaining a diet low in sodium and fluids, ways to improve sleep, methods to improve and/or utilize social support systems, and much more. Teaching patients about the purpose of the prescribed drug, the possible side effects, and helping them get into a routine that makes it easier for patients to remember when to take their medications are important nursing interventions to improve patient compliance with their medication regimen (Dunbar-Jacob, Bohachick, Mortimer, Sereika, & Foley, 2003). Educating patients about their condition and treatments is an invaluable intervention, as is education follow-up that “reinforces education, identifies early warning signs, and reduces the likelihood of readmissions or acute crisis” (Knox & Mischke, 1999, ¶ 29).

Since activity intolerance is such a major complication of congestive heart failure, it is very important for nurses to educate their patients about this condition. Nurses can educate patients about the causes, both physiological and psychological. Understanding the treatments for activity intolerance, such as exercise, diet, adequate sleep, and social support, will help the patient better understand how to work toward improving their quality of life.

Potential and Future Research

Although congestive heart failure is a commonly researched topic, several potential areas of research relating to activity intolerance and its effects on people exist. A potential also exists for more in-depth research on how patients adjust to changes in their activity intolerance. Research can be done to ascertain how patients are making changes in their lives. There is a need for studies to be completed to determine the association of quality of life outcomes specifically related to exercise compliance. Further
research is needed to determine the best type, length, duration, and intensity of exercise, to help CHF patients improve their activity tolerance (Duncan & Pozehl, 2003). Future research is also needed to determine more about the psychosocial effects that activity intolerance has on patients.

People suffering from congestive heart failure have many symptoms and complications that they must learn to live with that can be very difficult to adjust to. Those who experience activity intolerance must make major changes in their lives to try and regain some of their energy and stamina. Nurses play a key role in helping patients adjust to: living with fatigue and other symptoms, adhering to their exercise programs, helping them utilize their social support, and other adjustments such as managing their medication regimen and eating a healthy diet. With determination, hard work, and the help of nurses and other members of the health care team, people diagnosed with CHF can achieve a quality of life that they desire.

Chapter 3: Methodology

The purpose of this research was to learn about the true experience of living with congestive heart failure from people who currently live with the condition. Phenomenology was the methodology chosen to ascertain this type of knowledge. Phenomenology is a qualitative method that focuses and “reflects of the interrelationship of body, mind, spirit, and environment” (Fain, 2004, p.220). In this section, a basic description of the phenomenology method will be described, as will the selection of participants, the procedure for data collection, and Colaizzi’s Method for data analysis. Ethical considerations will also be discussed followed by a summary of the research design.
**Phenomenology Method**

"Phenomenology is both a philosophy and a research method that explore and describe everyday experiences in order to generate and enhance the understanding of what it means to be human" (Fain, 2004, p. 220). The phenomenology method is extremely well suited for learning about persons' living experience who have been diagnosed with CHF, because it is specifically designed to gain understanding of the human experience and its meaning to that person. This holistic approach allows researchers to gain a more well-rounded understanding of how CHF truly affects one's life.

**Human philosophy.** Phenomenology is based on philosophy. Human philosophy and sciences are focused on understanding and interpreting human experiences whereas natural sciences focus more on causal explanation, prediction, and control. Kant and Hegel were modern philosophers who explored the meaning of phenomenon. Kant determined that whatever is known is a phenomenon. According to Dr. John Ries, Professor of Philosophy at Carroll College in Helena, Montana, Kant believed that phenomena were spatial and temporal (personal communication via interview, October 16, 2004). In other words, phenomena are what we, as humans, bring to reality, what we see, hear, touch, smell, and taste. Kant discussed the transcendental subject in which the point is to understand what the subject brings to every experience, or the phenomena that each subject experiences (personal communication via interview with John Ries, October 16, 2004). He believed that there were some things humans cannot know because we do not have the structure that can put the ideas together (Lauer, 1958). For example, according to Kant, humans can think about God, but cannot know him. Hegel expanded
on Kant’s studies by saying that reason allows humans to go beyond Kant’s “structure” and allows humans to know phenomena that they have not already experienced. Ideas can explain reality, according to Hegel, which differs from Kant’s beliefs that ideas cannot explain reality. Hegel taught that “phenomena is the unfolding of rationality that we just have not gotten to yet” and that phenomena provide the basis for a universal science of being (personal communication via interview with John Ries, October 16, 2004). A few years later, Brentana and Stumpf worked toward reforming philosophy so as to better serve humanity by improving and expanding upon phenomenology. These philosophers developed the concepts of the “inner perception” that is “the awareness of how our own lived experience appears to our consciousness” and “intentionality” that means “everything that appears to one’s consciousness refers to an object, such as: we do not ‘hear’ without hearing something” (Fain, 2004, p. 221).

Pure experience. Husserl became known as the “father of phenomenology” due to his extensive work and leadership in developing phenomenology (Fain, 2004, p. 221). “It was Husserl’s intention that philosophy should be precisely a discipline, providing a method and instituting a technique for grasping the very essence of the objects that the human intellect can consider” (Lauer, 1958, p. 20). Husserl wished to describe phenomena as it truly is; the pure experience without biases (personal communication via interview with John Ries, October 16, 2004). This involves looking at situations from the consciousness of the person who is experiencing the phenomena. Husserl used a duality in the components of consciousness represented by the Greek terms noesis, meaning the action, or process of knowing, of consciousness, and noema is the object, or thing that you know, of consciousness (Lauer, p. 93; personal communication via interview with
John Ries, October 16, 2004). He also introduced the idea of transcendental subjectivity, also known as intersubjectivity. Husserl stated that “transcendental subjectivity” in the “concrete ultimate ground, whence all that transcends consciousness, including all that is real in the world, derives the sense of its existence” (as cited in Farber, 1943, p. 542-543). It is through transcendental subjectivity that subjective awareness and understanding can be shared with and understood by others (Farber; Fain).

**Phenomenological reduction.** Another important philosopher who contributed to the development of phenomenology was Heidegger who expanded on Husserl’s method of “phenomenological reduction” (personal communication via interview with John Ries, October 16, 2004). Phenomenological reduction is a method of phenomenological analysis using bracketing and intuiting (Fain, 2004).

**Bracketing.** Bracketing is utilized by researchers as a form of identifying and “disconnecting” any previous knowledge, ideas, or beliefs about the phenomenon being researched into a separate section of the thesis so that all previous experience with the phenomenon does not influence the researcher’s outcomes and/or ability to analyze the “true essence” of the phenomenon (Kockelmans, 1967, p. 138-139; Fain, 2004, p. 222).

