



Walden University
ScholarWorks

Walden Dissertations and Doctoral Studies

Walden Dissertations and Doctoral Studies
Collection

2017

Barriers Cardiac Nurses Face in Addressing Psychosocial Issues of Heart Failure Patients

Debra Kay Disbrow
Walden University

Follow this and additional works at: <https://scholarworks.waldenu.edu/dissertations>

 Part of the [Nursing Commons](#), and the [Social and Behavioral Sciences Commons](#)

This Dissertation is brought to you for free and open access by the Walden Dissertations and Doctoral Studies Collection at ScholarWorks. It has been accepted for inclusion in Walden Dissertations and Doctoral Studies by an authorized administrator of ScholarWorks. For more information, please contact ScholarWorks@waldenu.edu.

Walden University

College of Health Sciences

This is to certify that the doctoral study by

Debra Disbrow

has been found to be complete and satisfactory in all respects,
and that any and all revisions required by
the review committee have been made.

Review Committee

Dr. Andrea Jennings-Sanders, Committee Chairperson, Nursing Faculty

Dr. Mary Verklan, Committee Member, Nursing Faculty

Dr. Phyllis Morgan, University Reviewer, Nursing Faculty

Chief Academic Officer

Eric Riedel, Ph.D.

Walden University

2017

Abstract

Barriers Cardiac Nurses Face in Addressing Psychosocial Issues of Heart Failure Patients

by

Debra K. Disbrow

MS, Walden University, 2011

BS, University of Notre Dame of Maryland, 2008

Project Submitted in Partial Fulfillment

of the Requirements for the Degree of

Doctor of Nursing Practice

Walden University

May 2017

Abstract

Heart failure is a chronic disease and a common cause of hospitalizations and readmissions within 30-days of discharge. To decrease the cost of care for patients with heart failure, the Centers for Medicare and Medicaid Services initiated the Readmissions Reduction Program that reduces payment to hospitals with preventable readmissions.

Among the causes for readmissions of patients with heart failure are concurrent behavioral health issues that can lead to decreased medication compliance and increased risk for disease progression. The prevalence of comorbid depression is as high as 77% among patients with heart failure and may be an important factor in readmissions.

Although cardiac nurses in the emergency room, intensive care unit, and the progressive care units at a community hospital were perceived by managers to be in optimal settings to assess for behavioral health issues and make referrals as appropriate, assessments were not being conducted. The purpose of the project was to determine the barriers nurses faced in completing the assessments. Four audiotaped focus groups with a total of 18 cardiac nurses were held and the data were transcribed for analysis. Using Kalcaba's comfort contexts (physical, psychospiritual, social, and environmental), the barriers identified by the nurses were categorized into a fishbone diagram and a Pareto chart. The nurses identified lack of a standardized screening tool, lack of priority given to behavioral health assessments, lack of time to conduct the assessments, and lack of a clear facility policy related to the assessments as barriers. A positive social change resulting from the project is an initiative to address the barriers and ensure that patients with heart failure are cared for in a holistic manner that addresses physical and behavioral health issues.

Barriers Cardiac Nurses Face in Addressing Psychosocial Issues of Heart Failure Patients

by

Debra K. Disbrow

MS, Walden University, 2011

BS, University of Notre Dame, Maryland, 2008

Project Submitted in Partial Fulfillment

of the Requirements for the Degree of

Doctor of Nursing Practice

Walden University

May 2017

Dedication

The project is dedicated to all my friends and family who supported me while I was working it. Your encouragement and understanding of the hours that were poured into the development and analysis of the project made it easier to complete. Thank you for the gentle nudges, the small celebrations, and the constant outpour of love. To my children, Kathy and Ryan, I love you more than you could possibly know.

Acknowledgement

I would like to thank Shirley Kase for allowing me to work with her during my clinical hours. Dr. Margaret McNeil who agreed to spend her own time proof-reading my proposals and providing feed-back in a timely fashion, and Dr. Elizabeth Cipra who assisted in reviewing my research data. You both provided me with encouragement, and believed in me and my project when I struggled.

I would like to say a very special thank you to Dr. Kathryn Troupe who allowed me to spend countless hours sharing ideas with her, for teaching me to love heart failure, and allowing me to witness her practice in the heart failure clinic. Your knowledge and compassion for your job and your patients is an inspiration to me and other nurses.

Dr. Jennings, just when I thought about giving up, you took over as my project chair person and provided me with the supervision and support that I needed to get back on track to finish my degree.

Table of Contents

List of Tables	iv
List of Figures	v
Section 1: Overview of Evidence Based Project	1
Introduction.....	1
Problem Statement.....	4
Purpose Statement and Project Outcomes.....	5
Significance and Relevance to Practice.....	6
Implications for Social Change in Practice.....	7
Goals and Objectives.....	8
Project Question.....	9
Definition of Terms.....	9
Assumptions and Limitations.....	11
Summary.....	12
Section 2: Review of Literature and Theoretical Framework.....	13
Introduction.....	13
Literature Search Strategy.....	13
Nurse Barriers.....	15
Psychosocial Issues.....	17
Depression.....	17
Anxiety.....	20
Stress.....	22

Social Support.....	22
Theoretical Framework Literature.....	24
Kalcaba's Theory of Comfort.....	24
Summary.....	25
Section 3: Methodology.....	27
Introduction.....	27
Project Design.....	27
Population and Sampling.....	28
Data Collection.....	29
Data Analysis.....	30
Project Evaluation Plan.....	30
Summary.....	31
Section 4: Findings, Discussion, and Implications.....	32
Introduction.....	32
Findings and Implications.....	32
Kalcaba's Theory of Comfort.....	38
Recommendations.....	39
Strengths and Limitations of the Project.....	41
Analysis of Self.....	41
Summary.....	43
Section 5: Dissemination Plan.....	45
Introduction.....	45

Dissemination of Recommendations.....	45
Screening Tool.....	46
Education Plan.....	46
Policy Development.....	47
Implementation.....	48
Evaluation.....	49
Dissemination.....	50
References.....	51
Appendix A: Interview Questions	60
Appendix B: Email Invitation.....	61
Appendix C: Fish-bone Diagram.....	62
Appendix D: Pareto Chart.....	63
Appendix E: Minnesota Living with Heart Failure Questionnaire.....	64
Appendix F: Licensure for Minnesota Living with Heart Failure Questionnaire.....	65
Appendix G: Hospital and Anxiety Depression Scale.....	72
Appendix H: Power point presentation.....	74

List of Tables

Table 1. Fishbone Diagram Categories..... 30

Table 2. Combined Demographics of Focus Groups.....33

Table 3. Themes and Quotes from Focus Group Participants.....34

Table 4. Comparison of the Screening Tools.....47

List of Figures

Figure 1. Nurse's Comfort in Assessing Psychosocial Issues25

Section 1: Overview of Evidence Based Project

Introduction

Heart failure (HF) can be defined as the heart's inability to effectively pump blood and nutrients throughout the body to meet the demands of the organs and tissues (American Heart Association [AHA], 2015). Risk factors for the development of HF include smoking, inactivity, poor diet, high blood pressure, sleep apnea, heart damage, and alcohol/drug abuse (Wedro, 2013). Heart Failure affects 5.7 million Americans, and patients who are newly diagnosed are expected to reach 1.2 million annually by 2040 (Lea, 2014). With such a significant increase in HF patients, it is apparent why HF management has become a top priority for policy makers and care providers (Cene et al., 2012). Mortality rates for patients with HF are at 31%, 30 day all cause readmission rates for HF are reported at 24.7% nationwide and annual costs of health care—as high as \$32 billion—have been associated with treating HF patients (AHA, 2015; Center for Disease Control and Prevention [CDC], 2015).

Cost containment in health care has become a priority for the United States, and improvements in the quality of care for chronic diseases (such as HF) can help decrease the cost that Medicare and Medicaid pay out annually (Runyan, 2011). One way to help decrease these costs can be accomplished by focusing on holistic care, and promoting wellness programs which include access to appropriate behavioral health care providers (Runyan, 2011). Wellness programs include providing patient education on nutrition and the importance of maintaining exercise, establishing HF support groups, and allowing the

patient to take part in the care by providing tools for self-monitoring of weight and blood pressure (Bekelman et al., 2014).

Patients with HF often lead demanding lives consumed with doctor appointments, medication administration, and symptom management, all of which can lead to increased levels of stress, anxiety, and depression (Woltz et al., 2012). The psychosocial issues of stress, anxiety, and depression in patients with HF can exacerbate HF symptoms and put patients at higher risk for the progression of the disease (Chapa et al., 2014). HF patients who suffer from stress, anxiety, and depression may have more frequent hospitalizations, decreased compliance with essential medications, have an overall increase in the cost of their care, and can lead to mortality (Chapa et al., 2014). Prevalence of depression in HF patients ranges from 13- 77% which can impact readmissions to hospitals, increase mortality, and increase hospital costs (Woltz et al., 2012). Nurses who care for HF patients are in an optimal position to assess and evaluate stress, anxiety, and depression levels and then make referrals to a case manager, social worker, or psychiatrist if appropriate.

When patients are admitted to an acute care hospital for an exacerbation of HF, the telemetry (cardiac) nurses who care for them are focused on treating the patient to prevent the progression of the disease. Interventions include diuretic administration, accurate daily weights, intake and output measurements, cardiac monitoring, and if needed, administration of medications for arrhythmias. The psychosocial issues of HF patients are often undetected and often go untreated in the acute care setting because cardiac nurses may overlook the importance of prioritizing psychosocial care at the

bedside (Yohannes, Willgoss, Baldwin, & Connolly, 2010). When the psychosocial assessment is omitted, it may lead to a significant disconnect between treating the acute symptoms of HF to stabilize the patient, and treating the patient in a holistic manner.

To understand the relationship between HF and depression, it is important to review the pathophysiology of HF. Patients who suffer from HF produce a neurohormonal activation due to an increase in the left ventricular filling pressure, heart arrhythmias, inflammation, and hypercoagulability (Chapa et al., 2014). These responses can also be associated with the pathology of depressive states; therefore, it is difficult to differentiate between the symptoms of HF and depression (Chapa et al., 2014). Fatigue, decreased appetite, and difficulty sleeping are also symptoms associated with both HF and depression (Volz et al., 2011). For vulnerable HF patients, developing depression can speed up the HF disease process (Chapa et al., 2014).

Stress and anxiety, on the other hand, can stimulate the sympathetic nervous system and catecholamine release. Increased levels of plasma norepinephrine have been linked to predicting the mortality of patients with HF (De Jong et al., 2011). The sympathetic nervous system is associated with the *fight or flight* response, where the patient may experience increased heart rate, increased blood pressure, chest pain, and diaphoresis. Patients with increased levels of anxiety may participate in harmful behaviors to help calm them down. These behaviors include smoking, using alcohol, noncompliance to low sodium diet, and decreased involvement in physical activity which may exacerbate the HF symptoms of shortness of breath, weight gain, and fatigue (De Jong et al., 2011). Everyday hassles or stressors can build up and may also lead to

harmful health behaviors such as smoking, and noncompliance with medications (Dimsdale, 2008). Patients may experience stress and/or anxiety because of the complicated medication regimen, frequent hospitalizations, inability to work, hopelessness, loss of control, and financial concerns (De Jong et al., 2011). People who have chronic high stress levels can experience significant damage to the heart. Heart problems can include the development of arrhythmias because of the continuous increased heart rate, increase risk for stroke due to high blood pressure, and due to the release of cholesterol the arteries may thicken or become damaged (De Jong et al., 2011). Heart damage can impact the ability of the heart to pump effectively which can potentially lead to heart failure.

The typical symptom management of HF may also have an impact on the mental health of patients. Often there is implementation of strict diets, side effects of medications (insomnia, fatigue, nightmares, and sexual dysfunction), alcohol restriction, and physical limitations. These can lead to feelings of isolation, worthlessness, and decreased self-esteem (Smith, 2010). Health care providers should recognize the importance of validating these feelings and assess for depression in HF patients which could help with compliance of adhering to the diets, medication, and improve self-esteem.

Problem statement

The DNP project took place at Frederick Memorial Hospital, in Frederick, Maryland. According to the Centers for Medicare and Medicaid (2013), HF has the highest 30-day readmission rate at 21.9%. In 2012, the hospital and the Heart Failure

Service Line joined together to identify causes of readmissions with the goal of reducing the rate to below the national average (K. Troupe, personal communication, August, 2015). A HF program was established in 2012, and the patients who were high risk for readmission were identified. At that time, it was determined that depression could be a factor in these re-admissions and further investigation was needed to show the correlation (K. Troupe, personal communication, August 2015). While working as a clinical nurse specialist with the HF nurse practitioner, I determined that there was a need for a performance improvement project. The project identified different barriers cardiac nurses face in assessing psychosocial issues in the HF patient population.

Purpose Statement and Project Outcomes

The purpose of the performance improvement project was to identify barriers that cardiac nurses may face in assessing psychosocial issues in HF patients. Focus groups were held with cardiac nurses from the three different areas of the facility: the emergency room (ED), the intensive care unit (ICU), and the progressive care unit (PCU). These cardiac nurses are typically first to see the HF patient when he or she is admitted to the facility.

Identifying barriers that cardiac nurses experience in addressing psychosocial issues of HF patients will bring awareness to the current practice, and determine if there is a need to improve the process. If one of the barriers includes the lack of a relevant assessment tool, then recommendations will be given for using a valid and reliable tool according to the literature review. By implementing the use of a valid psychosocial assessment tool, cardiac nurses will be able to recognize issues (anxiety, stress, or

depression) of HF patients which could have a major impact on the quality of care and patient satisfaction (Worrel-Carter et al., 2012). If knowledge base of psychosocial issues is a barrier, the cardiac nurses can be educated on how decreasing symptom exacerbations have been associated with improved adherence to diet, compliance with medications, and improved physical activity (Chapa et al., 2014). Cardiac nurses will be able to understand the importance of identifying depression, stress, and anxiety which could lead to the patient enhancing feelings of liveliness, and self-worth.

