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The Relationships Among Health Promoting Behaviors, Perceptions Of Health, And Quality Of Life In Elders With Atrial Fibrillation

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THE RELATIONSHIPS AMONG HEALTH PROMOTING BEHAVIORS, PERCEPTIONS OF HEALTH, AND QUALITY OF LIFE IN ELDERS WITH ATRIAL FIBRILLATION

by

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A Thesis
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THE RELATIONSHIPS AMONG HEALTH PROMOTING BEHAVIORS, PERCEPTIONS OF HEALTH, AND QUALITY OF LIFE IN ELDERS WITH ATRIAL FIBRILLATION

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Abstract

Atrial fibrillation is the most common cardiac arrhythmia affecting elders and contributes to increased risks of stroke and disability due to symptoms imposed. Chronic illness such as atrial fibrillation has been linked to years of damaging health behaviors that impact quality of life. Elders with atrial fibrillation may need assistance in coping with their illness as it may interfere with activities of daily living or impair accomplishment of developmental tasks. Further, old patterns of health behavior may be extinguished and new patterns learned to enhance health and well being. The purpose of this study was to define health-promoting behaviors, perceptions of health, and quality of life in elders with atrial fibrillation to develop a basis for development of guidelines for nurse practitioners in practice. Pender’s (1987) Health Promotion Model and Stevenson’s Theory of Development Tasks for the Four Stages of Adulthood were the theoretical frameworks for this descriptive correlational study. The settings located in rural Mississippi included a cardiac rehabilitation program, an internal medicine clinic, and a small community clinic. Data were gathered with researcher developed tools, the Health Perceptions Questionnaire, and the Health Promoting Lifestyle Profile II. The data were analyzed using the Pearson Product-Moment correlation coefficient and descriptive statistics. The sample population (N=18) ranged in age from 55 to 77 years with a mean age of 69.44 years. Most of the subjects (55.6%) were male, White (77.8%), and married (77.8%).
Educational level of subjects varied with 50.0% of the subjects having a high school education or less. Only two (11.1%) subjects did not have a coexisting illness and 77.8% took five or more medications. The first directional hypothesis, health promoting behaviors of elders with atrial fibrillation will positively correlate to perceptions of health, was rejected as no significant relationship emerged ($p = .514$) between the variables. The second directional hypothesis, health-promoting behaviors of elders with atrial fibrillation will positively correlate to perceptions of quality of life, was accepted as a positive correlation emerged ($p < .001$). The research question, what is the relationship between perceptions of health and quality of life in elders with atrial fibrillation, did not find significant correlation ($p = .221$). While health-promoting behaviors did not significantly correlate with perceptions of health, it did significantly correlate with quality of life. Also, perceptions of health did not significantly correlate with quality of life. Therefore, nurse practitioners should evaluate perceptions of health and quality of life separately for an accurate health assessment of the client. An evaluation of the client’s health perceptions also may reveal the likelihood of participation in health-promoting behaviors. One recommendation for future research involves the replication of this study with a larger sample size and increased collection time.
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Chapter I
The Research Problem

Atrial fibrillation has been determined to be the most common arrhythmia in elders and its incidence has been related to advanced age (Feinberg, Blackshear, Laupacis, Kronmal, & Hart, 1995). The chronic illness of atrial fibrillation affects approximately 5% of the population over the age of 60 (Jenkins & Bubien, 1996). While atrial fibrillation was more prevalent in men than women across the ages, the total number of men and women with atrial fibrillation was about equal due to the longer life expectancy of women (Feinberg et al., 1995). Atrial fibrillation is responsible for over a million hospital admissions a year (Bialy et al., as cited in Jenkins & Bubien, 1996), and doubles mortality (Kannel et al., as cited in Benjamin et al., 1994). The risk of stroke was greatly increased with atrial fibrillation and continued to increase with age (Feinberg et al., 1995). Atrial fibrillation is a contributing factor to disability in the elderly (Benjamin et al., 1994) and causes high levels of impairment (Wenger et al., as cited in Jenkins & Bubien, 1996).