**Intuiting.** Intuiting is the ability to understand the phenomena and requires the “researcher being immersed in the descriptions of the lived experience to acquire a comprehensive and accurate interpretation” (Fain, 2004, p. 222). According to Dr. Ries, intuiting is “the underlying thought that needs to be there to understand the experience” and it is something that cannot be proved (personal communication via interview, October 16, 2004). For example, someone can see a picture that only shows an animal’s paw, and through intuiting, one can see the paw and know that it belongs to a dog without
having to see the entire picture of the dog. Heidegger also placed importance on hermeneutics, which is the analysis of language and written texts. Many researchers “believe language captures the essence of the lived experience as understood by the individual” (Fain, p. 222).

The purpose of phenomenological research was to understand the “essence” of human experience. Fain (2004, p. 221) described essences as “the elements related to the true meaning of something that give common understanding to the phenomenon under investigation”. This type of research is an in-depth investigation of human experiences related to a phenomenon. This research is descriptive, always retrospective, and interpretations are derived immediately and continuously from the human experience. The final product of phenomenological research should be a complete, extensive description of how humans truly experience a certain phenomenon (Fain, p. 220-229).

Selection of Participants

When conducting a phenomenological study, the sample size should be small and purposeful. The group should be large enough to create saturation, which occurs when the “participants” descriptions become repetitive, with no new or different ideas or interpretations emerging” (Fain, 2004, p. 226). Participants were referred to this researcher through nurse managers at local assisted living facilities in the city of Helena, Montana. The researcher contacted nurse managers of assisted living facilities and explained the purpose of the study and the need for people with CHF to participate in the study. Participants were required to currently be living with CHF for at least one month. The nurse managers introduced the researcher to possible participants of the study who had CHF. The researcher provided the prospective participants with an explanation of the
study as well as what the participant requirements were. The prospective participants were then asked if they would like to volunteer to be a participant. If the person agreed to participate, they were given a consent form that they read and signed in front of the researcher. This researcher was available to the participants to answer any questions and address any concerns they might have had.

Data Collection

Typical methods of data collection in phenomenological studies are received from any one or combinations of extensive interviews, diaries, reviews of art, music, and literature (Fain, 2004). The data collection in this study was conducted through interviews of the participants that were set-up to be unstructured and ended when the participant had fully described his/her experience. The participants chose the location of the interview. The interviews lasted between 45 to 80 minutes, and were conducted in a private location with only the researcher and participant present in the interview area. The participants were asked mostly open-ended questions and a few directed questions to explain any changes in energy level and how any activity intolerance affected their lives. The interviews were audio taped and the researcher took handwritten notes. The tapes were transcribed verbatim.

Data Analysis

Colazzi's method of analysis. Phenomenological data is analyzed by: “reflection on data, explication of themes, constitutive patterns, and essences of the experience” (Fain, 2004, p. 225). Colaizzi’s Method was used to guide data analysis in this study. Following Colaizzi’s Method, the researcher searched for a group of two to ten persons who were currently living with CHF. The researcher then followed the nine steps of
Colaizzi's Method, as outlined in Fain's (p. 231) *Reading, Understanding, and Applying Nursing Research*, to analyze the data collected. First step was to "describe the lived experience under study", which in this study was describing CHF. Second, "collect participant descriptions of the lived experience", which was completed through interviews with each participant. Third, "read all participants' descriptions of the lived experience", which was completed after the interviews had been transcribed verbatim and used in congruence with handwritten notes from each interview. Fourth, "extract significant statements". Fifth, "articulate the meaning of each significant statement". Sixth, "aggregate the meanings into clusters of themes". Seventh, "write an exhaustive description". Eighth, "return to participants for validation of the exhaustive description". Ninth, "incorporate any new data revealed during validations into a final exhaustive description".

**Ethical Considerations**

In order to receive accurate and truthful accounts from the participants, the researcher must be able to build a trusting relationship with each participant. The researcher ensured each participant that his/her identity would remain confidential in this study. Confidentiality was maintained by assigning each participant a code number that was only known to the researcher. A code number was used to identify participants and data. The interviews were completed in private areas in which only the researcher and participant were present. The informed consent process included discussing the purpose of the study, as well as what his/her personal descriptions would be used for, until the participant had a clear understanding of their role in this research. The participants were informed that they could end their participation at any time and that their participation
was entirely voluntary. Each participant received, read, and signed an informed consent that stated the purpose and also provided the phone numbers for the researcher and the supervising professor.

**Limitations**

Phenomenology inherently has limitations in that these studies can be difficult to duplicate, as well as the results from using this method might be weakened by the researcher's own biases. The researcher brought limitations and biases into this project because of previous experience with two family members who lived with CHF. Also, the data gathered using this method relies on the participants' memories, which can be altered depending numerous factors including how the participant feels while being interviewed, old age, medications or other substance use, and many other reasons. Other limitations include that this research was done on a very small scale as a pilot project for an undergraduate Honors Thesis at Carroll College in Helena, Montana, so saturation of themes was not done in depth. Carroll College did not have an Institutional Review Board to approve the ethical status of this research project. The project was approved by the thesis committee, and informed consent met the guidelines for protection of human subjects (Fain, 2004).

**Summary of Research Design**

This qualitative phenomenological study was designed to gain a better understanding of the experience of living with congestive heart failure in a population located in assisted living facilities in Helena, Montana. Persons living in assisted living facilities who were currently living with CHF for at least one month were asked to participate in the study. The interviews were mostly open-ended with a few directed
questions about activity intolerance. The questions asked to each participant were: how did you find out you had CHF; tell me about your life since having CHF; have you made any changes in your life related to having CHF; how has your activity and energy level been affected; tell me about any exercise/rehabilitation programs that you do or have been recommended for you to do; tell me about your spirituality; what can nurses do to help you adjust to and cope with living with CHF; and have any nurses or other healthcare providers helped you deal with CHF.

The interviews lasted about one hour, but no time limit was placed. Interviews were audio taped and handwritten notes were also taken. The tapes were transcribed verbatim and were used for analysis guided by Colaizzi’s Method. Informed consent was obtained from each participant before the interviews took place, and each participant was given a code number known only to the researcher to maintain confidentiality. From the transcripts, the researcher determined themes in the participants’ accounts. Each participant was contacted a second time to validate the interpretations from the previous interview, and all new data received from the second meeting was then incorporated into the final description.

Chapter 4: Results

Congestive heart failure significantly changes the lives of those who suffer from the condition. In one participant’s words, “my life has been turned upside down” (personal communication via interview with Participant #3, October 4, 2004). In this study, four participants shared their stories, each had unique experiences, but six common themes surfaced that described the lived experiences of the participants. In this section, these themes will be listed and briefly described. Further discussion of each theme can be
Congestive Heart Failure

found in Chapter 5. The six themes that emerged from these four participants were:
tolerating symptoms, loosing independence, coping with life stressors, managing
medications, worrying about money, and disregarding fluid and salt restrictions.