Significance and Relevance to Practice

In the past, nursing care was based on Maslow's hierarchical theory of needs to address the basic human needs of the patient, which involved pharmacologic and technical interventions to relieve symptoms and treat underlying causes of illness (Davidson, Cockburn, Daly, & Fisher, 2004). Nursing theorists and theories now include a holistic approach to providing nursing care. These include Jean Watson's theory of caring, Kolcaba's comfort theory, and Orem's self-care theory. These theories focus on treating the underlying illness and addressing psychosocial, spiritual, and emotional concerns (Davidson et al., 2004).

If psychosocial factors are not addressed correctly, the hospital can expect increased hospitalizations, increased length of stay, increased readmission rates, and a significant loss of revenue due to the new reimbursement strategies from the Centers of Medicare and Medicaid Services (Yohannes et. al., 2010). The new Patient Protection and Affordable Care Act (PPACA) mandates an improvement of screening and caring for patients who are diagnosed with mental illnesses (Sorrell, 2012). Other elements of the

PPACA regarding behavioral health include the following: adequate screening for substance abuse, behavioral issues, and depression, and tracking referrals and providing proper coordination of outpatient care (Runyan, 2011). Under the PPACA, promoting the treatment of patients in a holistic and preventative manner will help reduce overall hospital costs and improve quality of life (Runyan, 2011).

Screening for behavior health issues by cardiac nurses allows for the integration of psychiatric care into the acute care setting if the patient requires treatment. The integrated service delivery model can ensure the patient is treated by a team of professionals to provide holistic care while ensuring the acute problems of HF and psychosocial issues are being addressed at the same time (Runyan, 2011). Cardiac nurses may play a key role in determining the amount of reimbursement the hospital will be allowed by the Centers of Medicare and Medicaid (CMS) by decreasing the length of stay, improving quality of care, and ultimately decreasing HF readmissions.

Implications for Social Change in Practice

Social change consists of raising awareness and providing education to help overcome preconceived stigmas associated with anxiety, depression, and stress. The project will be in alignment with the PPACA because it recognizes the importance of treating HF patients in a holistic and preventative manner (Runyan, 2011). One goal of the PPACA is to provide integrated, interdisciplinary care by using a public healthcare delivery model (Northridge, Glick, Metcalf, & Shelley, 2011). Patient-centered medical homes can facilitate access to care and provide the coordination of primary, acute, behavioral health, and supportive community health services (Northridge et al., 2011;

Jeon, et al., 2010). The PPACA will ensure that the public health approach to healthcare will include community planning to increase safety and prevent injuries (Northridge et al., 2011).

As noted before, the symptoms of HF and depression and HF and anxiety often mimic each other. It may be necessary to offer the nurses some back ground or refresher courses on the pathology of depression, anxiety, and stress and the impact they can have on physical health. HF patients who are properly diagnosed with depression, anxiety, and/or stress will have a greater opportunity to obtain the appropriate referrals for continued outpatient follow-up care. The patient-centered medical homes can coordinate and develop support groups for patients with chronic illnesses that suffer from depression, currently at the project facility it is not being done. The change in care will expose the community to the psychosocial issues that patients with chronic illnesses may have, and could potentially change the community's views and perceptions regarding the chronically ill patient.

Goals and Objectives

The proposed project was focused on identifying barriers that cardiac nurses have in addressing the psychosocial issues of HF patients. One objective of the project was to determine the knowledge base of the cardiac nurses on how psychosocial conditions can impact the disease trajectory of HF. Another objective was to discuss how PPACA identifies the importance of assessing patients for psychosocial conditions and how the acute cardiac nurses can play a role in the assessment. Cardiac nurses can provide holistic care while the patient is in the acute care setting which may help decrease

readmissions, and possibly help with patient compliance with their medications and diet restrictions. A final objective was to review the current practice of the nurses and how they assess psychosocial health in HF patients.

A goal of the project was to bring awareness to the nurses regarding their practice of assessing psychosocial issues in HF patients. The facility has electronic medical records and nurses chart by exception, so if the nurse does not recognize stress, depression or anxiety the patient may not be treated for a psychosocial condition. Results of the project may change the way cardiac nurses assess psychosocial health not only in the HF patient, but other cardiac patients as well. In addition, the results will be used to develop an educational component that addresses the barriers that prevent cardiac nurses from addressing psychosocial issues in HF patients.

Project Question

1. What are the barriers that cardiac nurses in the ED, ICU, and PCU face in identifying psychosocial issues of heart failure patients?

The project question was addressed by holding focus groups with nurses from the ED, ICU, and PCU. The nurses participating in the focus groups were asked about current practices, and policies regarding psychosocial assessments on HF patients. The nurses were also asked about barriers that are in place that may prevent the nurses from completing the psychosocial assessment.

Definition of Terms

The following terms were used to guide the project.

Anxiety: An emotional experience that can have a cognitive, neurobiological, and/or a behavioral component (Konstam et al., 2005).

Assumptions: Statements that are perceived to be true, even if they have not been scientifically tested and proven true (Burns, & Grove, 2009).

Biopsychosocial model: A medical model that suggests that biological, psychological and social factors all play a major role in health and in illness (Thomas et al., 2008).

Heart failure: Occurs when the heart muscles do not pump blood as effectively as it should; can be caused from coronary artery disease, or high blood pressure, diabetes and obesity (AHA, 2015).

Integrated service delivery model: A delivery model of care that is a patient-focused team approach to provide health and social services (Northridge et al., 2011).

Limitations: Constraints or weaknesses that the researcher cannot control but they can impact the generalizations of the findings (Burns, & Grove, 2009).

Mortality: The relative frequency of death in a specific population (Volz et al., 2011).

Neurohormone: Hormones released by the nervous system (Nair et al., 2012).

Patient centered medical home: Integration of medical care that facilitates access and coordination of primary and acute general health services, behavioral health, and community based support (Northridge et al., 2011).

Patient Protection Affordable Care Act: Signed into law in 2010 by President Obama to help increase the quality and affordability of health insurance, lower the

uninsured rate, and reduce the cost of healthcare for individuals and the United States government (Sorell, 2012).

Psychosocial issues: The combination of psychological and social factors. Examples include anxiety, depression, substance abuse, age, marital status, and family dynamics (Sayers et al., 2007).

Stress: The psychological response to a stressor (Dimsdale, 2008). Examples of stressors can include a new diagnosis of HF, learning multiple medications, the loss of independence, and job stress due to absenteeism.

Assumptions and Limitations

Assumptions

The project planner assumed that cardiac nurses had limited knowledge regarding the correlation between stress, anxiety, and depression with the effects on HF. Another assumption was the cardiac nurses had some understanding of the PPACA, as well as Medicare/Medicaid regulations regarding mental health. Another assumption was that the participants would answer the interview questions openly and honestly.

Limitations

There were several identified limitations to the project. The questions that were used during the focus groups were not validated prior to the study. A second limitation is that the barriers identified may not be the same for the cardiac nurses in the ED, ICU, and PCU because each department has a different focus in dealing with the HF patient as they come into the facility. A third limitation is that the DNP student was employed at the hospital where the project took place, which may have influenced participation. A final

limitation to the project may be due to the negative stigma attached to behavior health issues and nurses may feel uncomfortable addressing these (Sayers et al., 2007).

Summary

In Section 1, an overview of heart failure, depression, anxiety, and stress and the importance of proper assessment/screening was discussed. Typically, cardiac nurses in acute care settings are focused on treating the symptoms of HF and may face obstacles in addressing the patient's psychological state. If the barriers are overcome and HF patients are properly diagnosed with a psychosocial problem, healthcare providers will be able to treat the patient's body, mind, and soul. Patients who are not appropriately diagnosed with depression, anxiety, and stress on top of their HF may experience a fast progression of their disease process (Chapa et al., 2014).

Section 2: Review of Literature and Theoretical Framework

Introduction

The purpose of the project was to identify barriers that cardiac nurses face in assessing psychosocial issues in HF patients. A comprehensive literature review was completed which showed there is a correlation between HF and psychosocial issues. A separate literature review was completed to identify barriers cardiac nurses have in assessing psychosocial issues. A description of the theoretical framework that was chosen for the proposed project is also included in Section 2.

Literature Search Strategy

A comprehensive review of literature was performed to help justify the relationship between psychosocial issues and the impact they have on the HF patient. The Cumulative Index of Nursing and Allied Health Literature (CINHAL), PUBMED, and MEDLINE databases were used via Walden University's Library. Key words and combinations of the words used during the search included: *heart failure, psychosocial issues, nurse barriers, nurse psychosocial assessments, missed nursing care, depression, stress, and anxiety*.

To evaluate nurse barriers in addressing/assessing psychosocial issues of patients, a literature review was performed using the key words *psychosocial nursing assessment* and *acute care*. In CINAHL, there were 1,789 results, the search was then filtered and the key word *heart failure* was added which resulted in 27 articles. A search using *psychosocial nursing assessment, heart failure, and barrier* resulted in 32 articles,

another search using the key words *missed nursing care* resulted in 91 articles and a final search using *missed nursing care and heart failure* only provided two articles.

To determine the effects of depression on the HF patient, a literature search was performed with the key words of *depression* and *heart failure*. In the CINAHL search engine a total of 948 results were found, the search was then filtered to scholarly peer-reviewed articles from a time frame of 2003 – 2013 and there was a total of 754 articles. A search using the terms *chronic depression* and *heart failure* resulted in zero articles. Using MEDLINE search engine, the key terms *depression* and *heart failure* initially resulted in 2,412 articles. After filtering to a scholarly journal and the same time frame as above, 473 articles were deemed relevant. A final search using the terms *depression/heart failure/Unites States* had 33 articles for review.

The same search method was used for the key terms *anxiety* and *heart failure*. Using CINAHL and 315 articles were found; after filtering to scholarly journals and using the date of 2003 – 2013, there were 245 results. The final search used the terms *anxiety/heart failure/United States* and yielded 16 articles. Using the MEDLINE search engine and the three key terms only six articles were available.

The literature search for *stress* and *heart failure* was completed using CINAHL search engine with an initial result of 6,524. The search was redefined using the terms *psychological stress* and *heart failure* with a time frame of 2003–2013, and 24 results were given. The same search was completed using MEDLINE and 21 articles were provided. Reviewing these articles showed the term *stress* ranged from myocardial stress to oxidative stress and stress of the caregiver of patients with HF. Another search

through MEDLINE was conducted using the key terms *psychological distress* and *heart failure* which yielded 51 articles. The next literature review focused on social support for heart failure patients. The database CINAHL produced 153 articles using the terms *social support* and *heart failure*.

The final search was completed using the time frame of 2003 through 2013, and limited to scholarly journals, resulting in 99 potential resources. The search engine MEDLINE was then used for the terms *social support* and *heart failure*, producing 353 articles. A final search was made using the same time frame criteria as above and 53 articles were found. Different definitions exist for social support, but for the DNP project, the definition involves obtaining resources such as emotional support (love and caring), instrumental support (having the ability to obtain tangible goods), and informational support through social interaction (Cene et al., 2012; Graven & Grant, 2013; Jeon et al., 2010).

After the literature search was completed, 29 articles were selected as the most relevant to use for the project. The articles were grouped in the following categories: nursing barriers, depression and HF, stress and HF, and anxiety and HF and Kolcaba's Theory of Comfort. Other websites that were also used to collect data include: Frederick Memorial Hospital, Centers for Medicare and Medicaid (CMS), American Association of Heart Failure Nurses (AAHFN), American Nurses Association (ANA), American Heart Association (AHA), and the American Association of Critical Care Nurses (AACN).

Nurse Barriers

Lea (2014) provided some insight on barriers of assessing depression in heart failure patients and reported that healthcare providers may be reluctant to ask their patients of depressive symptoms, they may not be using a valid screening tool during the initial admission process, and depression is often overlooked. There is also a misbelief that depression screening should only be completed by the primary care physician, therefore the cardiologist, or hospitalist in the acute care setting may not detect or assess for emotional well-being (Lea, 2014). According to Lea, these barriers can be overcome by changing the behavior of the nurses. This may improve their confidence and ability to perform successful depression screens on their heart failure patients. More research is needed on the barriers of cardiac nurses assessing psychosocial issues of heart failure patients.

Missed care is defined as nursing care that is required to be completed but is omitted in whole or part or delayed (Blackman et al., 2014). Kalisch, Landstorm, and Williams (2009) surveyed 449 nurses on missed/omission of nursing care, in which 66% reported missing care related to the providing emotional support to the patient and/or family. Omission of care can lead to adverse outcomes. Kalisch et al. reported the top three reasons for missing care include communication issues, labor resources (staffing), and material resources which included lack of functioning equipment, and missing supplies. Kalisch et al. acknowledged emotional support as being omitted, described reasons for missing care, but did not identify nurse barriers for missing the care or how the emotional status of the patient was being assessed. Blackman et al. found that the top three reasons for missed care were staff assignments, patient conditions worsening, and

an increase level of the patient's acuity. However, Blackman et al. did not indicate if a psychosocial assessment was omitted or barriers for the nurses that lead to the omission of care. Other researchers showed that the missed care of comforting and talking to patients was reported at 42% which could have a 2-8% chance of the heart failure patient being readmitted (Brooks Carthon, Lasater, Sloane, & Kutney-Lee, 2015). The readmission rate as it correlates to nurses not comforting their patients is interesting, but researchers did not report if a psychosocial assessment was missed or identify barriers that nurses have in performing a psychosocial assessment.

Psychosocial Issues

Depression

Shen et al. (2011), followed 238 HF patients for six months. At the six-month period, 164 completed the follow-up assessment which indicated that 25% of the patients reported mild depression, and 24% of the patients had moderate to severe depression and 51% had no depression symptoms (Shen et al., 2011). These researchers used the Minnesota Living with Heart Failure Questionnaire (MLHFQ) to assess the level of depression for their participants at baseline and at the six-month timeframe (Shen et al., 2011). Shen et al. also found that depression can essentially speed up the disease process and exacerbations of HF symptoms, which leads to an increased rate of mortality (Shen et al., 2011). The study was chosen because the data showed the prevalence of depression in HF patients, and how the level of depression can predict the deterioration of physical health (Shen et al., 2011).