Elders with atrial fibrillation may need assistance in coping with illness as it may interfere with activities of daily living or impair ability to accomplish important developmental tasks, such as adapting to aging or preparing for the much anticipated retirement. Nurse practitioners are primary care providers focused on disease prevention
and health promotion through education and counseling. They can assist the elder with atrial fibrillation by explaining the disease process and educating them about how to better care for themselves through diet, exercise, and compliance with medication regimens. As the number of elders with atrial fibrillation increases, so does the need for nurse practitioners to determine guidelines for support, guidance, and education for this chronic illness to the aging population. The focus of this study was to determine the relationship among the variables of health-promoting behaviors, perceptions of health, and quality of life in elders with atrial fibrillation to establish a basis for development of guidelines for nurse practitioners in practice to care for these clients.

Establishment of the Problem

Pender (1987) believed that chronic illness was the result of years of health damaging behaviors and unhealthy environments. Benjamin et al. (1994) substantiated this belief, concluding that many risk factors for cardiovascular disease, such as smoking, hypertension, congestive heart failure, and diabetes, also are risk factors for atrial fibrillation. These risk factors are related to years of health damaging behaviors such as eating foods high in fat and salt, excessive alcohol consumption, smoking, and a sedentary lifestyle. Elders with the chronic illness of atrial fibrillation should be assessed to determine their health behaviors and subsequently educated and counseled as needed to increase health promoting behaviors. "Frequently, old patterns of behavior must be extinguished and new patterns of behavior learned to enhance health and well-being" (Pender, 1987, p. 59).
Ferrini, Edelstein, and Barrett-Conner (1994) researched older adults' health beliefs and health behaviors and concluded that women and older subjects were more likely to be uncertain about what to do to stay healthy and were, therefore, less likely to make behavioral changes. Elders who reported positive health beliefs were more likely to make positive changes while those who reported confusion about health and lacked motivation were less likely to make positive behavior changes. By eliminating confusion about health and increasing motivation in elders with atrial fibrillation, nurse practitioners can increase the likelihood of behavioral changes. According to Pender (1987), motivation is critical to starting and maintaining health-promoting behaviors that enhance quality of life and assist in maintaining independence in elders.

Quality of life is another important aspect in the patient's treatment. Quality of life is the patient's prime concern and defined as whatever the patient says it is (Jenkins & Bubien, 1996). However, while there is no standard definition for quality of life, it is generally accepted as the measure of physical, social, and psychological aspects as well as symptoms and side effects (Aaronson, as cited in Kinney, Burfitt, Stullenbarger, Rees, & DeBolt, 1996). Individuals' quality of life is directly affected by their perceptions of health (Kinney et al., 1996). Whittle and Goldenberg (1996) found that elders become more dependent as health perceptions decline. Elders who have an illness cannot evaluate their quality of life without considering the impact the illness has on their health. Research on quality of life related to health strives to encompass the impact of illness on one's life (Jenkins & Bubien, 1996). Therefore, quality of life in elders with atrial
fibrillation is an important variable to monitor to determine the effects of this chronic illness on their health.

Significance to Nursing

In 1994, Hamer, Blumenthal, McCarthy, Phillips, and Pritchett concluded that it was the subject's perception of the illness rather than the illness itself that was disruptive to his/her life. Therefore, the nurse practitioner must be aware of the client's health perceptions and of the holistic care these patients require. Clients with atrial fibrillation need help coping with their illness and this can be done by teaching them the disease process, coping skills, how to decrease stress, and encouraging strategies to increase their involvement in self-management, such as diet, exercise, and compliance with medication regimens. Elder's families will likely be involved and should be included in the plan of care. Many clients may desire spiritual guidance or require counseling to help them deal with their illness effectively and in a healthy manner. The nurse practitioner is responsible for attending to the "whole" person and can assist the client with these concerns or refer to appropriate personnel.