*T tolerating symptoms

Each participant experienced symptoms of CHF long before any of them went to
a healthcare professional. Participant #4 stated that he had been feeling poorly for about
two years before his wife forced him to go to the hospital when his CHF had advanced so
much that his lungs were extremely congested and he could barely breath. In his own
words he was not feeling well for

“about two years that I was getting more out of breath all the time. Getting shorter
on breath. Then I’d do some exercise. Cutting wood. Some days I can’t even walk
20, 30 feet and I’m gasping for air. I had to pull my legs up to get into the car and
stuff. But I just thought it was from lack of exercise and stuff, and it wasn’t, you
know. So this has been going on for a while until it got so bad where I had no
choice” (personnel communication via interview, October 4, 2004).

None of the participants believed they had anything wrong with their hearts when they
went to their doctors, rather they went in because they had not felt well for such a long
time that it was starting to significantly affect their activities of daily living. Participant
#3 only visited her doctor, after feeling poorly with shortness of breath, fatigue, and
activity intolerance, before she left for a long trip to her granddaughter’s wedding. She
wanted to feel well during the trip and wedding, so she decided to visit her doctor. After
doing the assessment, her doctor promptly sent her to the intensive care unit (ICU) in
Helena, Montana, where she was diagnosed with CHF and hospitalized for five days.
CHF had progressed so much in each participant by the time that they saw a healthcare professional that each was hospitalized in an ICU for several days.

_Losing Independence_

The loss of independence was a major issue for each participant, who expressed this loss in different ways. Three of the four participants had to move from independent retirement village living arrangements to assisted living facilities in an entirely different town to be closer to their children, as well as receive additional physical and medical support from certified nurse’s assistants and nurses. The fourth participant was required to depend much more heavily on his wife to care for his increased physical and medical needs.

Participant #1 stated that selling her car was the hardest change for her since “it’s the last thing you do”, while trying to maintain independence and Participant #3 refused to sell her car, even though she did not drive anymore, “because it gives me a little freedom, independence, because somebody can always drive it” (personal communication via interviews, September 7, 2004; October 4, 2004).

Each participant was placed on oxygen therapy after his or her CHF diagnosis. Three of the four participants continue to require continuous oxygen therapy, Nebs treatments, or oxygen therapy at night. One participant refused oxygen therapy because she did not like having to wear the nasal cannula all the time. The other three participants did not like the oxygen therapy, but chose to wear the nasal cannula and have Nebs treatments, rather than suffering from shortness of breathe.
Participant #2 discussed that he missed being able to care for his wife the way that he used to. He was unable to help her because his fatigue and shortness of breathe. The morning that he was forced to go to the hospital he stated,

"I hadn’t pushed [his wife] down for a meal, but I just ... I was ... tried to make her bed because she liked it made a certain way ... I just didn’t feel good, so I told her that I was going to lie down" (personal communication via interview, September 7, 2004).

He also missed doing chores around his apartment, such as filling the bird feeder. His fatigue and weakness limited his ability to perform tasks so his daughter filled it for him.

The two female participants both mentioned that they missed spending time with their friends and going to social events, such as church and card clubs. Participant #3 missed driving herself to church and being active in art clubs. Participant #1 stated that it was difficult to make friends when she moved to Helena, but she had recently joined the “Over 90 Club” and that had helped her meet a few more people (personal communication via interview, December 22, 2004).

Coping with Life Stressors

Each participant coped with the diagnosis of CHF, and the life changes that come along with that condition, in their own way. The two female participants suffered from depression, whereas the two male participants stated that they had learned to accept life for what it is and that no one lives forever. Participant #3, female, stated, “It is time to be done ... you get tired of living after a while, when you’re not well ... I don’t have much to look forward to” (personal communication via interview, October 7, 2004). Participant
#2, male, stated, “You don’t have any choice. One thing you do learn is to accept things as they are” (personal communication via interview, September 7, 2004).

Three of the participants moved closer to their children, and all stated their children were the most supportive and helpful people in their lives. These three participants enjoyed talking about their grandchildren visiting them and being close enough to their children that they can spend holidays and special occasions with them.

All four participants relied on family members for support. Two participants living in an assisted living facility stated that they enjoyed the support from the nursing staff who worked there.

Managing Medications

Along with the diagnosis of CHF, came the prescription of multiple medications. Each participant took no less than five medications a day to treat CHF, and as many as 11 pills a day. The dosage of the medications, such as coumadin, frequently changed, depending on the results of routine laboratory blood tests. Only one of the participants managed her medications without anyone else’s help or supervision. The remaining participants relied on either their spouse (Participant #4), or the nursing staff at the assisted living facility they resided in to keep up with the changing dosages and medication regimen. These three participants did not know what medications they were taking; only how many pills a day they took. Participant #3, the only one who independently managed her medications, had to write each medication down on a piece of paper, the dosage, and the time of day she takes each pill so that she could remember to take them properly.
Worrying About Money

Three participants mentioned money as a primary factor in their lives. Two stated that they were very thankful to have good insurance coverage and for the fact that they had saved enough money over the years to pay for their housing, their expensive medications, and also their multiple visits to healthcare professionals over the past few years. Participant #2 stated, “the one thing that I had going for me was a very good retirement” (personal communication via interview, September 7, 2004). Participant #3 had a different experience with finances and had to relocate from one assisted living facility to another because her previous residence significantly increased the monthly rate out of this participant’s budget capabilities.

Disregarding Fluid and Salt Restrictions

All four participants stated that they had not been prescribed or recommended to adhere to a low sodium/low fluid diet. The participants did state that their appetite had decreased, but that they generally ate whatever they wanted to when they were hungry. Participant #3 stated, “I never get hungry . . . just the smell of the food filled me up” (personal communication via interview, October 4, 2004). When asked about any diet recommendations that Participant #4’s physician had given him, he responded, “There’s no diet recommendation stuff. But one thing he said, no smoking . . .” (personal communication via interview, October 4, 2004). His wife overheard this answer and entered the room in which the interview was taking place and stated, “He’s got a whole thing of the fridge that he can’t eat now. Fast foods. All that stuff” to which the participant responded, “Okay, I don’t pay attention . . .” (personal communication via interview, October 4, 2004).
None of the participants discussed weighing themselves daily or the knowledge that a weight gain of three or more pounds in one week was a significant sign of excess fluid retention and indication to contact their healthcare provider (Ignatavicius & Workman, 2002). Participant #4 was the only participant who stated that he knew that “salt retains water”, and that was after his wife reminded him (personal communication via interview, October 4, 2004). All of the participants had lost a significant amount of weight, with the exception of Participant #4 who had just recently begun treatment for CHF. The other three participants lost 20 to 30 pounds since their diagnosis and treatment. Participant #1 looked at the weight loss as a positive change, but Participants #2 and #3 were saddened and unhappy about their weight loss.

