

provide unpaid care to an adult age 50 or older and these caregivers provide care to cardiovascular patients for more than 20 hours per week (NAC and AARP, 2015 and 2009). Approximately 80% of people requiring long-term care receives this care from spouses, relatives, and friends. These caregivers have generally a poor quality of life and often experience poverty, isolation, frustration, health problems and depression, and often are excluded from labor market earlier (Eurocarers, 2016). Although caregivers in HF care are so important few studies have explored HF caregivers needs. In the last ten years' studies showed major recurrent themes that require further exploration. Aim: The aim of the project is to investigate the needs of informal caregivers of patients with heart failure.

Methods: Sequential exploratory mixed method study. The first qualitative research phase uses a semi-structured individual interview to gather the meaning of the whole experience of caregivers. A narrative approach will be adopted to get a deeper insight into caregivers' experience and needs. A qualitative narrative methodology will be used to interpret the findings. To categorize the narrative data a qualitative content analysis will be performed. Lincoln and Guba's criteria to establish trustworthiness will be followed by the analysis. All the data were analysed with Atlas.Ti software. The second phase is quantitative, and verifies the previous variables in a larger sample, with different validated questionnaires that will be used to establish the power of the relations between patients and caregivers characteristics and their influence on burden and needs.

Discussion: Explore caregiver needs is necessary to develop an intervention in order to allow them to care their relatives in a safe and correct way, without stress or anxiousness. Mix method, qualitative and quantitative research, can be the way for nursing to involve all the aspects of nursing competence: technical, intellectual and interpersonal relational skills; using a team approach with users and others professionals.

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Symptoms and health related quality of life in heart failure patients

AK Ketilsdottir,¹ BI Ingadottir² and TJ Jaarsma³

¹Landspítali University Hospital, Department of Cardiology, Reykjavik, Iceland

²Landspítali University Hospital, Department of Surgery, Reykjavik, Iceland

³Linköping University, Department of Social and Welfare Studies, Linköping, Sweden

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Background: Two of the main goals of heart failure (HF) management are to decrease symptoms and to improve quality of life and these are often leading goals in the care provided

in HF clinics. To meet the needs of patients and to provide optimal care at outpatient heart failure clinics it is therefore important to have a clear profile of the patient population.

Purpose: To describe symptoms and health related quality of life of patients with chronic HF who attend a outpatient HF clinic in Iceland and to assess related factors.

Methods: In this cross sectional study questionnaires were sent to 227 patients enrolled in an outpatient HF clinic in the fall of 2014. Symptoms, health related quality of life, sense of security and self-care were measured with the following previously validated and structured instruments; Edmonton Symptom Assessment System-ESAS, Hospital Anxiety and Depression Scale-HAD-S, European Heart Failure Self-care Scale-EHFScB, Sense of Security in Care-SEC-P and Kansas City Cardiomyopathy Questionnaire-KCCQ, which includes the total quality of life score (QoL, possible scores 0-100), the Overall Summary Score (OSS, possible scores 0-100) and the Clinical Summary Scores (CSS, possible scores 0-100). Participants' (N=124) mean age was 73 (± 15) and 69% were males. Most were either in New York Heart Association functional class II (37%) or III (55%).

Results: Participants reported a prevalence of 4.8 (± 2.6) symptoms; most common was tiredness (82%), shortness of breath (77%) and drowsiness (76%). Symptoms of anxiety were reported by 12% and symptoms of depression were reported by 18% of participants. Quality of life was rated 59.3 (± 27.4) and the OSS and CSS of the KCCQ were 61.3 (± 23.4) and 63.2 (± 23.8) respectively. A total of 67% of participants reported scores over 50 on the OSS. Participants with higher NYHA-class had more symptoms ($p = 0,002$) and worse QoL $p < 0,001$). Older participants had fewer symptoms ($r = -0,262$ $p = 0,003$) and less Anxiety ($r = -0,262$ $p = 0,003$) but worse QoL ($r = -0,253$ $p = 0,005$). Depressed participants had lower self-care ($r = +,19$ $p = 0,041$) and lower sense of security ($r = 0,27$ $p = 0,003$).

Conclusions: Although a majority of the participants reported fair or good quality of life the results indicate that they were quite symptomatic. It is important to identify those suffering from symptoms of depression and anxiety since they may interfere with self-care and diminish sense of security. Comprehensive assessment of these symptoms is therefore of great importance in outpatient heart failure clinics. Systematic assessment of health related quality of life would provide valuable information to identify patients in need of additional resources.