Also, the nurse practitioner should be aware of the importance of continuing client education and reinforcement of the information with each visit. Elders frequently get confused because they don't see or hear well and many times are too embarrassed to ask for clarification. The nurse practitioner should be sure that the client has a clear understanding by giving written information as well as verbal instructions to increase the likelihood of understanding and compliance. Elders with chronic illnesses may be confused about what is healthy for them so they should be encouraged to continue
positive health practices and educated a little with each visit so as not to become overwhelmed with information and give up. Therefore, an evaluation of health behaviors and perceptions of present health would be good indicators on where to focus education efforts for elders.

Nursing research needs to continue to probe the depths of client’s feelings of self-worth. Treatment is without merit if the quality of life has not been improved. Through health-promotion, nursing positively affects clients and their families before illness is encountered. Nurse practitioners must remember that the best treatment is prevention through health promotion. For these reasons, it is important to study the relationships between health-promoting behaviors, perceptions of health, and quality of life in elders with atrial fibrillation.

The purpose of this study was to determine the relationship among the variables of health-promoting behaviors, perceptions of health, and the quality of life in elders with atrial fibrillation as a basis for practice guidelines for nurse practitioners. Understanding how the diagnosis of atrial fibrillation relates to these variables could lead to development of culture-based care with interventions to assist the elder in coping with this chronic illness.

Theoretical Framework

Pender's Health Promotion Model is the theoretical framework on which this study was based. Pender (1987) described health promotion as increasing the level of wellness, enhancing health. Health promotion was determined to be a continuous activity of the individual's everyday lifestyle. Pender described variables that affect the likelihood
of an individual participating in health promoting behaviors. These variables are related to two types of factors—cognitive/perceptual factors and modifying factors. The cognitive/perceptual factors have a direct influence on the likelihood of a person participating in health promoting behaviors and include the following: (a) the importance of health, (b) perceived control, (c) perceived self-efficacy, (d) definition of health, (e) perceived health status, (f) perceived benefits of health-promoting behaviors, and (g) perceived barriers to health-promoting behaviors. Because of the direct influence on the likelihood of participation in health-promoting behaviors, cognitive/perceptual factors must be carefully evaluated by the nurse practitioner in the elder with atrial fibrillation to ensure appropriately directed education and counseling. Determining the relationship among perceptions of health, health-promoting behaviors, and quality of life in the elder with atrial fibrillation will guide the nurse practitioner in providing more focused education and counseling to increase compliance.

The second element influencing health-promoting variables are the modifying factors. They have an indirect influence on the likelihood of an individual participating in health promoting behaviors and include: (a) demographic characteristics, (b) biological characteristics, (c) interpersonal influences, (d) situational factors, and (e) behavioral factors. Modifying factors relate more to the surroundings and circumstances that affect health behaviors rather than health beliefs affecting health behavior. The nurse practitioner should take modifying factors into consideration to better understand elders to increase cooperation and compliance. Participation in health-promoting behaviors is initiated by a cue to action. A cue is the personal awareness of the potential for an
increased level of wellness or enhanced health and may be the result of either information from friends, media, healthcare provider, or an internal awareness of potential for an increased level of wellness. The nurse practitioner can educate (cue) elders with atrial fibrillation on how to eat a better diet and prescribe an exercise program to increase the level of wellness. The benefits of such actions must be explained to increase the likelihood of compliance and heeding the cues to action. Pender (1987) has suggested that the described factors influence the individual's actions to the cue for increased level of wellness. If health-promoting behaviors can be positively correlated to quality of life as a result of this study, then there is researched based support for the nurse practitioner to take time to educate elders about the benefits of health-promoting behaviors.