Chapter 5: Discussion

The purpose of this research was to learn about and describe the experience of living with congestive heart failure. Once the interviews were transcribed and analyzed, six common themes arose among the participants. Each participant tolerated the early to moderate symptoms of CHF and did not seek medical help until severe symptoms were present. After the participants were diagnosed with CHF, each participant experienced a loss of independence and developed unique ways of coping with life’s stressors. The fourth theme that arose was that each had to find a way to manage the complex and frequently changing medication regimen. All of the participants had worries about money, and finally, each disregarded fluid and salt restrictions. These six themes, as well as a section discussing the differences between the male and female participants, will be discussed in detail in this chapter.
Tolerating Symptoms

All of the participants tolerated mild to moderate symptoms of CHF for an extended amount of time before seeking medical help. Common symptoms of CHF include: shortness of breath, especially when lying down; tired, run-down feeling; swelling in feet, ankles and legs; weight gain from fluid buildup; and confusion or inability to think clearly (AHA website, 2004; Ignatavicius & Workman, 2002). Each participant stated that he or she had simply “felt badly”, or “just didn’t feel well” for a period of time ranging from six months to two years before he or she visited a healthcare professional (personal communication via interview, September 7, 2004; October 4, 2004).

None of the participants believed that when they visited their doctors that they were having any type of heart problem, rather one believed he was suffering from pneumonia, another went in for a check-up to see if the doctor could help her gain her energy back before she went to her granddaughter’s wedding, and still another went in for a colonoscopy with no idea that she was suffering with CHF. The participants all described feeling short of breath at rest and especially upon exertion, easily fatigued, and the inability to do activities that they had previously had enough energy and strength to participate in, but none of those mild to moderate symptoms prompted the participants to call their healthcare providers.

Three of the four participants were seen in emergency departments with severe shortness of breath. One was brought in by his wife, another called LifeLine, and the other was sent by ambulance after his wife notified the nurses at the assisted living facility they resided in of his deteriorating condition. Participant #3 was the only one who
made an appointment with her primary physician because she did not want her symptoms of fatigue and shortness of breath to interfere with her upcoming trip and granddaughter’s wedding. By the time that each participant saw a healthcare provider, the CHF was so severe that each had to be hospitalized in intensive care units for several days and typically stayed one to two weeks in the hospital before being discharged home.

According to Riegel and Carlson (2004), “elder [heart failure] patients often assume that symptoms are a normal part of aging; these changes need to be redefined as abnormal and legitimate reasons for seeking formal healthcare” (p. 175). The male participants, especially, considered the fatigue, general malaise, and shortness of breath as part of the normal aging process and getting out of shape. Participant #2 stated, “Unfortunately I don’t feel as good as I used to, but I’m getting old” (personal communication via interview, September 7, 2004). Participant #3 stated, “I just thought it was shortness of breath from not having exercised and old age, and it wasn’t” (personal communication via interview, October 4, 2004). The female participants did not connect their symptoms with heart problems either and also waited until their symptoms were significantly affecting them before seeking medical help.

*Nurses’ role in ascertaining if patients are tolerating symptoms.* Nurses play a key role in educating patients. The participants in this study might or might not have been educated about the early signs of CHF, but all of them certainly did not attribute their symptoms of shortness of breath, fatigue, and activity intolerance to the condition. Healthcare professionals had assessed three of the four participants at least once within two years. During these check-ups was an optimal time for nurses to discuss with their patients normal changes that occur as one gets older and the difference between normal
changes in physical functions and abnormal changes. Since CHF is so prevalent in the United States, with nearly five million Americans living with it in 2004, nurses could also have opened up a dialogue with their patients and ask them specifically if they had experienced any of the common symptoms in CHF (AHA website, 2004). One participant stated that he had not been to a healthcare professional in ten years; so educating him, and others like him, would require efforts to educate the elderly community as a whole. Ways in which communities could learn about the normal aging process and heart health/diseases could be through local events that have content that teaches about these issues such as events with guest speakers, with poster information, with handouts and flyers, with videotapes, and numerous other teaching strategies and methods. Events could range from auctions to fashion shows, and countless other social opportunities (Stanhope & Lancaster, 2004).

Losing Independence.

The loss of independence was a significant issue for each of the participants. Each participant was unable to take part in activities they had once enjoyed and were forced to become more dependent on other people to help them with their activities of daily living. Three of the four participants had to move from retirement villages and/or homes to assisted living facilities. The participants’ adult children ultimately convinced these three participants to move into assisted living facilities in Helena to be closer to them and receive more care than they had in their previous living arrangements. Participants also experienced loss of independence through being unable to care for his/her spouse the way he/she had before the diagnosis with CHF, through being oxygen dependent, being unable to drive his/her car, and decreased socialization with friends. All of these losses
were related to the fact that the participants did not have enough energy, were not strong enough, and were in many cases physically incapable of participating in activities they had once enjoyed. This lack of energy was due to the heart’s inability to meet the body’s oxygen needs because of CHF, and this created significant, life-altering activity intolerance for all of the participants.

*Moving to assisted living facilities.* Three of the participants moved from primarily independent living circumstances to assisted living facilities after they were diagnosed with CHF. These participants stated that they were completely independent before CHF, and that moving was a difficult, but necessary, change in their lives. Participant #1 stated that she, “didn’t want to go into assisted living since I had lived so long independently”, and Participant #3 stated, “I knew that I could no longer be by myself, so I went into an assisted living place” (personal communication via interview, September 7, 2004; October 4, 2004). All three of these participants said that their families played a major role in convincing them to move from their independent living conditions to places where they could receive more around-the-clock care. Participant #1 moved from a state over 1000 miles away to be closer to her family in Helena, Montana. Participant #1 decided that she needed to move closer to her family after a hospital visit in which she was hospitalized for exacerbation of CHF and felt that she was “at [the hospital’s] mercy...if you don’t have anybody in town that’s coming and checking on you, why, you’re kind of at their mercy. They can do anything they want to you” (personal communication via interview, September 7, 2004). Participant #1 also said that after that experience at the hospital she “felt like I only had the two girls...that I needed to be near family. So that’s the reason that I made this trip up here” (personal
communication via interview, September 7, 2004). The other two participants who moved to assisted living facilities in Helena relocated from other cities in Montana to be near family.

*Inability to care for significant others.* Participant #2 was most affected by the fact that he became weaker and easily fatigued due to the effects of CHF, which in turn made it increasingly difficult to care for his wife. He used to push her in her wheelchair to meals, make her bed, and other physical chores. When Participant #2 returned from the hospital after he was diagnosed and treated for exacerbation of CHF, the first thing the staff at his assisted living facility and he decided was “that that there would be no more wheelchair pushing” (personal communication via interview, September 7, 2004). Participant #2 wished that he could still care for her the way that he previously had because at the time of the interview his wife had been moved to a nursing home after falling in their apartment. She ended up needing more care than provided at the assisted living facility, and Participant #2 felt guilty that he could not lift her and provide physical cares for her either.

Two of the four participants, #1 and #3, stated that they missed caring for their spouses, who were deceased. Participants #1 and #3 admitted that they would not be able to care for their spouses the way they used to after the participants developed CHF because they would be too weak and easily fatigued.