Worrel-Carter et al. (2012) wanted to identify nurse's knowledge in screening cardiac patients for depression. They did a pretest and posttest with educational sessions in between. At the end of the sessions it was reported that 80% of the nurses who participated felt they had a good understanding of depression and how it correlates with cardiac disease compared to 30% at the beginning of the research (Worrel-Carter et al., 2012). Although the study was developed to identify the nurse's knowledge of depression in cardiac patients, the researchers did identify barriers of nurses performing a depression screening which include a general lack of knowledge regarding depression and a lack of a formalized screening tool (Worrel-Carter et al., 2012). The barriers identified are similar to the nurse barriers identified by Lea (2014). A significant improvement of screening for depression was reported after the educational sessions had ended, which the DNP student found relevant (Worrel-Carter et al., 2012).

A case study was completed by Sykes and Simpson (2011) in which they developed a three-session educational intervention for heart failure patients with identified psychosocial issues. Due to funding, and a lack of appropriate patients, the educational intervention became an intervention for one patient over a six-month period. Session 1 was focused on providing coping skills to increase self-control, Session 2 emphasized the importance of planning pleasurable activities weekly, and Session 3 was aimed at improving lifestyle behaviors for example: smoking cessation, sleep and relaxation techniques (Sykes & Simpson, 2011). Even though the participation was lacking, the patient reported an improvement with his depression symptoms; however, the research was limited to a six-month period (Sykes & Simpson, 2011). More research

is required to determine if the educational sessions provided to the patient would be beneficial for other HF patients with psychosocial disorders over a longer period.

Thomas et al. (2008), concluded that there are several physiological responses of HF and depression that are similar. These responses include a neurohormonal activation which contributes to worsening left ventricular function, inflammatory mediators are triggered (interleukin-6, and tumor necrosis factors), heart arrhythmias can be present in both disease processes, and hypercoagulability (Thomas et al., 2008). The article concluded that nurses need a better understanding of depression and how it can impact the ability of the HF patient to be compliant with their treatment plan (Thomas et al., 2008). Thomas et al. identified two challenges in evaluating depression in HF patients: the setting where the assessment was taking place, and the variety of methods used to assess depression. According to Thomas et al. the patient who is in the hospital with exacerbations of HF symptoms, may be too physically ill to correctly be screened for depression, and a more appropriate setting for the screening should take place in an outpatient environment. The challenges noted are similar to barriers that were identified in two other studies, and it was determined the information regarding the physiological response of HF and depression relevant to the project.

Woltz et. al. (2012) completed a systematic review on interventions of depression in the HF patient population. The review of data determined that HF and depression symptoms may be difficult to differentiate; therefore, the symptoms of depression in HF patients may go undetected and untreated (Wolz et al., 2012). After reading the systemic review, the DNP student concluded that there is a need for further research to determine

what treatment for depression is most effective for HF patients, which should include alternative therapies, exercise, and conventional therapy. Another study showed that 42-64% of HF readmissions could be attributed to non-adherence to their diet and medication regimen; these patients were also linked to some form of depression (Konstam, Moser, & De Jong, 2005). Konstam et al. (2005) reported there are limited studies that focus on medical treatment of depression in HF patients and more research is needed to determine if medications should be given to treat the symptoms of HF or the symptoms of depression. Although Konstam et al. showed the correlation between HF patients with depression and re-admissions, it did not identify barriers that nurses face in assessing depression in HF patients. In a final study, it was found that HF patients who were hospitalized and diagnosed with major depression had a significant increase in their length of stay which increased the cost of the hospital stay by 25-50% (Sayers et al., 2007). Sayers et al. (2007) suggested more routine screening of depression in HF patients is needed, but did not explain how often, when the screening should take place, or who should do the screening. Specific barriers of nurses assessing depression was not discussed in the Sayers et al. study.

Anxiety

De Jong et al. (2011), the authors followed 147 HF patients for 12 months; the patients with higher anxiety scores (54% of the participants) were more likely to visit the emergency department, be admitted to the hospital, or die. As with depression, anxiety has physiological effects on the body that can compromise the trajectory of the disease process for HF patients. When a patient experiences anxiety, the sympathetic nervous

system is activated and the body releases catecholamine into the blood which can lead to trembling, and shortness of breath (De Jong et al., 2011). These are also symptoms of HF and may be treated as such and not as symptoms of anxiety. The study did not identify how the patients were screened for anxiety or if there were barriers in assessing them.

In another study, it was found that patients who suffered from both depression and anxiety were found to use mental health services 81% of the time compared to those with depression (41%) and anxiety (51%) (Cully, Johnson, Moffett, Khan, & Deswal, 2009). The study had 2,180 HF patients and 8.5% were diagnosed with anxiety within 12 months of their initial HF diagnosis (Cully et al., 2009). The study did discuss that HF patients are at higher risk for unrecognized and undertreated psychosocial issues due to the following barriers: the patient's knowledge of mental health, provider knowledge of mental health, and screening practices. (Cully et al., 2009). The study was the fourth one to recognize barriers in assessing psychosocial issues in HF patients, and the DNP student concluded the barriers identified in all four studies were similar in nature.

Volz et. al. (2011) completed a study on 111 HF patients over a 12-month period in which 28.8% reported anxiety symptoms. Patients who reported severe anxiety symptoms had a threefold risk of cardiac-related readmissions (Volz et al., 2011). Patients reported that they had anxiety related to participating in physical activity for fear of having a cardiac event which led to an increase in inactivity (Volz et al., 2011). Although the study did show that anxiety in HF patients could be related to increase in re-admissions, the study did not identify barriers in assessing anxiety or other psychosocial issues.

Stress

Holly and Sharp (2012) found that 29% of 289 patients with heart failure had symptoms of stress. Approximately one third of HF patients experience high levels of stress, but like depression and anxiety, it is often missed and therefore not treated (Holly & Sharp, 2012). Patients who are unemployed or chronically ill are more likely to experience some symptoms of stress (Holly & Sharp, 2012). Holly and Sharp identified that although routine psychosocial assessments on HF patients should be completed, the high cost of the screening tool and the cost of training the staff how to use the tool may be barriers in performing these assessments. The study did identify some barriers, however these barriers are not related to others in previous studies.

Social Support

Social support is important to include in the project because if HF patients perceive a positive social support, there may be an affirmative impact on their quality of life, and they may experience a decrease the episodes of symptom exacerbations. In a study of 139 patients, it was discovered that patients with a lower social support had higher HF related readmissions, and decreased medication adherence than those with a higher reported social support (Wu et al., 2012). In the same study, the patients who had a low perceived social support were 3.5 times more likely to suffer from a cardiac event (Wu et al., 2013). Wu et al. showed the correlation of readmissions and perceived social support, but the study did not identify barriers in assessing the patient's social support. Gravin and Grant (2013) completed a systematic literature review on the impact of social support and HF patients. In their review, it was discovered that patients with a lower

perceived social support can suffer from social isolation which can lead to depression, anxiety and stress (Gravin, & Grant, 2013). Social isolation has been related to non-compliance with medications, depression, and inability to make follow-up appointments (Gravin, & Grant, 2013). The study did report that patients are assessed for depression using self-reported screening tools, but the researchers did not identify any barriers that are associated with self-reported depression assessment.

Plach (2008), reported that role balance in women with HF was a large predictor of positive personal relationships, self-acceptance, and purpose of life. Women with HF live longer than men with HF, but are more likely to be admitted to the hospital due to disease complications (Plach, 2008). Women often take on the roles as the homemaker, and caregiver which can lead to feelings of guilt when admitted to the hospital (Plach, 2008). Patients with a higher perceived social support have an increase compliance with medications and diet adherence (Plach, 2008). Plach described how patients are assessed for functional health, HF symptom burden, and role discrepancy, but did not identify barriers in any of these assessments.

Gallagher, Luttik, and Jaarsma (2011) determined the types and level of social support provided by partners of HF patients. Of the 333 patients that participated, only 58% reported that their partner had adequate knowledge regarding HF (Gallagher et al., 2011). Heart failure symptoms can be physically limiting and social support is important to ensure the patient is able to attend follow up physician appointments, take the appropriate medications, and obtain the education needed to understand the disease process (Gallagher et al., 2011). Social support can also improve symptom management

(recording daily weights), encourage routine exercise, and promote self-care (Gallaher, et al., 2011). The DNP student determined that although the research identified the importance of social support, the study was not relevant to the DNP project.

Cene et al. (2012) followed 12,995 patients during a two-year period to determine if patients with low or high risk for social isolation have increased HF incidents. They concluded that there was a greater risk for cardiac events among the patients with higher social isolation (Cene et al., 2012). For the HF patient population, social isolation can also lead to the development of other co-morbidities, frequent hospitalizations and even mortality (Cene et al., 2012). The study concluded that social isolation can lead to increased hospitalizations, but the study did not determine how social isolation was assessed or if there are barriers in performing the assessment.

Theoretical Framework Literature

Kalcaba's Comfort Theory

For the DNP project, Kalcaba's comfort theory will be used (Figure 1). Kalcaba's theory recognizes four different areas of comfort: physical comfort, psychospiritual, socioculture, and environmental comfort (Kalcaba, Tilton, Drouin, 2006). For the cardiac nurses, physical comfort can be assessed by asking the participants about adequate staffing, functioning equipment, and other tools needed to perform the psychosocial assessment on the heart failure patient. The physical lay-out of the patient's room and the hospital can also impact the nurses' physical comfort, because the nurse may not be comfortable asking behavioral health questions if privacy cannot be maintained. Psychospiritual comfort can be assessed by enquiring about nurse

empowerment to perform psychosocial assessment, autonomy of nursing practice in the facility, and leadership support for learning. Sociocultural comfort includes strong communication in the organization (sharing patient information), collaboration of care (holistic care), valued teamwork, and providing education for the nurses as needed. Environmental comfort may be evaluated by reviewing the nurse's patient workload – does it allow time for the nurses to perform an in-depth psychosocial assessment of their patients? The different levels of nurse's comfort, if met, may improve nurse satisfaction, enhance commitment to the treating the patient in a holistic manner, and help the nurses work more effectively (Kalcaba et al., 2006).

Nurse's Comfort			
Physical Comfort: -Staffing -Equipment	Psychospiritual Comfort: -Empowerment -Leadership support	Sociocultural Comfort: - Communication -Collaboration	Environmental Comfort: -Adjusted workload -Nursing department

Figure 1. Nurse's comfort in assessing psychosocial issues.

Summary

A thorough literature review was performed to find evidence that there are barriers that nurses must overcome in assessing the psychosocial issues of HF patients. Barriers identified during the review include the lack of a specific tool, the misbelief that only physicians can perform a psychosocial assessment, and reluctance of nurses to perform the assessment (Lea, 2014). Another research identified lack of nursing

knowledge to be a barrier (Worrel-Carter et al., 2012). The literature also validated that there is a correlation between HF, stress, anxiety, depression, and the trajectory of the disease process. Very few research articles exist that specifically ask nurses about the barriers, the DNP project will provide more insight to what the cardiac nurses perceive as barriers in assessing psychosocial issues of HF patients.

Kalcaba's theory of comfort was used for the project to help assess the nurse's comfort levels in performing a psychosocial assessment. Environmental comfort, physical comfort, sociocultural comfort, and psychospiritual comfort will be addressed with the participants in the focus groups. According to Kalcaba (2006), if the different levels of comfort are met by nurses, they will perform more effectively and care for the patient in a more holistic manner.

Section 3: Collection and Analysis of Evidence

Introduction

The purpose of the project was to identify barriers that cardiac nurses may encounter assessing psychosocial issues in patients with HF. Section 3 will define the project design, the sampling, how the data collection took place, the method used for data analysis, and analysis of the project. The analysis from the project may be used to improve how nurses perform a psychosocial assessment and provide holistic care to their patients.

Project Design

The performance improvement project was qualitative in nature and was completed by performing several focus groups with cardiac nurses from the ED, ICU, and PCU. The purpose of the focus groups was to determine the participants' perception of psychosocial issues of HF patients, to identify what (if any) barriers within the organization exist, and ask for suggestions on what needs to occur for psychosocial assessments to be performed by cardiac nurses on HF patients. The DNP student provided a brief background on the purpose of the research, which included reviewing the manifestations of the HF disease process and behavioral health symptoms.

The focus groups took place over a two-week period, and were scheduled on different dates and times to allow participation from dayshift and night shift. The focus groups were conducted as informal group discussions and were facilitated by the DNP student. For their contribution, the participants were provided with light refreshments and points for their clinical ladder portfolio.

The participants answered six major questions during the focus group (Appendix A). The questions were developed by the project manager and reviewed by the hospital's Director of Nursing Professional Development (a PhD nurse), and the chairperson of the Nursing Research and Quality Council (a DNP nurse). Changes were made to the questions based off the feedback to ensure the questions remained relevant to the project and not leading the participants. For example, it was suggested to use open-ended questions, to ask no more than 10 questions, and during the focus groups have a mediator if possible to keep the discussion on track. It was also suggested to review Kalcaba's theory of comfort and incorporate questions to assess the nurse's comfort. The questions developed allowed the participants the ability to answer without me leading them on how the questions should be answered.

Population and Sampling

Prior to starting the focus groups, the project was approved by Walden University's Internal Review Board, and Frederick Memorial Hospital's Internal Review Board to ensure the integrity of the project and to protect the rights of the participants in the facility. I am currently employed at the facility therefore, participation was voluntary and nurses from the unit I work were not invited to participate to avoid coercion. The cardiac nurse's participation was on a voluntary basis with the goal to have seven to eight nurses during each session with a final goal of 25 participants. Limiting the number of participants per session, allowed the project planner the ability to engage everyone in the focus group discussion. Recruitment of the nurses was completed by using convenience sampling. A group e-mail was sent to the cardiac nurses, nurse managers, and clinical

nurse specialists who work in the ED, ICU, and PCU with an invitation to participate (Appendix B).