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The meaning of living with chronic heart failure

MI Saracibar Razquin,¹ C Oroviogicochea,² J Martin Martin,¹ M Perez Diez Del Corral,¹ P Ara-Lucea,² A Simon-Ricart² and M Olano-Lizarraga¹

¹University of Navarra, Departamento de Enfermería de la Persona Adulta, Pamplona, Spain ²Clinica Universidad de Navarra, Enfermería, Pamplona, Spain

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Introduction: Currently among the existing chronic illnesses, the cardiovascular diseases produce the most morbidity and mortality. Close to 15 million persons in Europe and more than 5 million in the USA suffer chronic heart failure (HF). Progressive deterioration in the state of health and acute episodes of decompensation characterize HF. Patients experience physical losses and undergo emotional, cognitive, social, economic and spiritual changes that affect their lives. They face complex treatment regimens and strict self-care behaviors.

In the 21st century, healthcare attention is changing from focusing on the disease and its treatment to a paradigm in which health is perceived as a human experience that is integrated into people's lives and which includes personal well-being. However, the care for these people with HF continues to center primarily on the medical treatment of the disease and its complications. To understand what all of this means in the lives of these patients would help to refocus their care and to respond to their true needs.

Purpose: To understand what living with chronic heart failure (HF) means to the person suffering from this disease.

To understand the following from the patient's perspective: 1) The effect that HF has on its diverse personal dimensions; 2) How they experience repercussions of HF in their lives and 3) To identify what contributes to a patient perceiving better well-being.

Method: A phenomenological-hermeneutic study was performed in a specialized HF unit (2013-2016). A sample of 20 adult patients with HF in phase NYHA II-IV was included. Individual conversational interviews were carried out focusing on what it means to live with HF.

Results: This research has identified six essential topics that underlie the experience of living with HF: 1. To live with HF means a profound change in the life of a person, 2. The person that lives with HF must accept his situation, 3. The person with HF needs to feel that he has a normal life and have others perceive it that way, 4. The person with HF needs to live with hope, 5. To suffer HF means to have the thought of dying continually on one's mind and 6. For the person with HF, this disease has a negative influence on his surroundings.

Conclusions: 1) The methodology used (phenomenology of practice) and the paradigm of this research (humanist and unitary vision of the person) have contributed to capturing the essence of the phenomenon that underlies the experience of living with HF; 2) It is necessary to transition from the professional nursing practice that has been centered on the medical aspects to a practice in which the focus is on the "person" who is ill, bringing together

aspects of curing and healing; 3) This study opens up diverse lines of research on the phenomenon of living with HF and, 4) The complexity of assisting and caring for patients with HF and of the current health context indicates the need to interdisciplinarily address their care.

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Time vortex formation in a experimental heart failure rat model as an index of mortality.

P H Gacon¹

¹University of Bourgogne, service de cardiologie clinique et interventionnelle, DIJON, France

The aim of this study is to assess in a rat experimental model the prognostic value of a non invasive measure of left ventricular diastolic pressure and diastolic dysfunction with echocardiographic indexes in a model of heart failure. The experimental model will be done by clipping the transverse aortic cross (TAC) in 24 Wistar rats to obtain a pressure overload from the 15 days to the 90 days, operated rats were compared with sham animals during the study.

Methods: All the rats measurement protocols will be done under anesthesia (4mg/100g body weight). To accurately identify rats with the left ventricular filling pressures and diastolic dysfunction four measurements will be done with echocardiographic indexes, the ratio of early transmitral velocity flow (E) to early septal mitral annulus velocity flow (Ea) the mitral annulus diameter (D) the duration of E wave (t), the mean blood flow time average (U) the S annulus wave in DTI and also the Time Vortex Formation $T = t \times U / D$ and left ventricular relaxation time. Also the systolic parameters function were studied (LVEF, ventricular diameters cardiac output)

Statistical analysis: Data will be expressed as mean \pm SEM, the statistical analysis will be performed with the student's t test for paired and unpaired variates.

Results: diastolic dysfunction parameters were observed at 14 days in rats operated and also at 90 days with an interaction between the time and the group;

Left atrial diameter (6,37 mm \pm 0,82 vs 3,9 mm \pm 0,18; $p < 0,005$).

Left atrial surface (55 mm² \pm 2,34 vs 20,1 mm² \pm 2,04; $p < 0,005$).

S velocity wave (0,002 m/s \pm 0,004 vs 0,0043 m/s \pm 0,0006; $p = 0,05$)

Diameter annulus mitral (7,26 mm \pm 1,47 vs 3,81 mm \pm 0,57; $p = 0,005$)

Time Vortex Formation (2,60 \pm 0,57 vs 3,81 \pm 0,37; $p = 0,03$)

TRIVG (22,5 ms \pm 1,52 vs 19,3 ms \pm 1,02; $p < 0,005$)