*Oxygen dependency.* After the diagnosis of CHF, all of the participants were sent home with orders to use oxygen treatments via oxygen tanks and nasal cannulas or daily nebulizer treatments. Only two of the four participants were still using the oxygen at the time of the interviews. Participant #3 decided that she did not like using the oxygen via
nasal cannula at night, so “I took myself off of it. The oxygen people didn’t like it very well, so I went to the doctor…” (personal communication via interview, October 4, 2004). At the time of the interview Participant #3 did not use any supplemental oxygen therapy.

Participant #2 and #4 were both using oxygen treatments at the time of the interview. Participant #2 was oxygen dependent and had a nasal cannula on at all times. He noticed a significant difference in his energy level when he did not have the oxygen flowing, and knew that he needed the oxygen all the time. “I had a little trouble the other day…I just was running out of steam, and when I got [to the apartment], I checked my darn oxygen tank and I didn’t have it on” (personal communication via interview with Participant #2, September 7, 2004). Participant #4 had to take daily nebulizer treatments, and said, “it’s done me a lot of good” in regards to his activity tolerance because without the treatments he sometimes could not “walk 20, 30 feet” without “gasping for air” (personal communication via interview, October 4, 2004).

Without the supplemental oxygen, these participants could not walk to and from meals and/or walk to their mailbox without being significantly short of breath. These participants recognized that they were oxygen dependent. Being oxygen dependent required them to make notes reminding them to call the oxygen suppliers to refill the tanks and/or restock the nebulizer treatments. Participant #2 had to take showers with his oxygen on and could not go anywhere without having the oxygen with him. This required him to have extra long tubing so that he could move around his apartment without carrying an oxygen tank on his body, but he did have to drag an oxygen tank behind him when he walked to meals and/or anywhere he went outside of his room. This included
taking the tank with him when his family would come and take him out to dinner and any other outing he went on. Before he went out of his room/building, he had to make sure that his portable tank had enough oxygen to supply him throughout the entire time he would be using it. He could not go anywhere without thinking about whether or not he would have adequate oxygen supply.

Participant #4 had to start making extra preparations before going on his usual camping and hunting trips with his wife after his CHF diagnosis. He had to order extra nebulizer supplies before he went on his outings. He could not decide the day before that he wanted to go on a weekend trip because he might not have enough supplies to get him through the weekend. Participant #4 liked being able to breath better, but did not like having to always consider whether or not he would have enough oxygen to do the activities that he had once automatically participated in.

*Loss of driving capabilities.* Two of the four participants experienced a major loss of independence when they acknowledged the fact that it would not be safe for them to drive their cars anymore. Both dealt with this loss in different ways. Participant #1 stated, “When I couldn’t drive, that was hard to sell my car…it’s the last thing you do…” (personal communication via interview, September 7, 2004). Participant #1 viewed driving her car as a way to go wherever she wanted, when she wanted, and that losing the ability to drive her car took a great deal of her independence away from her. She had to rely on others to get her to and from the places that she wanted to go. She considered selling her car as “the hardest thing that I had to do” (personal communication via interview with Participant #1, September 7, 2004).
Participant #3 had a different reaction when she realized that she could not safely operate her car because she was so weak and easily fatigued. She did not sell her car, but rather kept it. Having the car gave her a sense of independence and selling her car would have taken more of her independence away than she was willing to give. “I have my own car sitting out here...I don’t even have any incentive to drive it. Now isn’t that terrible? And I’m keeping it because it gives me a little freedom, independence, because somebody can always drive it” (personal communication via interview with Participant #3, October 4, 2004).

*Decreased socialization with friends.* Three of the four participants discussed that since their diagnosis they had not participated in many of the activities that they had previously enjoyed. Reasons for being unable to participate in activities ranged from not being able to drive to them, being too tired and fatigued, and from moving away from friends, clubs, and churches. Participant #2 stated that since he moved to Helena and into an assisted living facility he did not receive many visitors and frequently got lonely. His family visited him once he moved to Helena, but he moved too far away from his previous residence for his friends who lived there to visit him. He did not talk about joining any clubs or being involved in any activities in the assisted living facility that would help him meet new friends.

Participant #1 also moved away from many friends when she came to Helena. During the interview in September, she stated that she was having difficulty making new friends in her building because it was hard to meet people with the same interests. In December, during the validation meeting, she stated that she had since joined the “Over 90’s Club” and that helped her meet some new friends, but she still missed her friends
Congestive Heart Failure

that she left when she moved. Participant #1 also “really enjoyed” taking “water classes at the YMCA” twice a week, but stopped going after she was unable to drive herself there. She also stated that if she could have found transportation to the classes that she would not participate anyway because of her deteriorating physical condition. She was “afraid walking around the water that I’d fall or slip on the floor and all that. And then it got to be too big a chore to get dressed” (personal communication via interview with Participant #1, September 7, 2004).

Participant #3 seemed to be the most affected by decreased socialization from moving away from friends, deteriorating physical condition, and inability to drive to activities such as church. “I miss my church. I miss my friends. I miss going to my card club, the senior citizens…There’s nothing for me over here” (personal communication via interview with Participant #3, October 4, 2004). She stated that she did play cards twice a week with some people she met in her building, but that it was not the same as it had been in her previous residence. Participant #3 stated that sometimes it was difficult for her to communicate with new people because she would lose her voice periodically. She mentioned several times that she missed participating in activities she had previously enjoyed. She stated that she was often too tired and easily fatigued to participate in art activities and knitting. “I used to be into everything, like they have arts here and I would be right in the middle of it. But I don’t do it. I have knitting to do. I’m off of knitting…” (personal communication via interview with Participant #3, October 4, 2004).

Activity intolerance. Activity intolerance affected and caused many of the main reasons why each of the participants felt that he/she had lost much of their independence. Because each participant became increasingly more easily fatigued and short of breathe,
all of the participants had to stop doing activities that they had once enjoyed, such as providing physical cares for significant others, driving his/her car, socializing with friends, and much more as previously stated in the above sections. Each of the participants had to be placed on oxygen with two still needing oxygen therapy and three moved to assisted living facilities that affected every aspect of his/her life. Being unable to participate in activities that had once brought the participants joy and satisfaction in life caused each to feel that they had lost much of their independence and freedom to live their lives the way they pleased.

The three participants living in assisted living facilities all stated that they “force” themselves to walk to and from their room to the dining room two to three times a day with “many breaks” because they “tire out so easily” (personal communication via interview, September 7, 2004; October 4, 2004). Participant #3 stated, “I push myself all the time. I make myself walk up here . . . I’m so out of breath all the time. I can’t walk and I can’t talk at the same time” (personal communication via interview, October 4, 2004). As participant #3 became weaker and more easily fatigued, she had to switch from using a cane to a walked and stated, “that was the worst thing I ever had to do, was to go to the walker” (personal communication via interview, October 4, 2004).