Data Collection

The focus groups were conducted by the project planner, at pre-assigned locations and times. In the email invitation, the project planner initially asked for a 45-minute commitment, all sessions lasted the full 45 minutes. Consent to participate was obtained by all volunteers at the beginning of each session. The project planner tape recorded the focus groups, and took hand written notes using a fishbone diagram (cause and effect diagram) to help organize and document the causes or barriers identified (Table 1). A fishbone diagram is a visual aid used to focus only the causes of the problem, whether it be a policy, procedure, manpower, equipment, or other identifiable causes (Kelly, 2011). The fishbone diagram is part of Six Sigma's tools and is useful in group discussions or for collecting quantitative data (Simon, 2010). Six Sigma is a data-driven approach and methodology used to eliminate defects and to help describe quantitatively how a process is performed (iSixSigma, 2013). The tape recordings were transcribed by the DNP student and the major themes were again incorporated into a fishbone diagram. All data collected and transcriptions are being stored on the project planner's personal computer and will be destroyed in five years. The transcriptions do not include any information that can identify any of the participant's identity. The consents that the participants signed are being stored at the project planner's personal residence and will also be destroyed in five years.

Table 1

Fishbone Diagram Categories

Category	Description	Kalcaba's theory
Policy/procedure	Evaluate facilities current policy and procedures	Environmental Comfort
Manpower	Assess empowerment of nurses to perform psychosocial issues	Psychospiritual Comfort Physical Comfort Environmental Comfort
Equipment	Evaluate tools in place used to screen for psychosocial issues	Physical Comfort
Culture	Determine if the facility would support the practice (nurse support)	Sociocultural Comfort Psychospiritual Comfort
Relevance	Inquire if the cardiac nurses feel it is relevant to their practice	Sociocultural Comfort

Data Analysis

To analyze the data collected from the fishbone diagrams, a Pareto chart was used to show the recurring themes identified during the focus group sessions. A Pareto chart is a bar graph that will visually show which situations are the most significant (Tague, 2004). The Pareto chart assisted in displaying how often the causes or barriers were identified and helped with prioritizing in the selection of interventions to improve the process of assessing psychosocial issues in HF patients (Kelly, 2011). The DNP student shared the data with a DNP nurse from the facility to validate the themes identified.

Project Evaluation Plan

The project relied on the interpretation of the data gathered during the focus group sessions. The evaluation process helped to decide the sustainability of the project and identify areas of improvement or if the project was unsuccessful (White & Dudley-

Brown, 2012). For a DNP project, evaluation is completed to provide accountability to the stakeholders (cardiac nurses), demonstrate a quality improvement, measure effective change in a specific population (cardiac nurses), and to provide clarity of the purpose of the study by identifying strengths and weaknesses (Zaccagnini & White, 2011). For the project, a summative evaluation was completed.

Summary

Section 3 described how the DNP project was developed by using focus groups to identify the barriers that ED, ICU, and PCU nurses face in assessing stress, anxiety, and depression in HF patients. Data was collected during the focus groups and the project planner used a fishbone diagram to divide significant themes into the following categories: policy/procedure, manpower, equipment, culture, and relevance. The questions asked during the focus groups were developed in order to integrate Kalcaba's theory of comfort into the project. Finally, the section described how the project was evaluated.

Section 4: Findings, Discussion, and Implications

Introduction

The purpose of the performance improvement project was to identify barriers that cardiac nurses from the ED, ICU, and PCU encounter in assessing the psychosocial issues of HF patients. Section 4 will discuss the top barriers that were identified by focus groups that were attended by nurses from the three different nursing areas. Also included are the project planner's recommendations to the facility, identified strengths and weaknesses of the project, and finally a self-analysis of the project planner.

Findings and Implications

A total of 18 nurses participated in the focus groups for the project: two from the ICU, two from the ED, and the remaining 14 were from the inpatient progressive care unit (Table 2). The participants included nurse managers, clinical nurse specialists, care transition nurses, and bedside nurses all with different years of experience. The nurses completed the consent form and the DNP student asked the participants questions (Appendix A). Each focus group had four to five participants which allowed every nurse the opportunity to partake and answer the questions freely.

During the focus groups, the DNP student took notes, and used a tape recorder to capture all the comments. After the focus groups were completed, the DNP student transcribed the tape recordings, and using a fishbone diagram, demonstrated how the participants answered the focus group questions (Appendix C). The transcribed material was evaluated again to identify the top themes identified by each of the groups.

Table 2

Combined Demographics of Focus Groups

Item	Number	Percentage
Total number of participants	18	100
Gender:		
Female	17	94
Male	1	6
Age:		
20-30	3	17
30 – 40	6	33
40-50	5	28
50-60	4	22
Shift:		
Days	16	89
Nights	2	11
Status:		
Full-time	18	100
Part-time	0	0
Years as an RN:		
<5 years	3	17
6-10	3	17
11-20	5	28
>21	7	38

The DNP student counted how many times the themes were identified by the participants and then these themes and numbers were inserted into a Pareto chart (Appendix D). To analyze the data using a Pareto chart, the top ten barriers were identified. The Pareto rule states that 80% of effects come from 20% of the causes (Kelly, 2011). For the project 80% of the barriers identified came from two out of the ten (20%) of the barrier types (lack of a screening tool and not a nursing priority). Lastly, the themes and quotes were embedded into a table for easy viewing (Table 3).

Table 3

Themes and Quotes obtained from Focus Groups

Themes	Quotes	Number
Not a nursing priority	"Too many other priorities; this gets lost in the admission process"	7
	"In the ED, focus is on symptom treatment/management"	2
	"Decreased priority for acute care nurses"	1
	"This may be evaluated at any time during the hospital stay. During the admission process, there are a few key questions that are asked, but it does not isolate psychosocial issues."	3
	"The case managers do a better job in assessing for psychosocial issues"	2
Lack of a screening tool	"Not a standardized tool in the hospital"	10
	"If there was a tool, and education on how to use it, it would be done"	3
	"Currently not a standardized tool, but nurses can assess family support, history of behavioral health issues, review home meds and assess the patient's presentation"	3
	"Would like a standardized tool that can be re-evaluated with the patient"	3
Limited education	"Not every nurse is empowered to address these issues"	2
	"Limited education; nurses may not know what to look for unless it is obvious"	5
	"In the ICU, the nurses complete the CAM assessment; but training had to be done on how to complete. A new screening tool would require the same approach"	2
	"Bedside nurses have good intentions, but they are task oriented. They have minimal training on how to perform a psychosocial assessment"	6
	"Novice RN's may not have the confidence and knowledge and may feel uncomfortable doing assessment"	1
Not enough time	"In the ED, time is a factor"	2
	"Not enough time to sit and listen to the patient"	5
	"May be done, but not documented due to lack of time"	4
	"Nurses have become task oriented, complete work from worklist"	5
Patient Load	"Patient load too heavy"	3
	"Acuity of patients may have impact"	3
Unaware of policies	"No idea if we have a policy"	4
	"We had a policy, but the hospital got rid of it; each employee has to complete a psychosocial competency on hire. Is there a new policy?"	3

The nurses identified several barriers to performing a psychosocial assessment on their patients with HF. The most common barrier reported was that the facility does not have a standardized screening tool for the nurses to use during the patient's

hospitalization. With the current practice, during the admission process, the patient is asked if they are dealing with something or a situation that causes them to have fear or anxiety. If the patient answers “yes” a social worker consult is placed. The nursing physical assessment that is completed every shift, does have a psychosocial component, but the hospital’s policy is to chart by exception so if symptoms are not visible, the psychosocial assessment does not need to be addressed. In the ED, there currently is not a screening tool used during the intake process, but the ED participants were not sure if the case managers completed a screen during the discharge process. All 18 of the nurses indicated that if there was a standardized tool, they would perform the screen on their patients.

The second barrier identified was the nurses felt that performing the psychosocial assessment is not a top priority when dealing with a patient who is having exacerbated symptoms of their heart failure. Emergency department nurses are trained to observe the patient’s airway, breathing, and circulation (ABCs) when the patient is brought to the hospital. According to one participant, “stopping to perform a psychosocial assessment before stabilizing the patient would not be a priority of the ED team. The ED nurses are focused on the physical side of the patient, not the psychosocial.” In the ICU, the patient may be intubated or incapable of answering questions and the treatment course is to concentrate on the symptoms of HF. Although the ICU nurses do perform a Confusion Assessment Method (CAM), they do not focus in on the psychosocial issues of the patient; they may however, have interactions with the family members which may provide indirect information. The nurses from the PCU also agreed that the first few days

of hospitalization, the priority of nursing care is to stabilize the patient. Performing a psychosocial assessment is not an initial priority, however, most the participants felt that an in-depth psychosocial assessment should be completed prior to discharge and follow up care provided if necessary.

A third barrier included the nurses having limited education on how to properly perform a psychosocial assessment. Not every nurse is comfortable addressing psychosocial health with their patients, “I wouldn’t even know where to begin” stated one participant from the focus group. Another participant felt that nurses may be able to identify anxiety, and depression and ask for a psychiatric consult, but if the signs are not “obvious or mimic HF symptoms, more education for the cardiac nurse is needed.” Newer nurses may be uncomfortable performing a screen or they may have a lack of confidence in identifying stress, anxiety or depression.

Other barriers identified during the focus groups sessions included lack of time to perform a thorough psychosocial assessment, heavy patient loads, and lack of knowledge regarding policies related to psychosocial assessments. The nurses felt if staffing or patient load was decreased, they could have more time to sit and talk to the patient. If time allowed, one of the participants stated they would “ask the patient questions about their habits, their home, their social support, and their understanding regarding their disease process.” It was also identified that patients may not feel comfortable answering these questions without forming a rapport with the nursing staff.

In regards to the question if the culture of the facility promotes performing a psychosocial assessment the participants were split down the middle. Half of the nurses

said no because the current focus of the organization is on other quality measures such as decreasing falls, preventing hospital acquired conditions, and improving the patient experience in the hospital. The other nurses who said yes, noted that the facility uses evidenced based practice, and if performing a psychosocial assessment could prove to be cost-saving, the culture of the organization would accept it.

The last question discussed during the focus groups asked if the nurses felt performing a psychosocial assessment on patients with HF is relevant to their practice. All the nurses agreed that it was relevant to help improve patient compliance with treatment, decrease re-admissions, and promote independence with care (or improve patient involvement with every aspect of their disease management). One participant summed it up by saying, “Happier patients leads to better compliance. Nurses can impact the patient’s happiness and compliance by acknowledging their stress, anxiety, and/or depression.”

The themes identified by the focus groups were similar to the findings that Lea (2014) identified. Lea identified that nurses have a lack of understanding of screening (lack of education), a lack of ability to perform a screen (lack of time), and a lack of a valid screening tool to be barriers for nurses to perform a psychosocial assessment on HF patients. Worrell-Carter et al. (2012) stated that there is a general lack of nursing knowledge regarding the importance of screening patients, but with informal educational sessions, the nurses would be able to quickly assess patients using a valid tool. In the Worrell-Carter et al. study, 10% of the nurses identified that lack of time or decreased

priority was a barrier in assessing for depression, which the focus groups in the project also identified as barriers.

These findings validated the DNP student's assumptions regarding the lack of knowledge that the nurses have. One participant stated "I had no idea that stress, anxiety, and depression can mimic symptoms of HF. We should know this. How are we going to get the information out to the front-line staff?" The findings also confirmed that the facility did not have a standardized screening tool. The participants felt that the nurses are not properly equipped to perform a psychosocial assessment; however, several participants felt that case managers were completing an assessment prior to discharge.

Kalcaba's Theory of Comfort

The DNP student integrated Kalcaba's theory of comfort during the focus groups. Environmental comfort was addressed by asking about the current policies and procedures that the facility has, and by asking about manpower. The nurses identified that the facility does not have a current policy, and that the work load of the patients may be too heavy, and they felt there is limited time for completing a screening. Physical comfort was addressed by asking if the nurses felt they had the available manpower as well as the appropriate tools needed to perform a psychosocial screen. The responses eluded that the nurses did not feel empowered to perform a psychosocial assessment because they did not have a standardized tool to use. Psychospiritual comfort was assessed by asking again about manpower, and if the culture of the facility would support the practice. The nurses felt that the culture at the facility is focused on providing quality service and reducing costs, and with some awareness of the importance (providing

education to the nurses and to the senior leadership) the culture of performing these screenings would become a routine practice. Sociocultural comfort was also addressed with the question about the culture of the facility, and by asking about the relevance to nursing practice. The nurses did all agree that performing the screenings is relevant to nursing. According to Kalcaba et al. (2006), if all levels of comfort are achieved the nurses will have higher job satisfaction, increased efficiency, and the ability to care for the patient in a holistic manner.

Recommendations

Based on the barriers identified by the participants, several recommendations may be made. First, there is a substantial need for the organization to adopt a standardized, valid, and reliable screening tool to help identify stress, anxiety, or depression in patients with HF. One tool that has been proven to be valid is the MLHFQ (Bilbao et al., 2016). The questionnaire uses a five-point Likert scale to assess different degrees of impact HF has on the patient's quality of life (Bilbao et al., 2016). There are 21 questions that asks about the patient's physical, mental, social, and emotional health, but it relies on the patient's ability to complete the survey (Appendix E). The questionnaire can be given during the inpatient stay and again at follow up in the physician's office to determine if the patient had improvements in their quality of life. Bilbao et al. (2016) did point out that the questionnaire does not address the specific areas of behavioral health, so if providers want to address depression, stress or anxiety on a more specific level, they would have to use a different screening tool. A score of < 24 indicates the patient has a good quality of life, a score of 24-45 represents a moderate quality of life, and a score

>45 indicates a poor quality of life (Behloui, 2009). Another screening tool that could be adapted is the Hospital Anxiety and Depression Scale (HADS) which has 14 questions (seven related to anxiety and seven related to depression) which uses a 0-3 Likert scale in which the patient scores how they are feeling (Shen et al., 2011). The scores are summed and the patient/nurse can determine if they scored normal, borderline, or abnormal for stress and depression (Appendix G). The recommendation would be that nurses would ask for a psychiatric consult if the patient had abnormal scores.