Another theory relevant to this study is Joanne Stevenson's theory of Developmental Tasks for the Four Stages of Adulthood (Bellack & Edlund, 1992). Stevenson’s tasks of development are more closely related to today's aging population. The main areas of concern for today’s adult are: (a) family life and parenting, (b) work and recreation, (c) social involvement and community, and (d) responsibility and personal maturity. The stages relevant to this study’s population are the Developmental Tasks of Middlescence II, the new middle years, ages 50 to 70 and the Developmental Tasks of Late Adulthood, ages 70 and greater. The theory demonstrates the study's variables of quality of life and perceptions of health. The tasks relevant to this study are those that address availability of leisure time, adapting to the accelerated aging process, and preparing for retirement. Elders reaching the new middle years and late adulthood are looking forward to slowing down, spending time with family, spending time around the
house, and pursuing a new hobby or interest. Stevenson viewed adults as progressing through the developmental tasks in their own unique way and at their own pace. Because they progress at their own pace, they may overlap stages. Elders with chronic illness may not be able to progress into the next stage of development because of their chronic illness. Elders with atrial fibrillation may have disruptive symptoms and hospitalizations that will interfere with their achieving tasks of development or decrease their quality of life. Therefore, establishing a link between health-promoting behaviors and quality of life as a result of this study would be beneficial to developing guidelines of care of elders with atrial fibrillation to perhaps include interventions to assist elders to continue accomplishing their tasks of development with subsequent increased quality of life.

For elders with atrial fibrillation to have minimal complications and continued achievement in the tasks of development set forth by Stevenson, they must be participants in health-promoting behaviors advocated by Pender. Health-promoting behaviors can assist the elder in dealing with the physical and emotional turmoil that can be caused by a chronic illness such as atrial fibrillation. There needs to be an understanding by the nurse practitioner as to what stage in the tasks of development the client is in and what factors are preventing the client from achieving the tasks so that appropriate assistance may be offered.

Assumptions

The assumptions of the study were as follows:

1. Elders between 55 to 77 years of age are fulfilling the developmental tasks associated with the new middle years and late adulthood.
2. Cognitive/perceptual and modifying factors influence elders’ health-promoting behaviors, perceptions of health, and quality of life.

3. Elders with a diagnosis of atrial fibrillation engage in health-promoting behaviors.

4. Elders with a diagnosis of atrial fibrillation have perceptions of health and quality of life.

5. Health-promoting behaviors, quality of life, and perceptions of health are measurable.

Statement of the Problem

Elders with a diagnosis of atrial fibrillation have a higher risk of death, disability, and an impaired ability to complete developmental tasks. To better serve this population, healthcare providers need to have a better understanding of health-promoting behaviors, perceptions of health, and perceptions of quality of life in the elderly with atrial fibrillation. This understanding would assist the primary caregiver in implementing more appropriate care to assist the client with coping. Therefore, the purpose of this study was to initiate a basis of understanding about the relationship among the variables of health-promoting behaviors, perceptions of health, and quality of life in elders with atrial fibrillation for nurse practitioner practice.
Hypotheses and Research Question

Two hypotheses and one research question guided this study.

Hypotheses:

1. Health-promoting behaviors of elders with atrial fibrillation will positively correlate to perceptions of health.

2. Health-promoting behaviors of elders with atrial fibrillation will positively correlate to perceptions of quality of life.

Research Question:

What is the relationship between perceptions of health and quality of life in elders with atrial fibrillation?

Definition of Terms

The theoretical and operational definitions of terms used in this study are as follows:

1. Atrial fibrillation
   Theoretical: A cardiac arrhythmia characterized by disorganized electrical activity in the atria that causes quivering instead of pumping in an organized manner.
   Operational: A cardiac disrhythmia documented by self-report of previous diagnosis according to a physician or by EKG and recorded in the client’s chart.

2. Health-promoting behaviors
   Theoretical: Positive actions that help the client reach optimal level of functioning.
   Operational: Positive actions of elders assessed by the Lifestyle Profile II.
3. Quality of life

Theoretical: A multidimensional concept that is a measure of psychological, physical, social, and level of wellness as perceived by the individual.

Operational: Individual interpretation and perception of the elder as determined by a visual analogue scale.