These three participants stated that when they were diagnosed with CHF they did not receive recommendations, instructions, or education about the benefits of exercise. They also did not know that light to moderate exercise, when completed on a regular basis, could help decrease the symptoms of fatigue and shortness of breathe as shown by numerous research studies. The National Institute for Clinical Excellence (NICE) recommended that exercise training should be offered and encouraged in patients with
CHF (Appleton, 2004, p. 452). Benefits of exercise for CHF patients includes the following: improvement of stamina and strength, muscle tone, maintenance of bone strength, improved circulation, reduction of high blood pressure, reduced stress, improved sleep, and also increases sense of wellbeing and confidence (Appleton, p. 455). The American Heart Association (AHA) also recommends exercise training for CHF patients (Morantz, 2003, ¶ 1).

“This Committee on Exercise, Rehabilitation, and Prevention of the American Heart Association Council on Clinical Cardiology concludes that exercise training in patients with heart failure seems to be safe and beneficial in improving exercise capacity, as measured by peak VO₂, peak workload, exercise duration, and parameters of submaximal exercise performance. Benefits have been reported in muscle structure and physiologic responses to exercise, such as improvements in endothelial function, catecholamine spillover, and oxygen extraction in the periphery” (Morantz, ¶ 10).

Participant #4, who had been recently diagnosed with CHF, did state that his physician encouraged him to “start exercising to build my body back up, but not to overdo it to start off with. Ease into it” (personal communication via interview, October 4, 2004). However, he did not know any particular exercises/activities that were safe for him to do. He also did not know the benefits of regularly exercising.

Nurses’ role in helping patients regain independence. Nurses could play a major role in working with patients with CHF to regain some of the independence that was lost due to activity intolerance. There are several factors that cause fatigue, such as respiratory deficiencies that cause hypoxia and dyspnea, nutritional complications, and
sleep impairments. Decreased fatigue and dyspnea lead to increased energy, which has been shown to improve a person’s quality of life. Nurses, with the right interventions, could help their patients increase their energy levels, decrease their fatigue and dyspnea, and consequently improve their patients’ quality of life. Studies have shown that exercise is a key factor in decreasing fatigue and dyspnea, but patients typically have a difficult time complying with a long-term exercise program. Researchers have found that nursing interventions such as patient education, follow-up care with nurses, especially in the patient’s home, and providing unconditional support and monitoring rehabilitation progress are successful and effective interventions.

Many CHF patients do not understand the importance of adhering to treatment plans prescribed by their health care providers. Because of this lack of knowledge about their treatments, many do not comply with their regimens, leading to increased activity intolerance and many other serious exacerbations caused by the effects of CHF. A study completed by Knox and Mischke (1999) found that educating CHF patients about their treatment regimens decreased the rate of hospital readmissions. The Cardiology Pre-Eminence Roundtable (1994) found that “frequently, patients are discharged without adequate education and resources and this contributes to a 30 day national readmission rate of 23%” (as cited in Knox & Mischke, 1999, ¶ 3). By adhering to exercise recommendations, patients improve their chances of increased energy and quality of life, while at the same time decrease their chances of having health complications that require readmission to a hospital. To help educate patients, nurses must use “written, verbal, and audio teaching methods [that] are available to enhance compliance and target individual learning styles” (Knox & Mischke, 1999, ¶ 19).
There are many factors of activity intolerance that patients need to be educated about. Patients need to be taught the importance of increasing their activity as tolerated, and taking frequent rest periods to allow the heart to recover. Patients need to be cautious about spending too much time outdoors, or in extreme climates, because this puts added stress and increased workload on their hearts.

Patients need to be encouraged to continue working hard and improving. Nurses can provide this support in many ways, such as verbal and written exclamations on the patient’s success and improvement. Nurses can also encourage patients by using graphs to chart and monitor the patient’s progress. Duncan and Pozehl (2002) completed a quantitative study that tested “the effectiveness of an adherence facilitation intervention consisting of goal setting, graphic feedback, and provider guidance” in a sample of 13 CHF patients prescribed a home exercise program after completing a supervised exercise program (¶ 1). Nurses played a major role by using the graphs and helping the patients set goals, and also they served “in the role of coach by helping patients understand past progress and the need for future changes” (Duncan and Pozehl, 2002, ¶ 10). The results of this 12-week study of home exercise adherence showed that the interventions of “goal setting, graphic feedback, and problem-solving guidance was effective in increasing exercise adherence in a sample of heart failure patients” (Duncan and Pozehl, 2002, ¶ 24). The study suggested that the graphic feedback and the nurse’s support and guidance seemed to be very helpful to CHF patients who did not fully understand their exercise programs and/or could not easily remember their program. The graphs also helped participants in the intervention group see their progress, which gave them satisfaction and increased confidence to continue with their exercise program. This study shows that
nurses can use graphs and provide support and guidance in the practical setting to work toward improving patients’ compliance and satisfaction with their exercise regimens. By providing support and a tool to monitor progress and set goals with, nurses can help their patients stay on track with their exercise rehabilitation programs.

Coping with Life Stressors

The participants in this study each coped with the diagnosis and affects of CHF in their own, unique, ways. Three of the four participants moved closer to their adult children and all four stated that the families were the greatest support that the participants had in their lives. Two of the participants suffered from depression and felt that CHF had drastically affected their lives in a negative manner. The other two participants looked at the diagnosis and changes as an event that needed to be accepted, that it was just the natural process of life, and that no one lives forever.

All of the participants stated that they relied on their family the most for support. Participant #2, who moved closer to his children, stated, “I get help from my two daughters...they are a big help” (personal communication via interview, September 7, 2004). Participant #3, who also moved closer to her children, stated, “My family is wonderful to me” and proceeded to talk about how she loves when they come visit her, especially when they bring the grandchildren (personal communication via interview, October 4, 2004).

According to Profant and Dimsdale (2000), “Depression is common among patients with cardiovascular disease and, in many studies, in predictive of excess medical morbidity and mortality” (13). The two female participants suffered from depression after they were diagnosed with CHF. These participants missed being active in events
that they had once enjoyed. One participant took antidepressant pills, while the other female participant stated that she did not need antidepressant pills but that her doctor had discussed prescribing them to her in the past. Participant #3 stated, “My quality of life isn’t very much…every night I pray that the Lord takes me. But he’s not answering my prayers” (personal communication via interview, October 4, 2004).

The two male participants viewed being diagnosed with CHF and living with the affects of the condition as a normal part of life that must simply be accepted. Participant #3 stated, “I think that probably the fact that I’ll be 90 affects [my life] more than the CHF…I keep going” (personal communication via interview, September 7, 2004). Participant #4 stated, “none of us is going to live forever…but I found out that I’m not invincible or indestructible” (personal communication via interview, October 4, 2004).