Currently the organization has daily multidisciplinary rounds that each inpatient unit participates in. During the focus groups, three of the participants suggested that the psychosocial element should be discussed during rounds. By doing so, case managers, physicians, and the nurses would be able to develop a follow up plan for the patient at discharge.

Another recommendation would be to develop educational in-services for nurses regarding stress, anxiety, and depression and how it can impact the disease progression of heart failure patients. Although it was the third common theme from the focus groups, with increased knowledge of the importance of performing a psychosocial assessment, nurses may recognize the practice is a priority to complete during the hospital stay. One participant in the focus groups stated, “The information should be covered during nursing orientation or during the critical care course.”

A final recommendation is to develop a policy which discusses performing psychosocial issues of all patients in the organization. The lack of a current policy was discovered during the focus groups. According to CMS, Accountable Care Organizations

(ACOs) are incentivized for treating the patient in a holistic manner (Golden & Vail, 2014). One regulation that CMS has established for ACOs is implementing mandatory screening for depression, and if necessary having a documented follow-up plan (Golden & Vail, 2014). By having a policy to follow for the inpatient units, the hospital, which is recognized as an ACO, will be compliant with the regulation which can impact the reimbursement from CMS.

Strengths and Limitations of the Project

One limitation of the project was the validity of the questions asked during the focus groups, as the questions were developed by the DNP student and changes were made based upon recommendations from the Director of Nursing Professional Development (a PhD nurse) and the Chairperson of the Nursing Research and Quality Council (a DNP nurse). The purpose of changing the questions was to ensure that the questions were relevant to the purpose of the project, and to ensure that the project planner was not leading the participants in how to answer the questions. A second limitation is that I am currently employed at the facility which could have influenced the participation of nurses. A strength of the project was the evidence that the barriers the nurses identified are similar to the barriers identified in the literature review. Another strength is the successful implementation of Kalcaba's theory of comfort during the focus groups. Additional studies, need to be completed to validate these findings.

Analysis of self

Throughout the project I learned a lot about the research process and data analysis, mainly that patience is a virtue. I was also able to develop a deeper knowledge

regarding stress, anxiety, and depression and how any one of these can impact the disease process for the heart failure patient. I also learned to have a passion for the project which increased confidence to talk to different groups of healthcare professionals. There were limited scholarly articles that identified nursing barriers in addressing psychosocial issues of HF patients which forced me to think outside the box. As a clinical scholar, I will be in a position to assist with implementation of the recommendations to help improve the current practice at the facility (Zaccagnini & White, 2011, p 67).

Planning the project was a challenge. It was difficult to arrange classrooms, and recruit participants because the times of the focus groups were dictated by room availability, and were not necessarily convenient for the cardiac nurses. The transcribing of the tape-recordings was a long, tedious process that the student did not take into consideration. During the project, I sought input from Doctorate level nurses within the facility and gained valuable support and guidance.

The most daunting part of the project was completing the written proposal. There were many re-writes, revisions, and perceived delays. With each rewrite I would review the DNP project overview to determine the next step, and the quarterly plan was reviewed to determine if the project was within the timeline. It is without saying, that the initial timeline given by myself was not realistic. The most important virtue of a project planner is to be flexible and be willing to accept any, and all feedback.

Being a first-time project manager is overwhelming. There were many times I started over and developed a new framework for the project. Project management is an area where I obtained personal and professional growth and I plan to seek more

opportunities to learn and grow. As a nurse manager in the facility, I have a unique opportunity to network with other leaders and potentially seek out other projects to plan and/or manage.

Summary

Four focus groups were held with nurses from the ED, ICU, and PCU to identify barriers that cardiac nurses face in assessing psychosocial issues of HF patients. The most common identified barrier was the facility does not currently have a standardized tool for nurses to use to complete a psychosocial assessment. The nurses also identified that higher priority is given to assessing and treating the physical symptoms of the patient and the psychosocial assessment may be overlooked until that patient has been stabilized. A third barrier identified is minimal knowledge that the nurses have in the importance of performing a psychosocial assessment on the heart failure patients. The correlation between the physiological effects of stress, anxiety, and depression with heart failure needs to be addressed with the cardiac nurses. Lack of time, too heavy patient load, and the absence of a current hospital policy were the other top barriers identified by the focus groups.

I recommend that the facility consider using a standardized tool to assist the nurses in assessing for stress, anxiety, and depression in HF. The MLHFQ and the HADS are two valid and reliable screening tools that could be considered. It is also recommended to develop an educational program to help identify how behavioral health can impact heart failure and other chronic diseases to increase the base knowledge of the

nurses. A final recommendation will be to develop a current policy that addresses performing a psychosocial assessment.

Section 5: Dissemination Plan

Introduction

The project was completed to identify barriers that cardiac nurses in the ED, ICU, and PCU face in assessing the psychosocial health in patients with HF. Four focus groups were held, and the participants did identify the major barriers: the facility does not have a standardized screening tool, the nurses felt that performing a psychosocial assessment on patients who are in the acute setting is a low priority (especially in the ED, and ICU), the nurses also felt they had limited education on how to assess stress, anxiety, and depression (if symptoms are not visibly obvious), lack of time, high acuity (heavy patient load), and nurses feeling uncomfortable were the most frequently reported barriers. These barriers were also similar to the ones reported in the literature review (Lea, 2014). Section 5 will describe how the final results of the project will be shared with the facility. I plan to disseminate the results by submitting the abstract for a poster presentation to the American Association of Heart Failure Nurses Annual meeting in 2017. The DNP student would also like to publish the manuscript in a scholarly publication.

Dissemination of Recommendations

There are several recommendations that I have for the facility. First, some considerations should be made to adopt a standardized screening tool that could be used with each HF patient on admission to the hospital. Second, I would like to develop an education plan to help enhance the cardiac nurse's knowledge regarding HF and

psychosocial issues. Lastly, develop a written policy on performing a psychosocial assessment.

Screening Tool

The results of the project was shared with the Heart Failure Service Line at the scheduled meeting, February 2017. Members of the service line include the HF nurse practitioner, a HF medical director, case managers, and nurses who work in the ED, ICU, and PCU. I shared the common barriers that were identified and focus on the literature regarding the differences in the screening tools (Table 4). Examples of the MLHFQ and the HADS questions will be provided. The recommendation was for the team to determine which tool, if any, is appropriate for the facility. I agreed to work with the leaders at the facility to adopt the screening tool, and educate the nurses on how to use them. Implementing a standardized screening tool will address the top barrier that the focus groups identified.

Education Plan

It was also identified that the nurses felt they had a limited knowledge base regarding the correlation between HF and psychosocial issues. I will develop and teach an in-service that targets the nurses from the ED, ICU, and PCU to break the barrier. The AACN (2015) states that “acute and critical care nurses restores, supports, promotes, and maintains physiologic, and psychosocial stability of patients.” In order to maintain the physiologic and psychosocial stability, the nurses must first understand the how stress, anxiety, and depression can impact the HF patient. If a screening tool has been selected, the in-service can also include information regarding the tool and how to use/score it.

Table 4

Screening Tools

Items	MLHFQ	HADS
Valid	Yes	Yes
Likert-scale	0-5 scale	0-3 scale
Questions	21	14
Physical Health	Yes	No
Mental Health	Yes	No
Social Health	Yes	No
Emotional Health	Yes	Yes
Specific to depression, anxiety, or stress	No specific questions regarding depression, anxiety or stress	7 questions related to anxiety 7 questions related to depression 0 questions related to stress
Scoring	<24 good quality of life 24-45 moderate quality of life life >45 poor quality of life	0-7 = normal 8-10 borderline abnormal 11-21 abnormal

Objectives of the in-service include:

1. Participants will be able to identify the physiological effects that stress, anxiety and depression can have on HF.
2. Participants will gain understanding of the PPACA in regards to behavioral health.
3. Participants will recognize the importance of assessing psychosocial issues in HF patients.
4. Participants will review screening tool adapted by the facility (if applicable).
5. Participants will use new knowledge to care for HF patients in holistic manner.

Policy Development

Seven of the participants identified that a policy on psychosocial nursing assessments be developed. DNP projects can provide an evidence-based approach in the development of policies at the local, state or federal level (Zaccagnini, & White, 2011). A well-written policy reduces variability across the organization and can promote compliance with regulations, and accreditation (Irving, 2014). I will use the organizations policy template to develop a policy that will standardize the procedure for performing a psychosocial assessment on patients within the facility. The policy will be available on the organization's intranet and will serve as a reference for staff.

Implementation

The implementation of the screening tool will need to be approved by different groups within the organization. The findings of the project will need to be presented to the senior leadership team, the nursing leaders, and physicians in the organization. The presentation will include the background behind the project, a brief description of the literature review, the top three barriers that the nurses identified, and recommendations for the facility. Each group may have suggestions that may require additional investigation. If there are copyright restrictions, approval from the finance department to purchase the rights to use the tool will need to be obtained. Once a tool has been approved, the legal department, health information services department, and the information technology department will need to review to tool to ensure it is properly implemented in the facility. Education regarding the screening tool with need to take place and I will ask the Clinical Nurse Specialists (CNS) group to help with the education and roll out of the screening tool.

The in-service objectives and materials will be presented to the HF service line members, and the Director of Critical Services for approval. I will then work with the Clinical Education Center (CEC) to reserve classroom space. The CEC will also be consulted to review the course objectives and education material. The Director of Critical Care Services, the CEC, and the DNP student will determine the frequency of the in-service and the length of the program. I will also meet with the CNS group to determine if the material is suitable to add to the critical care course that the hospital offers twice a year for the ED, ICU and PCU nurses.

A meeting will be scheduled with the Director of Nursing Professional Development to determine if a new policy on psychosocial assessments is indeed warranted. The CEC is responsible for maintaining all current policies in the facility, and I can work with the CEC and the manager of the Behavioral Health unit to develop the policy. Once the policy is written, the nursing directors are required to review and approve the policy. A meeting may be required to provide background on the project, review the results of the project, and share the recommendations. Having a formalized policy at the facility will provide guidelines to nurses on how to perform a psychosocial assessment.

Evaluation

Once the recommendations are implemented, it is important to evaluate them to determine the significance of the project. To evaluate the screening tool, the project planner will complete chart checks to make sure the tool is being used on HF patients. The nurses and patients should be surveyed to see if they like/dislike the screening tool.

If the patients are properly identified and treated for stress, anxiety and depression, the hospital should see a decrease in the re-admission rate of HF patients which could impact the amount of reimbursement that the hospital receives. It may be beneficial to follow up with the cardiologists to see if the tool is being used in the outpatient setting, and if so, determine if the patient's scores are improving.

A survey monkey can be used to ask nurses in the ED, ICU, and PCU if the identified barriers are still in place. The results of the survey will help to determine if the implementation of the project planner's recommendations regarding the top identified barriers were effective. If the barriers are the same, a new literature review will need to take place and based off the literature, it may be necessary to develop different recommendations for the facility.

Dissemination

A power point presentation was developed to share with the focus group participants, the Nursing Research and Quality Council, and the Heart Failure Service Line (Appendix H). The presentation will also be given to the clinical leadership team to help identify how the project can be monitored for sustainability. The power point includes a brief description of the project, the theoretical framework, and the top barriers that were identified by the cardiac nurses. I will continue to work with my preceptor during the implementation phase. Consideration will also be given to submitting the abstract for a poster presentation at the American Association of Heart Failure Nurses Annual meeting for 2017.

References

- American Association of Critical Care Nurses. (2013). Progressive care fact sheet. Retrieved from <http://www.aacn.org/WD/Practice/Docs/ProgressiveCareFactSheet.pdf>
- American Association of Critical Care Nurses. (2015). AACN scope and standards for acute and critical care nursing practice. Retrieved from <http://www.aacn.org/wd/practice/docs/scope-and-standards-acute-critical-care-2015.pdf>
- American Nurses Association. (2010). Code of ethics for nurses with interpretive statements. Retrieved from <http://www.nursingworld.org/MainMenuCategories/EthicsStandards/Tools-You-Need/Code-of-Ethics.pdf>
- American Heart Association. (2015). About heart failure. Retrieved from http://www.heart.org/HEARTORG/Conditions/HeartFailure/AboutHeartFailure/About-Heart-Failure_UCM_002044_Article.jsp#.VuMf_ogo6YM
- Behlouli, H., Feldman, D.E., Ducharme, A., Frenette, M., Giannetti, N., Grondin, F., . . . Pilote, L. (2009). Identifying relative cut-off scores with neural networks for interpretation of the Minnesota living with heart failure questionnaire. *Engineering in Medicine and Biology Society*, 2009, 6242-6246.
doi:10.1109/IEMBS.2009.5334659
- Bekelman, D.B., Hooker, S., Nowels, C.T., Main, D.S., Meek, P., McBryde, C., . . .