4. Perceptions of health

Theoretical: An awareness of the physiological, psychological, and social condition of the client.

Operational: Elders' awareness of their health status as determined by the Health Perceptions Questionnaire.

5. Elder

Theoretical: An older person between the ages of 55 to 77, male or female.

Operational: An older person diagnosed with atrial fibrillation for at least four months, with coexisting chronic illnesses controlled.

These criteria were determined by a chart audit or self-report.
Chapter II

Review of the Literature

There has been much clinical research done related to atrial fibrillation. However, few studies have focused on the relationship of atrial fibrillation to quality of life, health behaviors and health perception in the elderly population. The following studies address some of the relationships of health behavior, quality of life, and health perceptions in the elderly population with atrial fibrillation.

Benjamin et al. (1994) examined subjects of the Framingham Heart Study for risk factors that would predispose them to atrial fibrillation. The study was based on 38 of 40 years of follow-up for the original cohort. The variables expressed were as follows:

(a) gender, (b) age, (c) smoking, (d) alcohol consumption, (e) body mass, and (f) health variables such as diabetes, electrocardiography left ventricular hypertrophy, hypertension, myocardial infarction, congestive heart failure, and valve disease. Valve disease was defined as a diastolic murmur or as a systolic murmur with a grade of 3/6 or more. Hypertension was defined as a diastolic pressure of 95 or more or a systolic pressure of 160 or more on two different readings. Incidental atrial fibrillation was defined as atrial fibrillation occurring up to the next exam.

The sample consisted of 2,090 men and 2,641 women between the ages of 55 and 94 years of age who had no history of atrial fibrillation. Data were obtained from records
of admissions with diagnosis of cardiovascular disease. A cardiologist diagnosed atrial fibrillation if an electrocardiogram indicated atrial fibrillation or atrial flutter. Subjects with a diagnosis of atrial fibrillation on routine exam were examined to look for risk factors of atrial fibrillation.

Each subject was examined every two years for history of atrial fibrillation. The age and gender-specific risk factors were measured and then evaluated by logistic regression models to determine those associated with onset of atrial fibrillation. Possible risk factors were adjusted for age and examined by gender bivariate models and then significant variables were put into gender specific multivariable models. The regression results were measured as odd ratios and population-attributable risks as follows:

\[
\frac{\text{prevalence (odds ratio-1)}}{\text{prevalence (odds ratio-1)+1}}.
\]

In order to examine the sex and risk factor relationship, the data for both sexes were combined and the sex-interaction terms were evaluated for atrial fibrillation risk factors. All insignificant interactions (p > .05) were discarded using backward elimination.

Benjamin et al. (1994) found that men had a 1.5 times greater risk of developing atrial fibrillation than women (p < 0.0001) The incidence of atrial fibrillation increased with age, almost doubling with every 10-year increment in age. Incidence also increased when the following variables were present: (a) diabetes in men (p < 0.01) and women (p < 0.0001), (b) left ventricular hypertrophy (p < 0.0001), (c) myocardial infarction (p < 0.01), (d) congestive heart failure (p < 0.0001), (e) hypertension (p < 0.0001), and
valvular heart disease \( (p < 0.0001) \). Alcohol and body mass were not significant factors related to the development of atrial fibrillation. Hypertension had the strongest correlation to the development of atrial fibrillation at a 14% chance for both sexes \( (p < 0.0001) \), and congestive heart failure had the second strongest correlation \( (p < 0.0001) \) with men having a 10% percent chance and women having a 12% chance of developing atrial fibrillation. Men had a 5% chance of developing atrial fibrillation post-myocardial infarction and women had a 1% chance of the same fate \( (p < 0.01) \), but women were much more likely to have valvular disease contribute to atrial fibrillation compared to men \( (p < 0.0001) \).

In conclusion, Benjamin et al. (1994) determined that valvular disease, congestive heart failure, diabetes, and hypertension were significant independent risk factors for the development of atrial fibrillation. The incidence of atrial fibrillation significantly increased with age and although men had a diagnosis of atrial fibrillation more often, women were significantly affected by atrial fibrillation.