Nurses’ role in helping patients cope. It is important for nurses to assess and address how patients with CHF are coping with their condition and if each patient has a reliable and adequate support system. “The literature…suggests not only that psychosocial factors may play a role in the precipitation and exacerbation of CHF but that there are also significant psychosocial consequences of CHF” (Profant &Dimsdale, 2000, ¶35). Nurses need to educate their patients on how to recognize the signs and symptoms of depression as well as emotional stressors because emotional stress places higher demands on the heart by increasing the heart rate, respirations, and blood pressure (Carpenito, 2002).

Many patients undergo life changes, such as the participants in this study, which prevent patients from doing activities that they once enjoyed. Many patients do not have anyone to depend on and help him or her adjust to the changes that they experience.
Treatments can be difficult and cause extreme frustration. All of these factors and more can lead to depression. Nurses must be able to recognize this condition in their CHF patients and develop appropriate interventions to help their patients.

Noncompliance has been correlated with depression and low self-esteem, so nurses should screen for depression when noncompliance is noticed. Nurses must assess patients’ social support system and their feelings about their health and treatment. Nurses should help the patients develop social support strategies such as joining a support group or finding transportation to a church group (Richardson, 2003).

Nurses must also help patients adjust to the changes that they are experiencing. Nurses can help the patient realize that they still have control over the situation and develop strategies to feel more in control of their lives. Patients need to be guided to use the coping skills that they already have. Nurses can help patients better accept both positive and negative feelings. It is important for nurses to be unconditionally supportive of patients, to show confidence in them, and help the patients set goals for themselves (Carpenito, 2002).

Nurses must open a dialogue with their patients to determine the patients’ feelings about their condition, their family, their support system, and other aspects of their lives. Nurses must be very supportive, nonjudgmental, and understanding toward their patients. Once patients begin to share their feelings, nurses should search for aspects of their life that bring them hope and joy. Many patients state that they find hope in their family and friends, so it is very important that “support for these relationships must be a focus of interventions by the nurses” (Westlake & Dracup, 2001, ¶ 22).
Managing Medications

The medication regimen for patients with CHF frequently changed and typically consisted of multiple prescriptions that needed to be closely adhered to. Each participant took at least five medications a day, and one participant took 11 pills a day but did not know how many of those were to treat the heart. Three of the participants depended on other people, the nursing staff at the assisted living facility he/she resided and in one case the spouse, to manage the medications. Only one participant was able to manage her own medications by writing the name of each medication on a piece of paper, the time that she needed to take them, and the dosage. She would update this list every time that she received a new prescription or change in dosage.

Participant #4 stated, “[My wife] is a CNA so she...makes up my medications for a week...I’d get them screwed up” (personal communication via interview, October 4, 2004). This participant also was taking ten medications, one of which was coumadin that required him to go to a clinic for weekly blood draws to measure the effectiveness of the dose he was taking. His coumadin doses were changed nearly every time he had his blood drawn. Both Participants #1 and #2 had the nurses at the assisted living facility they resided in manage their medications. Neither knew exactly which pills were for their heart condition.

Nurses' role in helping patients manage medications. With the frequently changing medications, nurses need to educate their patients to the best of the nurse’s ability about when, why, and how to correctly follow the medication regime. With patients who live at home, nurses can use picture tables or other forms of visual tools with the regimen on it. Nurses must assess how the patient best learns and provide
teaching individualized to each patient. Patients can be encouraged to set a routine of filling pill boxes at the same time every week, or any other of the numerous strategies to help patients understand what, when, why, and how to take their medications. As in Participant #4’s situation, nurses can teach a spouse, significant other, family member, or close friend how to administer the correct medications. According to Dunbar-Jacob et al. (2003), in the role of being an advocate for patients, nurses should try to get medications changed to an easier, simpler regimen by approaching health care professionals on behalf of the patient.

Worrying About Money

Three participants discussed finances and money as factors that impacted their lives. Two discussed money matters in a positive light. Both mentioned that they were thankful that they had good insurance coverage and that they had saved money for this stage in their lives. One participant was more negatively affected by financial issues and moved from one assisted living facility to another when her previous residence significantly raised the monthly rent rate.

Participant #1 discussed how expensive her medication bill was and that she was thankful for her broad insurance coverage because that allowed her to pay for the things that she needed, such as medications and her room and board. Participant #2 stated that his retirement was “the one thing I had going for me” (personal communication via interview, September 7, 2004). His retirement money and insurance helped him pay for his room and board as well as covered the costs of his wife’s room and board at a nearby nursing home. Money was an important asset to these two participants who believed that their lives would be more difficult without their savings and insurance.
Participant #3 discussed that she needed to save money and that she made the decision to move from one assisted living facility to another because the monthly rent rate was raised. In response to the increased rates, she stated, “Why spend everything [on room and board]? So I just came over [to a new residence]. I’m saving $600 a month over here” (personal communication via interview, October 4, 2004).

Nurses’ role in assessing patients’ financial concerns. Nurses must assess a patient’s ability to cover his/her costs of living as well as healthcare coverage. To help patients financially, nurses can intervene in many ways. Nurses can educate the patients about types of insurance available and/or refer patients to social services. Encouraging patients to budget and purchase generic foods and medications also can help reduce costs (Stanhope & Lancaster, 2004).

Disregarding Fluid and Salt Restrictions

Each participant stated that they had not been prescribed or recommended to change their diet to a low sodium/low fluid diet, which is an important lifestyle change that can greatly affect the health of a person with CHF (Ignatavicius & Workman, 2002). People with CHF who consume too much fluid and/or salt retain water place increased demand and workload on the heart and could cause an exacerbation of CHF and even death (Ignatavicius & Workman, 2002). Regardless of whether or not the participants in this study were truly educated about changing their diet, none of the participants were following a low sodium/low fluid diet. Participant #4, who had been very recently diagnosed at the time of the interview, stated that he had been told to stop smoking but not to change his diet in any way. His wife overheard his response and stated that she had placed a long list of foods that he was not allowed to eat on the refrigerator in their home,
and that he had been told to change his diet to low sodium/low fluid. Participant #4 responded that at times he did not pay attention. All four participants stated that they ate and drank whatever they desired.

Having decreased to no appetite is a fairly common side effect in patients with CHF. In a study by Jacobsson, Pihl, Martensson, and Fridlund (2004), many patients with moderate to severe heart failure “ate because they had to and not because they wanted to. The motive for eating was not hunger but the knowledge that food is necessary for survival” (p. 520-521). All of the participants stated that they had experienced a decrease in appetite, but none were as affected by the decrease in appetite as Participant #3.

Participant #3 discussed that simply the aroma of food could make her stomach feel full. “I eat because I have to...I never get hungry” (personal communication via interview with Participant #3, October 4, 2004).

None of the four participants mentioned that they weighed themselves daily, or even that they knew the importance closely monitoring their weights. A weight gain or three or more pounds in one week is a sign of excess fluid retention and a serious indicator to contact a healthcare professional (Ignatavicius & Workman, 2002).