- Heidenreich, P.A. (2014) Feasibility and acceptability of a collaborative care intervention to improve symptoms and quality of life in chronic heart failure: Mixed methods pilot trial. *Journal of Palliative Medicine, 17*(2), 145-151. doi:10.1089/jpm.2013.0143
- Bilbao, A., Escobar, A., Garcia-Perez, L., Navarro, G., & Quiros, R. (2016). The Minnesota living with heart failure questionnaire: comparison of different factor structures. *Health and Quality of Life Outcomes, 14*(23), 1-11. doi:10.1186/s12955-016-0425-7
- Blackman, I., Henderson, J., Willis, E., Hamilton, P., Toffoli, L., Verrall, C., . . . Harvey, C. (2014). Factors influencing why nursing care is missed. *Journal of Clinical Nursing, 24*(1/2), 47-56. doi:10.1111/jocn.12688
- Brooks Carthon, J.M., Lasater, K.B., Sloane, D.M., & Kutney-Lee, A. (2015). The quality of hospital work environments and missed nursing care is linked to heart failure readmissions: a cross-sectional study of US hospitals. *BMJ Quality & Safety, 24*(4), 255-263. doi:10.1136/bmjqs-2014-003346
- Brummett, B.H., Babyak, M.A., Mark, D.B., Clapp-Channing, N.E., Siegler, I.C., & Barefoot, J.C. (2004). Prospective study of perceived stress in cardiac patients. *Annals of Behavioral Medicine, 27*(1), 22-30. Retrieved from MEDLINE with Full Text
- Cene, C.W., Loehr, L., Lin, F.C., Hammond, W.P., Foraker, R.E., Rose, K., . . . Corbie-

- Smith, G. (2012). Social isolation, vital exhaustion, and incident heart failure: findings from the Atherosclerosis risk in communities study. *European Journal of Heart Failure, 14*(7), 748-753. doi:10.1093/eurjhf/hfs064
- Centers for Disease Control and Prevention. (2015). Heart failure fact sheet. Retrieved from http://www.cdc.gov/dhdsdp/data_statistics/fact_sheets/fs_heart_failure.htm
- Centers for Medicare & Medicaid. (2013). Medicare hospital quality chartbook 2014. Retrieved from <https://www.cms.gov/.../Medicare-Hospital-Quality-Chartbook-2014.pdf>
- Chapa, D.W., Akintade, B., Son, H., Woltz, P., Hunt, D., Friedmann, E., . . . Thomas, S.A. (2014). Pathophysiological relationships between heart failure and depression and anxiety. *Critical Care Nurse, 34*(2), 14-25. doi:10.4037/ccn2014938
- Cully, J.A., Johnson, M., Moffett, M.L., Khan, M., & Deswal, A. (2009). Depression and anxiety in ambulatory patients with heart failure. *Psychosomatics, 50*(6), 592-598. doi:10.1176/appi.psy.50.6.592
- Davidson, P., Cockburn, J., Daly, J., & Sanson-Fisher, R. (2004). Patient-centered needs assessment: Rationale for a psychometric measure for assessing needs in heart failure. *Journal of Cardiovascular Nursing, 19*(3), 164-171. Retrieved from CINAHL Plus with Full Text
- De Jong, M.J., Chung, M.L., Wu, J.R., Riegel, B., Rayens, M.K., & Moser, D.K. (2011). International perspectives on quality of life in cardiopulmonary disorders:

Linkages between anxiety and outcomes in heart failure. *Heart & Lung*, 40(5), 393-404. doi:10.1016/j.hrtlng.2011.02.002

Dimsdale, J.E. (2008). Psychological stress and cardiovascular disease. *Journal of American College of Cardiology*, 51(13), 1237-1246.
doi:10.1016/j.jacc.2007.12.024

Frederick Memorial Hospital. (2013). Frederick Memorial's 2013 community health needs assessment for Frederick County, Maryland. Retrieved from <http://www.fmh.org/workfiles/Community%20Health%20Assessment%20PDF.pdf>

Gallagher, R., Luttik, M.L., & Jaarsma, T. (2011). Social support and self-care in heart failure. *Journal of Cardiovascular Nursing*, 26(6), 439-449.
doi:10.1097/JCN.0b013e31820984e1

Golden, R.L., & Vail, M.R. (2014). The implications of the affordable care act for mental health. *Generations: Journal of the American Society of Aging*. Retrieved from <http://www.asaging.org/blog/implications-affordable-care-act-mental-health-care>

Graven, L.J., & Grant, J. (2013). The impact of social support on depressive symptoms in individuals with heart failure. *Journal of Cardiovascular Nursing*, 28(5), 429-443.
doi:10.1097/JCN.0b013e3182578b9d

Holly, D., & Sharp, J. (2012). Distress thermometer validation: heart failure. *British Journal of Cardiac Nursing*, 7(12), 595-602. Retrieved from CINAHL Plus with Full Text

Irving, A.V. (2014). Policies and procedures for healthcare organizations: a risk

- management perspective. Patient Safety and Quality Healthcare. Retrieved from <http://www.psqh.com/analysis/policies-and-procedures-for-healthcare-organizations-a-risk-management-perspective/#>
- iSixSigma. (2013). What is Six Sigma. Retrieved from <http://www.isixsigma.com/new-to-sixsigma/getting-started/what-six-sigma/>
- Jeon, Y.H., Jowsey, T., Yen, L., Glasgow, N.J., Essue, B., Kljakovic, M., . . . Aspin, C. (2010). Achieving a balanced life in the face of chronic illness. *Australian Journal of Primary Health, 16*, 66-74. doi:10.1071/PY09030
- Kalisch, B.J., Landstrom, G., & Williams, R.A. (2009). Missed nursing care: Errors of omission. *Nursing Outlook, 57*: 3-9. doi:10.1016/j.outlook.2008.05.007
- Kelly, D.L. (2011). *Applying Quality Management in Healthcare: A Systems Approach*. (3rd ed.). Chicago, IL: Heath Administration Press
- Kolcaba, K., Tilton, C., & Drouin, C. (2006). Comfort Theory: A unifying framework to enhance the practice environment. *Journal of Nursing Administrators, 36*(11), 538-544. Retrieved from CINAHL Plus with Full Text
- Kolcaba, K. (1994). A theory of holistic comfort for nursing. *Journal of Advanced Nursing, 19*(6), 1178-1184. doi:10.1111/j.1365-2648.1994.tb01202.x
- Lea, P. (2014). Factors affecting nurses' intent to assess for depression in heart failure patients. *Dimensions of Critical Care Nursing, 33*(6), 320-326, doi:10.1097/01.DCC.0000455078.68176.63

- Nair, N., Farmer, C., Gongora, E., & Dehmer, G.J. (2012). Commonality between depression and heart failure. *American Journal of Cardiology*, *109*(5), 768-772.
Retrieved from CINAHL Plus with Full Text
- Northridge, M.E., Glick, M., Metcalf, S.S., & Shelley, D. (2011). Public health support for the health home model. *American Journal of Public Health*, *101*(10), 1818-1820. doi:10.2105/AJPH.2011.300309
- Plach, S.K. (2008). Psychological well-being in women with heart failure: Can social roles make a difference? *Health Care for Women International*, *29*(1), 54-75.
Retrieved from CINAHL Plus with Full Text
- Runyan, C.N. (2011). Psychology can be indispensable to health care reform and the patient-centered medical home. *American Psychological Association*, *8*(2), 53-68.
doi:10.1037/a0023454
- Sayers, S.L., Hanrahan, N., Kutney, A., Clarke, S.P., Reis, B.F., & Reigel, B. (2007). Psychiatric comorbidity and greater hospitalization risk, longer length of stay, and higher hospitalization costs in older adults with heart failure. *Journal of the American Geriatrics Society*, *55*(10), 1585-1591. doi:10.1111/j.1532-5415.2007.01368.x
- Shen, B.J., Eisenberg, S.A., Maeda, U., Farrell, K.A., Schwarz, E.R., Penedo, F.J., . . . Mallon, S. (2011). Depression and anxiety predict decline in physical health functioning in patients with heart failure. *Annals of Behavior Medicine*, *4*(3), 373-382. doi:10.1007/s12160-010-9251-z
- Simon, K. (2010). The cause and effect (a.k.a. bonefish) diagram. Retrieved from

<http://www.isixsigma.com/tools-templates/cause-effect/cause-and-effect-aka-fishbone-diagram/>

Smith, L. (2010). Evaluation and treatment of depression in patients with heart failure.

Journal of American Academy of Nurse Practitioners, 22(8), 440-448.

doi:10.1111/j.1745-7599.2010.00533.x

Sorrell, J. (2012). The patient protection and affordable care act: What does it mean for

mental health services for older adults? *The Journal of Psychosocial Nursing &*

Mental Health Services, 50(11), 14-8. doi:10.3928/02793695-20121003-04

Sykes, C., & Simpson, S. (2011). Managing the psychosocial aspects of heart failure: a

case study. *British Journal of Nursing*, 20(5), 272-279. Retrieved from CINAHL

Plus with Full Text

Tague, N.R. (2004). *The Quality Toolbox*. Retrieved from [http://asq.org/learn-about](http://asq.org/learn-about-quality/cause-analysis-tools/overview/pareto.html)

[quality/cause-analysis-tools/overview/pareto.html](http://asq.org/learn-about-quality/cause-analysis-tools/overview/pareto.html)

Thomas, S.A., Chapa, D.W., Friedmann, E., Durden, C., Ross, A., Lee, M.C.Y., & Lee,

H.J. (2008). Depression in patients with heart failure: Prevalence,

pathophysiology mechanisms, and treatment. *Critical Care Nurse*, 28(2), 40-2,

44-8, 50-5. Retrieved from CINAHL Plus with Full Text

Thombs, B.D., Roseman, M., Coyne, J.C., De Jonge, P., Delisle, V.C., Authurs, E., . . .

Ziegelstein, R.C. (2013). Does evidence support the American Heart Association's

recommendation to screen patients for depression in cardiovascular care? An

updated systematic review. *Plos One*, 8(1), e526524.

doi:10.1371/journal.pone.0052654

- Volz, A., Schmid, J.P., Zwahlen, M., Khoos, S., Saner, H., & Barth J. (2011). Predictors of readmission and health related quality of life in patients with chronic heart failure: a comparison of different psychosocial aspects. *Journal of Behavioral Medicine*, 34, 13-22. doi:10.1007/s10865-010-9282-8
- Wedro, B. (2013). Congestive heart failure: Symptoms, causes, treatment – what are the risk factors for congestive heart failure? *MedicineNet.com*. Retrieved from http://www.medicinenet.com/congestive_heart_failure_chf_overview/page4.htm#what_are_the_risk_factors_for_congestive_heart_failure
- White, K.M., & Dudley-Brown, S. (2012). *Translation of Evidence into Nursing and Health Care Practice*. New York, NY: Springer Publishing Company, LLC.
- Woltz, P.C., Chapa, D.W., Friedmann, E., Son, H., Akintade B., & Thomas, S.A. (2012). Care of the patient with heart failure: Effects of interventions on depression in heart failure: A systematic review. *Heart & Lung*, 41(5), 469-483. doi:10.1016/j.hrtlng.2012.06.002
- Worrall-Carter, L., Ski, C., Thompson, D., Davidson, P., Cameron, J., Castle, D., & Page, K. (2012). Recognition and referral of depression in patients with heart disease. *European Journal of Cardiovascular Nursing*, 11(2), 231-238. doi:10.1016/j.ejcnurse.2011.04.005
- Wu, J-R., Frazier, S.K., Rayens, M.K., Lennie, T.A., Chung, M.L., & Moser, D.K. (2013). Medication adherence, social support and event-free survival in patients with heart failure. *Health Psychology*, 32(6), 637-646. doi:10.1037/a0028527
- Yohannes, A.M., Willgoss, T.G., Baldwin, R.C., & Connolly, M.J. (2010). Depression

and anxiety in chronic heart failure and chronic obstructive pulmonary disease: prevalence, relevance, clinical implications and management principles.

International Journal of Geriatric Psychiatry, 25, 1209-1221.

doi:10.1002/gps.2463

Yu, D.S.F., Lee, D.T.F., Woo, J., & Thompson, D.R. (2004). Correlates of psychological distress in elderly patients with congestive heart failure. *Journal of Psychosomatic Research*, 57(6), 573 – 581. doi:10.1016/j.jpsychores.2004.04.368

Zaccagnini, M.E., & White, K.W. (2011). *The Doctor of Nursing Practice Essentials: A New Model for Advanced Practice Nursing*. Sudbury, MA: Jones and Bartlett Publishers

Appendix A: Interview Questions

1. Is there a current process in place for assessing psychosocial issues of the HF patient?

If yes – is it the same for each department ICU, ER, PCU

Is it completed consistently?

Who does it?

If no ---why not?

2. Is there a policy for psychosocial assessments?

If yes, does everyone know it?

3. Is there enough manpower to perform a psychosocial well-being assessment on every HF patient?

Why/why not?

4. Are nurses equipped to assess psychosocial issues?

Why/why not?

5. Is there a culture that promotes the assessment?

6. Is there relevance in nursing to performing a psychosocial assessment in the HF patient population

Appendix B: Email invitation

My name is Debra Disbrow, and I am a Doctorate of Nursing Practice student at Walden University. I am inviting you to participate in a research study. Involvement in the study is voluntary, so you may choose to participate or not.

I am interested in learning more about barriers that cardiac nurses face in assessing and identifying psychosocial issues of heart failure patients. You will be asked to participate in a focus group of registered nurses from the Progressive Care Unit, the Intensive Care Unit and the Emergency Room. This will take approximately 30 -45 minutes of your time and light snacks will be provided. The date/time of the focus groups are:

- Thursday October 29, 2015 @ 2pm in Classroom 1
- Monday November 2, 2015 @ 5pm in Classroom 1
- Tuesday November 11, 2015 @ 0800 in Classroom 1
- Wednesday November 22, 2015 @ 4pm in Classroom 1

The benefit of the research is that you will be helping me to understand what (if any) barriers nurses have to overcome in assessing stress, anxiety and depression in the heart failure population. The project will also give me an opportunity to address the effects that psychosocial issues have on the trajectory of the heart failure disease process.

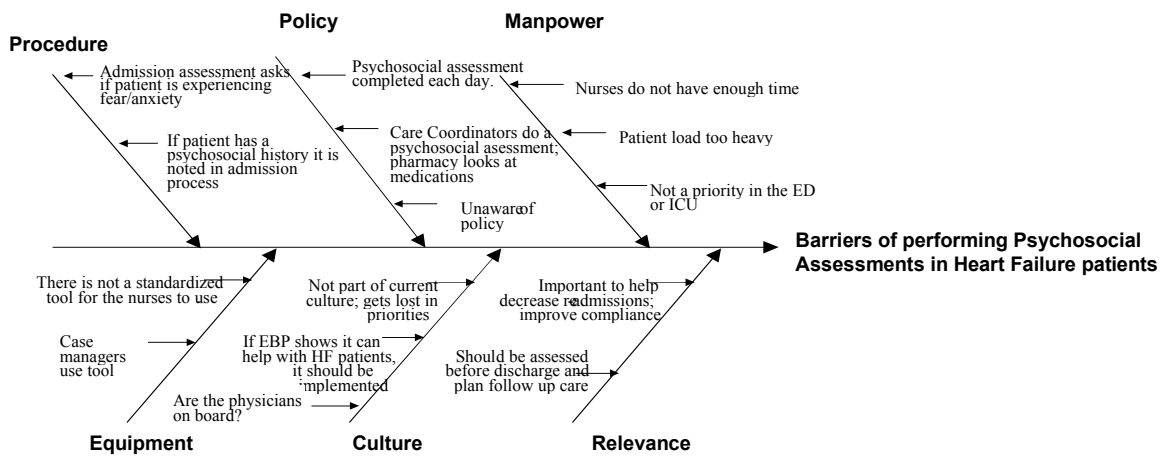
At the time of the focus group, I will ask that you read and sign a consent for participation.

Please feel free to ask any questions that you may have about the research; I will be happy to explain anything in greater detail.

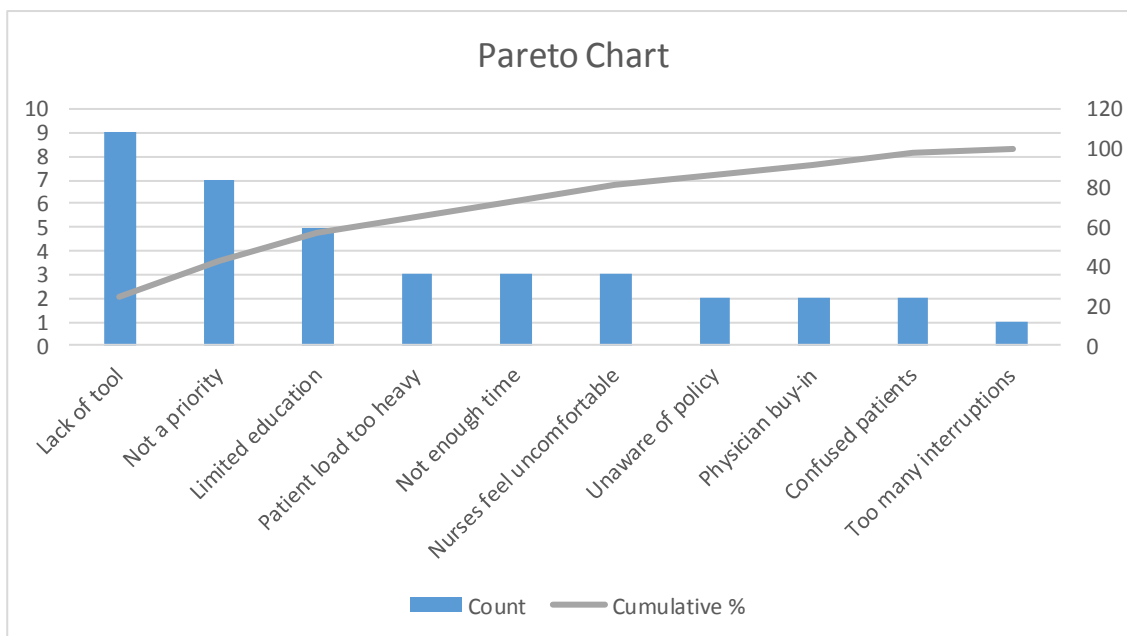
Debra Disbrow MSN, RN
DNP student
Walden University
Ddisbrow@fmh.org

Appendix C: Fish-bone diagram

Fishbone Diagram: RN Focus Group



Appendix D: Pareto Chart



Appendix E: Minnesota Living with Heart Failure Questionnaire
 MINNESOTA LIVING WITH HEART FAILURE® QUESTIONNAIRE

The following questions ask how much your heart failure (heart condition) affected your life during the past month (4 weeks). After each question, circle the 0, 1, 2, 3, 4 or 5 to show how much your life was affected. If a question does not apply to you, circle the 0 after that question.

Did your heart failure prevent you from living as you wanted during the past month (4 weeks) by -	No	Very Little	2	3	4	Very Much
1. causing swelling in your ankles or legs?	0	1	2	3	4	5
2. making you sit or lie down to rest during the day?	0	1	2	3	4	5
3. making your walking about or climbing stairs difficult?	0	1	2	3	4	5
4. making your working around the house or yard difficult?	0	1	2	3	4	5
5. making your going places away from home difficult?	0	1	2	3	4	5
6. making your sleeping well at night difficult?	0	1	2	3	4	5
7. making your relating to or doing things with your friends or family difficult?	0	1	2	3	4	5
8. making your working to earn a living difficult?	0	1	2	3	4	5
9. making your recreational pastimes, sports or hobbies difficult?	0	1	2	3	4	5
10. making your sexual activities difficult?	0	1	2	3	4	5
11. making you eat less of the foods you like?	0	1	2	3	4	5
12. making you short of breath?	0	1	2	3	4	5
13. making you tired, fatigued, or low on energy?	0	1	2	3	4	5
14. making you stay in a hospital?	0	1	2	3	4	5
15. costing you money for medical care?	0	1	2	3	4	5
16. giving you side effects from treatments?	0	1	2	3	4	5
17. making you feel you are a burden to your family or friends?	0	1	2	3	4	5
18. making you feel a loss of self-control in your life?	0	1	2	3	4	5
19. making you worry?	0	1	2	3	4	5
20. making it difficult for you to concentrate or remember things?	0	1	2	3	4	5
21. making you feel depressed?	0	1	2	3	4	5

Appendix F: Licensure for Minnesota Living with Heart Failure Questionnaire

Full License Agreement

Following is the full and final license agreement text.



Please read the terms and conditions of this license agreement ("Agreement") carefully. By clicking "Accept" on the "Review and Accept Agreement" page during the licensing process, you are agreeing to the following terms and conditions on behalf of the Licensee identified below, and you represent and warrant that you are authorized to do so.

The Minnesota Living with Heart Failure® Questionnaire can be used with the following educational project:

I am currently in a Doctorate of Nursing Practice (DNP) program and will be using the MLHF questionnaire in my final dissertation.

License Fee:

License Fee is \$0.00 USD, payable upon checkout.

Licensee: Debra Disbrow

Company - Walden University

Contact Email - debra.disbrow@waldenu.edu

Contact Phone - 240-315-8769

**And residing or
doing business at**

1818-A Monocacy View

Circle

Frederick, MD 21701

US

TERMS AND CONDITIONS - The following terms and conditions govern this Agreement by and between the Regents of the University of Minnesota, a constitutional corporation under the laws of the State of Minnesota, ("University") and the Licensee.

Definitions - For purposes of this agreement, the following terms have the following meanings.

"Accompanying Documentation" means the following:
The Overview Document (123 KB .PDF)

"Approved Copies" means duplicates of the Work that shall include the statement below:

©1986 Regents of the University of Minnesota, All rights reserved. Do not copy or reproduce without permission. LIVING WITH HEART FAILURE® is a registered trademark of the Regents of the University of Minnesota.

"Effective Date" means the date when the Licensee clicks the button indicating agreement with all the terms and conditions of the license and has successfully completed payment in the checkout process.

"Licensed Mark" means US Trademark Registration No. 2,378,845 for the mark "LIVING WITH HEART FAILURE", registered to the Regents of the University of Minnesota.

"Purpose" Means the use of the Licensed Technology pursuant to the Terms & Conditions of this Agreement, for use by the Licensee, who must be a student or teacher at an academic institution, exclusively for student project(s) or didactic purposes and for no other purpose.

"Licensed Technology" means collectively the Work, the Licensed Mark, Approved Copies and the Accompanying Documentation.

"Term" The Term of this Agreement shall commence on the Effective Date and shall expire, without any further action by the University, on the tenth (10th) anniversary of the Effective Date.

"Work" means the Living with Heart Failure ® Questionnaire and the Instructions for Data Collection and Scoring. This Work is in the English language; and is identified as University **Case #: 94019.**

Grant of License - Subject to the terms and conditions of the Agreement, University hereby grants to Licensee and Licensee accepts a limited, non-exclusive, non-transferrable, non-sub-licensable, revocable, world-wide license to reproduce the Work and use Approved Copies for the Purpose set forth in this Agreement.

Rights of the U.S. Government and Third Parties - No provision of this Agreement limits, conditions or otherwise affects the United States of America's or any other third party's rights and interests in the Licensed Technology.

University Intellectual Property Rights -Title to and ownership of the Licensed Technology shall at all times remain with the University and Licensee shall not have any title or ownership interest therein. All rights not expressly granted to Licensee under the Agreement are reserved by University.

Use of the University's Names and Trademarks - No provision of the Agreement grants the Licensee any right or license to use the name, logo, or any marks owned by or associated with the University or the names, or identities of any member of the faculty, staff, or student body of the University except as may be otherwise provided in this Agreement and Licensee shall not use such names or marks without the prior written approval of the Licensee's Office of University Relations.

Payment Terms - Licensee shall pay, upon checkout, the License Fee and any applicable taxes, duties, fees, excises or other charges. All amounts payable hereunder by Licensee are non-refundable and non-creditable. All amounts payable hereunder by Licensee shall be payable in United States funds.

Protection of Proprietary Rights - Licensee shall take all reasonable steps to protect University's ownership rights in and to the Licensed Technology. Licensee shall not distribute any part of the Licensed Technology except as may be allowed for the Purpose of the Agreement.

Audit - Licensors may audit Licensee's usage and records directly relating to the Licensed Technology to ensure that Licensee is using the Licensed Technology in compliance with the Agreement. Such audit shall be upon fifteen (15) working days advance written notice of such audit, which shall be conducted during normal business hours.

Termination - If the Licensee breaches or fails to perform one or more of its obligations under the Agreement, the University may deliver a written notice of default to the Licensee. Without further action by a party, the Agreement shall terminate if the default has not been cured in full within thirty (30) days. The University may terminate the Agreement immediately by delivering to the Licensee a written notice of termination if the Licensee or its agents or representatives commences or maintains an action in any court of competent jurisdiction or a proceeding before any governmental agency asserting or alleging, in any respect, the validity or enforceability of any of the Licensed Technology. The Licensee shall notify the University, in writing, at least thirty (30) days prior to the commencement of any such action or the instigation of any such proceeding. Upon termination or expiration, all rights granted to Licensee under this Agreement, with respect to the Licensed Technology, terminate; and upon request Licensee shall return (or destroy and certify destruction) of any copies of the Licensed Technology, however Licensee shall be permitted to keep copies of the Licensed Technology to ensure compliance with this Agreement and for its own internal data management purposes.

Indemnification - The Licensee shall release, defend (upon the request of the University), indemnify, and hold harmless the University and its regents, employees, agents and representatives from any loss, claim, damage, or liability, of whatever kind or nature (including, but not limited to, reasonable attorneys' and investigative expenses), that arises from or in any way relates to (i) the use of the Licensed Technology (including but not

limited to any product that contains or is manufactured with the use of the Licensed Technology) or (ii) Licensee's breach of any obligation or representation under the Agreement.

Permitted Trademark Usage - Licensee's use of a Licensed Mark in any manner shall inure to the benefit of the University. The Licensee agrees that it will not: (i) challenge, cause, or assist any other person to contest the validity of a Licensed Mark or the University's sole and exclusive rights in each Licensed Mark; (ii) use a Licensed Mark or any components thereof, or any words or designs confusingly similar thereto, in any way other than in connection with the Licensed Technology; (iii) attempt to register or register, assist in registering, or cause to be registered a Licensed Mark or any components thereof or any words or designs confusingly similar thereto, as or within any trademark, corporate name, trade name, or domain name; or (iv) commit any act that might prejudice or adversely affect the validity of a Licensed Mark or the University's rights in each Licensed Mark. The Licensee shall use the Licensed Marks in full compliance with all applicable federal, state, territorial, and provincial laws, including all applicable federal export laws and regulations.

Trademark Standards - Licensee recognizes the importance to the University of maintaining high, uniformly applied standards of quality in the Licensed Technology identified by a Licensed Mark, and covenants that Licensed Technology covered by this Agreement shall be of high standard and quality. The Licensee agrees to follow any and all written specifications of the University relating to the nature and quality of Licensed Technology and the use of the Licensed Marks. From time to time during the term of the Agreement, as requested by the University in writing, the Licensee shall submit sample(s) of requested Licensed Technology to the University for its inspection and approval. Such specimen(s) or sample(s) may be used by University in the filing, prosecution or maintenance of a Licensed Mark. Licensee further agrees to cooperate, from time to time as necessary, with the University in the filing, prosecution and maintenance of the Licensed Marks.

Disclaimer - THE LICENSED TECHNOLOGY IS PROVIDED "AS IS." UNIVERSITY MAKES NO WARRANTIES OR REPRESENTATIONS RELATING TO THE LICENSED TECHNOLOGY, EXPRESS OR IMPLIED, STATUTORY OR OTHERWISE, AND EXPRESSLY EXCLUDES THE WARRANTY OF NON-INFRINGEMENT OF THIRD-PARTY RIGHTS, FITNESS FOR A PARTICULAR PURPOSE OR MERCHANTABILITY. UNIVERSITY DOES NOT WARRANT THAT THE LICENSED TECHNOLOGY WILL SATISFY LICENSEE'S REQUIREMENTS.

LIMITATION OF LIABILITY - UNIVERSITY IS NOT LIABLE FOR ANY INDIRECT, INCIDENTAL, SPECIAL, OR CONSEQUENTIAL DAMAGES, OR DAMAGES FOR LOSS OF PROFITS INCURRED BY THE LICENSEE OR ANY THIRD PARTY, WHETHER IN AN ACTION IN CONTRACT OR TORT (INCLUDING NEGLIGENCE), OR ANY OTHER LEGAL THEORY, EVEN IF THE UNIVERSITY HAS BEEN ADVISED OF THE POSSIBILITY OF SUCH DAMAGES. IN NO EVENT WILL THE UNIVERSITY'S AGGREGATE LIABILITY UNDER THIS AGREEMENT EXCEED THE

LICENSE FEE PAID TO THE UNIVERSITY UNDER THE AGREEMENT. THIS LIMITATION APPLIES REGARDLESS OF WHETHER OTHER PROVISIONS OF THIS LICENSE HAVE BEEN BREACHED OR HAVE PROVEN INEFFECTIVE. THE EXISTENCE OF MORE THAN ONE CLAIM WILL NOT ENLARGE OR EXTEND THESE LIMITS. LICENSEE ACKNOWLEDGES AND AGREES THAT THE FOREGOING LIABILITY LIMITATIONS ARE ESSENTIAL ELEMENTS OF THIS LICENSE AND THAT IN THE ABSENCE OF SUCH LIMITATIONS, THE MATERIAL AND ECONOMIC TERMS OF THIS LICENSE WOULD BE SUBSTANTIALLY DIFFERENT.