Participant #4 was able to state that salt retained water, after his wife reminded him about why his physician had instructed him to follow a low sodium diet, but did not connect the fact that excess water retention could cause an exacerbation of CHF.

Three of the participants mentioned that they had lost a significant amount of weight, 20 to 30 pounds, since they had been diagnosed with CHF, but did not say that they weighed themselves frequently. Participant #1 was the only of the three who lost weight that viewed it as a positive change. She stated, “I feel better when I don’t weigh
so much” (personal communication via interview with Participant #1, September 7, 2004). Participant #2 and #3 were unhappy with their weight loss. In regards to her weight loss of over 30 pounds, Participant #3 stated, “Isn’t that terrible” (personal communication via interview, October 4, 2004).

Nurses’ role in helping patients make diet changes. In the case of the participants in this study, the most important nursing intervention would be education about diet and fluid restrictions. Patients need to be educated about the importance of eating a proper diet, low in sodium and fluids. Nurses can help their patients explore other methods of seasoning their food such as herbs and spices, as well as giving them lists of food high in sodium that they should not eat.

Since patients with CHF typically have complex treatment plans that include medications, exercise, diet, lifestyle changes, and frequent medical appointments, many may not be able to remember everything that they were prescribed to do. There are also many other reasons why CHF patients do not, or are unable to, comply with prescribed treatments, such as a change in diet. Nurses are responsible for doing their best to help patients discover methods to increase compliance, for the sake of the patients’ health and welfare.

Nurses must discuss with their patients whether or not the patients understand the purpose the change in diet (Carpenito, 2002). Many patients do not adhere to treatment plans because they believe that the treatments are pointless. Nurses must educate their patients of the importance of adhering to a proper diet and weighing themselves every day. Patients might also have cognitive disabilities that impede their ability to remember their treatment regimens. Nurses must be able to assess “clinical symptoms, functional
limitations, and debilitating changes associated with CHF and aging” to be able to properly form a plan to help the patient understand their treatments (Evangelista et al., 2003, ¶ 22).

Many patients feel that complying with their treatment regimen creates a decreased quality of life rather than improving it. Nurses must be able to discuss and assess the “patients’ appraisal of the cost-benefit ratio” (Evangelista et al., 2003, ¶ 22). Nurses need to determine any concerns that the patient has, any negative experiences with the treatment plan in the past, and if they are receiving support with the changes they are working to make. This allows open communication between the nurse and patient, so the nurse can address the patient’s concerns and they can try to work past the problems together (Carpenito, 2002).

Nurses need to assess what the patients’ concerns and difficulties are in adhering to recommended changes. Nurses can give written instructions outlining the treatment regimen, graphs, pictures, note cards, stickers, and other tools to try and help the patient. Nurses must try to simplify the instructions and present them in a way that best suits the patient.

Gender Differences

There were a few distinct differences between the two female participants and the two male participants in this study. First, the two male participants both stated that they had trouble sleeping since they began experiencing CHF. The females stated that they slept well through the night and had not experienced any change in sleep habits or pattern. Participant #2 needed to take Tylenol PM every night or he stated that he could not get to sleep. He also said that he went to bed earlier because he was so exhausted, but
would still wake up frequently during the night. Participant #4 stated that he also had a much more difficult time getting to sleep and maintaining sleep throughout the night. Both stated that they took more frequent and longer naps during the daytime than they had before they had CHF. A study of sleep in people with CHF completed by Brostrom, Stromberg, Dahlstrom, and Fridlund (2004), found similar results and stated, “the amount of estimated need for sleep was significantly shorter for women…and the number of awakenings per night was significantly increased for men” (p. 234)

Secondly, the females appeared more psychologically affected by the side effects of CHF than the males. The two female participants reported a lower quality of life and missing being active in social activities they had once enjoyed, whereas both males approached the diagnosis and symptoms as part of getting older and that they needed to simply accept their condition.

A third main difference between the males and females in this study was that both females went to a healthcare provider on their own accord because they were tired of not feeling well compared to the males who were taken to a nearby hospital by others. Participants #1 and #3 both made appointments with providers and from those appointments they were sent to the hospital. Participant #2 was taken to the hospital after his wife informed the nurses in the assisted living facility they were living in of his deteriorating condition. Participant #4’s wife took him to the hospital after she spent several days trying to convince him that he needed professional help and he finally became worried when he could barely breathe. Both males did not want to go see a healthcare provider and were eventually forced to by others. Both females did wait a long
time before seeing a provider, but they took the initiative and made their own appointments.

Nurses’ role in completing a thorough assessment. All patients are individuals with their own unique needs. It is the responsibility of nurses to complete thorough assessments and form plans of care that best meet those needs. Nurses should consider, but not assume, that female patients might need more support and guidance in dealing with decreased socialization and a feeling of worsening quality of life. Male patients might require more coaxing to visit healthcare providers and as a result present with advanced problems that need more critical and immediate care.

Since quality sleep is necessary for good health and a feeling of well-being, nurses should include a sleep assessment in all patients with CHF. Many CHF patients are unable to sleep adequately for their bodies to recuperate and heal. Patients can suffer from sleep apnea, paroxysmal nocturnal dyspnea, and other breathing disorders that impede a good night’s sleep. As people age, many suffer from insomnia. Side effects of medications and depression can also negatively affect one’s sleep patterns. Nurses must be able to recognize the signs and symptoms of inadequate sleep and implement necessary interventions, because studies have shown that patients are happier and healthier when they are getting enough quality sleep (Parker & Dunbar, 2002).

Nurses are responsible for obtaining a thorough sleep history of the patient. Nurses should ask very specific questions about the quality and quantity of their patients’ sleep. Once contributing factors are identified, further interventions, specifically formulated to treat those factors, should be applied (Parker & Dunbar, 2002).
Nurses can promote sleep in many ways, such as helping the patient to relax, decreasing or eliminating noise and other sleep disruptions, and/or use comforting measures like a warmed blanket or back rub before sleep. Nurses should help their patients realize what sleep strategies work best for them, and provide their patients with many options to help improve their sleep (Carpenito, 2002).

Chapter 6: Conclusion

Congestive heart failure affects every aspect of the lives of those who suffer from it. Changes occur physiologically, psychologically, socioculturally, and spiritually in these patients. Many of these changes require difficult adjustments, such as activity intolerance that can lead to being unable to do the most basic activities of daily living. Nurses can, and do, play an essential role in helping care for CHF patients. With the many interventions that nurses can implement, patients can receive excellent care, and develop strategies and methods for continually improving their life. Nurses have the knowledge, skill, and experience to successfully help patients live happily with a good quality of life despite living with this chronic disease.
References


*Journal of the American Dietetic Association, 12*, 1790-1795.


*The Journal of Cardiovascular Nursing, 14*(1), 55-75.


Websites

American Heart Association’s website:

www.americanheart.org/presenter.jhtml?identifier=1486