Export and Regulatory Restrictions - Copyright - The Licensee shall comply with all then-current applicable export laws and any regulations (e.g. federal, state, local, or provincial) regarding the use of the Licensed Technology in the relevant territory.

Right to Injunctive Relief - Licensee acknowledges and agrees that monetary damages are not sufficient to compensate University in the event of Licensee's material breach or violation of this Agreement, and that University may be irreparably harmed by such breach or violation, and that University will have the right to seek other remedies available to it in law and equity to remedy such breach or violation, including injunctive and equitable relief. If Licensee fails to perform an obligation or otherwise breaches one or more of the terms of this Agreement, Licensee shall pay the University's costs and expenses (including actual attorneys' and investigative fees) to enforce the terms of this Agreement.

Governing Law and Forum - The internal laws of the state of Minnesota shall govern the validity, construction and enforceability of this Agreement, without giving effect to the conflict of laws principles thereof. Any suit, claim, or other action to enforce the terms of this agreement, or any suit, claim or action arising out of or related to this agreement, may be brought only in the state courts of Hennepin County, Minnesota. The Licensee hereby submits to the jurisdiction of that court and waives any objections it may have to that court asserting jurisdiction over the Licensee or its assets and property. This Agreement is not to be governed by the United Nations Convention on Contracts for the International Sale of Goods, or by the Uniform Computer Information Transactions Act (UCITA) as may be enacted by the State of Minnesota.

Entire Agreement - This Agreement constitutes the entire understanding of the parties with respect to the subject matter hereof, and supersedes all prior agreements and understandings of the parties on such subject matter. This Agreement may be amended, only in writing, and duly executed by all the parties.

Assignments - The Licensee may not assign or delegate any right or duty under this Agreement, unless the University has consented, in writing, to such assignment or delegation. An assignment or delegation made in violation of this section shall be void and shall not bind the other party.

Compliance With Laws - Licensee represents and warrants that its use of the Licensed Technology will comply with all applicable laws and regulations.

Survival - The following provisions (to the extent they appear in this Agreement) survive termination of the Agreement: "Definitions, University Intellectual Property Rights, Protection of Proprietary Rights, Payment Terms, Termination, Disclaimer, Limitation of Liability, Indemnification, Export Control, Right to Injunctive Relief and Attorney's Fees, Governing Law, and any other provision, which by its nature is intended to survive.

Relationship of the Parties - In entering into, and performing their duties under the Agreement, the parties are acting as independent contractors and independent employers. No provision of the Agreement creates or is to be construed as creating a partnership, joint venture, or agency relationship between the parties. No party has the authority to act for or bind the other party in any respect.

Severability - If a court of competent jurisdiction adjudges a provision of the Agreement to be unenforceable, invalid, or void, such determination is not to be construed as impairing the enforceability of any of the remaining provisions hereof and such provisions will remain in full force and effect.

Notice - In order to be effective, all notices, requests, and other communications that a party is required or elects to deliver must be in writing and must be delivered personally, or by facsimile or electronic mail (provided such delivery is confirmed), or by a recognized overnight courier service or by United States mail, first-class, certified or registered, postage prepaid, return

receipt requested, to the other party at its address set forth below or to such other address as such party may designate by notice given under this section:

If to University:

Office for Technology Commercialization, University of Minnesota
Attn: Contracts Manager
McNamara Alumni Center
200 Oak St. SE, Suite 280
Minneapolis, MN
55455
OTCAgree@umn.edu

If notice alleges breach of the Agreement, a copy must be sent to:

**Office of the General Counsel, University of
Minnesota Attention: Director of
Transactional Law Services.
200 Oak Street, SE
Minneapolis, MN, 55455**

Contracts@mail.ogc.umn.edu

If to Licensee: As set forth above in the "Licensee" section.

Accept Terms - Clicking "Accept" on the "Review and Accept Agreement" page during the licensing process indicates that you agree with the terms and conditions of this license agreement, and agree to receive required notices from the University of Minnesota electronically.

Appendix G: Hospital Anxiety and Depression Scale
Hospital Anxiety and Depression Scale (HADS)

**Tick the box beside the reply that is closest to how you have been feeling in the past week.
 Don't take too long over you replies: your immediate is best.**

D	A		D	A	
		I feel tense or 'wound up':			I feel as if I am slowed down:
	3	Most of the time	3		Nearly all the time
	2	A lot of the time	2		Very often
	1	From time to time, occasionally	1		Sometimes
	0	Not at all	0		Not at all
		I still enjoy the things I used to enjoy:			I get a sort of frightened feeling like 'butterflies' in the stomach:
0		Definitely as much		0	Not at all
1		Not quite so much		1	Occasionally
2		Only a little		2	Quite Often
3		Hardly at all		3	Very Often
		I get a sort of frightened feeling as if something awful is about to happen:			I have lost interest in my appearance:
	3	Very definitely and quite badly	3		Definitely
	2	Yes, but not too badly	2		I don't take as much care as I should
	1	A little, but it doesn't worry me	1		I may not take quite as much care
	0	Not at all	0		I take just as much care as ever
		I can laugh and see the funny side of things:			I feel restless as I have to be on the move:
0		As much as I always could		3	Very much indeed
1		Not quite so much now		2	Quite a lot
2		Definitely not so much now		1	Not very much
3		Not at all		0	Not at all
		Worrying thoughts go through my mind:			I look forward with enjoyment to things:
	3	A great deal of the time	0		As much as I ever did
	2	A lot of the time	1		Rather less than I used to
	1	From time to time, but not too often	2		Definitely less than I used to
	0	Only occasionally	3		Hardly at all
		I feel cheerful:			I get sudden feelings of panic:
3		Not at all		3	Very often indeed

2		Not often		2	Quite often
1		Sometimes		1	Not very often
0		Most of the time		0	Not at all
		I can sit at ease and feel relaxed:			I can enjoy a good book or radio or TV program:
	0	Definitely	0		Often
	1	Usually	1		Sometimes
	2	Not Often	2		Not often
	3	Not at all	3		Very seldom

Please check you have answered all the questions

Scoring:

Total score: Depression (D) _____ Anxiety (A) _____

0-7 = Normal

8-10 = Borderline abnormal (borderline case)

11-21 = Abnormal (case)

Appendix H: Power point Presentation

Identifying barriers that cardiac nurses face in assessing psychosocial issues of heart failure patients

DEBRA DISBROW, MSN, RN, ONC, PCCN
WALDEN UNIVERSITY
PROJECT PRESENTATION

BACKGROUND

Heart Failure (HF) costs \$37 billion a year to treat

Psychosocial issues (stress, anxiety, depression) can cause exacerbations of Heart Failure symptoms

- Leading to
 - Increased re-admissions
 - Increase mortality of HF patients
 - Decrease compliance with follow-up care
 - Increase in overall cost of care

(Birkman, Dy, Becker, Wintrow, Hendricks, Yamashita, & Guttish, 2007)

BACKGROUND (CONTINUED)

Patients admitted to Frederick Memorial Hospital with a diagnosis of acute HF are given a brief psychosocial screen

- Providers are focused on treating HF
- Prioritize care to manage acute symptoms
 - Psychosocial issues are often overlooked or undetected
 - Patients are discharged without appropriate follow-up care for stress, anxiety or depression

(Johannes, Wiggins, Baddrin, & Conolly, 2010)

HEART FAILURE AND PSYCHOSOCIAL SYMPTOMS

Symptoms mimic each other

- HF produces a neurohormonal activation (due to an increase in the left ventricular filling pressure), heart arrhythmias, inflammation and hypercoagulability – same symptoms as depressive states
- Fatigue, decreased appetite, and difficulty sleeping are associated with HF and depression
- Stress and anxiety, on the other hand, can stimulate the sympathetic nervous system and catecholamine release
 - Increased heart rate, increased blood pressure, chest pain, or diaphoresis which can be associated with HF

(Vale, Schmidt, Zuckero, Kohls, Saor, & Barth, 2011)

AFFORDABLE CARE ACT

Under the Patient Protection Affordable Care Act, there is a push to provide adequate screening for behavioral health problems

- Compliance could impact re-imburement amount
- Appropriate screening can begin at the bedside of the hospital
 - Patients can be diagnosed and treated early
 - Decrease re-admissions
 - Increase compliance with medications, diet, and follow up care
 - Improve quality of life

(Rosen, 2011)

PURPOSE OF PROJECT

The purpose of the project was to identify barriers that cardiac nurses (ICU, ED, PCU) face in assessing psychosocial issues in HF patients.

Literature Review

Extensive literature search completed

- Only four articles identify nurse barriers in assessing psychosocial issues
 - There is a need for more research
- Research showed correlation between stress, anxiety, and depression and health deterioration in HF patients
- Reviewed screening tools for validity/reliability
- Kalcaba's Theory of Comfort chosen as the framework for the project

Using Theory in Research

Category	Description	Kalcaba's theory
Policy/procedure	Evaluate facilities current policy and procedures	Environmental Comfort
Manpower	Assess empowerment of nurses to perform psychosocial issues	Psychospiritual Comfort Physical Comfort Environmental Comfort
Equipment	Evaluate tools in place used to screen for psychosocial issues	Physical Comfort
Culture	Determine if the facility would support the practice (nurse support)	Sociocultural Comfort Psychospiritual Comfort
Relevance	Inquire if the cardiac nurses feel it is relevant to their practice	Sociocultural Comfort

Kalcaba's Theory of Comfort

Nurse's Comfort			
Physical Comfort -Staffing -Equipment	Psychospiritual Comfort -Empowerment -Leadership support	Sociocultural Comfort -Communication -Collaboration	Environmental Comfort -Adjusted workload -Nursing department

Methodology

Focus groups were held with nurses from the ED, ICU, and PCU

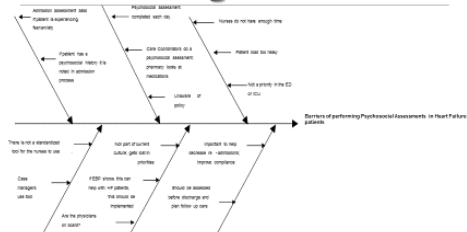
- 18 nurses participated
- Six questions were asked that focused on the following categories:
 - Current Policy
 - Manpower
 - Available Equipment
 - Culture of the facility
 - Relevance to practice

Data Analysis

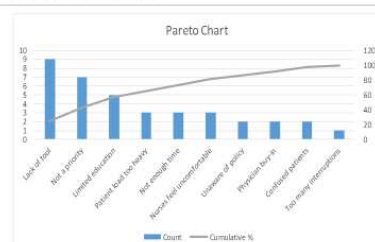
Data was transcribed

- Fishbone diagram completed
- Pareto chart used to show high priority of themes
 - 80% of the barriers identified came from 2 out of the 10 barriers identified. (80/20 rule).
 - Statistically significant

Fishbone diagram



Pareto Chart



Top 5 Barriers Nurses Identified

1. Lack of a standardized tool for nurses to use to assess psychosocial issues
2. Psychosocial assessment in not a priority while the patient has acute symptoms of HF
3. Nurses felt they had limited education regarding HF and psychosocial health
4. Patient load too heavy
5. Not enough time to complete

Recommendations

Adopt a valid standardized tool

- Minnesota Living with Heart Failure Questionnaire
- Hospital Anxiety and Depression Scale

Develop education for cardiac nurses

- Include in Critical Care Course
- In-services

Develop policy/procedures that can be used as guidelines

Discuss psychosocial issues at MDRs

Reference

- American Association of Critical Care Nurses: AACN. (2013). Tele-ICU nursing practice guidelines. Retrieved from <http://www.aacn.org/~/media/aacn/tele-icu-guidelines.pdf>
- Bekelmann, D.B., Dy, S.M., Becker, D.M., Wittstein, L.S., Hendricks, D.E., Yamashita, T.E., & Gotlib, S.H. (2007). Spiritual well-being and depression in patients with heart failure. *Journal of General Internal Medicine*, 22(4), 470-7. doi: <http://dx.doi.org/10.1007/s11966-006-9544-9>
- Frederick Memorial Hospital: FMH. (2013). Frederick Memorial's 2013 community health needs assessment for Frederick County, Maryland. Retrieved from <http://www.fmh.org/workfiles/Community%20Health%20Assessment%20PDF.pdf>
- Rumyan, C.N. (2011). Psychology can be indispensable to health care reform and the patient-centered medical home. *American Psychological Association*, 9(2), 53-65. Doi: 10.1037/a0023454
- Smith, L. (2010). Evaluation and treatment of depression in patients with heart failure. *Journal of American Academy of Nurse Practitioners*, 22(8), 440-448. doi:10.1111/j.1745-7599.2010.00533.x

Reference (Continued)

Volz, A., Schmid, J.P., Zwahlen, M., Khols, S., Sauer, H., & Barth J. (2011). Predictors of readmission and health related quality of life in patients with chronic heart failure: a comparison of different psychosocial aspects. *Journal of Behavioral Medicine*, 34, 13-22. DOI 10.1007/s10865-010-9282-8

Yohannes, A.M., Willgoos, T.G., Baldwin, R.C., & Connolly, M.J. (2010). Depression and anxiety in chronic heart failure and chronic obstructive pulmonary disease: prevalence, relevance, clinical implications and management principles. *International Journal of Geriatric Psychiatry*, 25, 1209-1221. DOI: 10.1002/gps.2463