The conclusion of the study suggests that prevention of diabetes, hypertension, and heart damage would reduce the incidence of atrial fibrillation. It is of interest to the current study to establish the prevalence of atrial fibrillation in elders and to establish risk factors for atrial fibrillation. Establishing risk factors allows for a focus in health behavior modification, as the established precursors are chronic illnesses known to be related to obesity and a sedentary lifestyle. Therefore, if health-promoting behaviors can be positively correlated to quality of life in the current study, then knowing risk factors for atrial fibrillation provides a focus for health behavior modification and then risk factors
can be reduced through teaching diet and encouraging exercise and no smoking to enhance their quality of life.

In 1994, Hamer et al. assessed the quality of life in patients with either paroxysmal atrial fibrillation or paroxysmal supraventricular tachycardia. The researchers sought to assess how patients with this type of arrhythmia cope and function with their disability.

The sample consisted of 69 subjects, of which 36 were women, with a diagnosis of paroxysmal atrial fibrillation or paroxysmal supraventricular tachycardia. The total number of subjects with atrial fibrillation was 26, of which 10 were women. The subjects were asked to complete tests to assess their behavior, mood, personality functioning, and adjustment to work and social life. The instruments used to gather data were the Health Locus of Control Scale, the Psychosocial Adjustment to Illness Scale, the State Trait Anxiety Inventory, the McGill Pain Inventory, the Coping Strategies Questionnaire, and the Hopkins Symptom Checklist.

The Health Locus of Control Scale is an 18-item true/false questionnaire that measures to what extent subjects think their health depended on the power of others, chance, and internal control. The Psychosocial Adjustment to Illness Scale measured the quality of adjustment to an illness by use of a 4-point Likert scale covering the areas of healthcare orientation, domestic and social environments, vocational, and sexual functioning. The State Trait Anxiety Inventory used a 4-point scale in a 20-item instrument to measure the subjects’ present level of anxiety. The McGill Pain Inventory measured pain in the dimensions of sensory, affective, and evaluative using listed...
adjectives in 20 different categories. The Coping Strategies Questionnaire is an instrument that measures six different strategies for coping with pain including:
(a) diverting attention, (b) reinterpreting pain sensations, (c) coping self-statements, (d) praying or hoping, and (e) catastrophizing. It also evaluates the increasing behavioral activity level, the amount of control over pain, the amount of pain decrease, anticipation of symptoms, and the amount of disturbance the symptoms cause in everyday life. The Hopkins Symptom Checklist is a 90-item instrument that evaluates emotional distress and psychopathology using a 5-point rating scale.

The subjects with paroxysmal atrial fibrillation and paroxysmal supraventricular tachycardia were analyzed as group data. Subjects were grouped on the basis of how disruptive their symptoms were to them, which was determined by a rating scale of 0-6. Those who were ≥ 3 on the scale (n = 47) were classified as "high" and those who were ≤ 2 (n = 22) were classified as "low."

Hamer et al. (1994) compared the high-disrupt group to the low-disrupt group using a one-way analysis of variance for each tool. There was no separation of gender for the analysis. The data were expressed as mean ± standard deviation. There was no significant difference in age between the high and low groups (54 ± 14 vs 51 ± 17 years). There was no significant difference in the number of years of symptoms (16 ± 13 vs 17 ± 13 years) or the total episodes in the last three months between the groups (1.1 vs 2.0 episodes). The Health Locus of Control subscales also indicated no significant difference between the groups (internal control, 24.02 ± 6.77 vs 24.41 ± 4.43, F [1,67] = 0.06,
\[ p = 0.81; \text{power of others, } 19.4 \pm 5.36 \text{ vs } 17.82 \pm 5.60, F_{[1,67]} = 1.28, p = 0.26; \text{chance, } 7.26 \pm 3.22 \text{ vs } 7.41 \pm 3.46, F_{[1,67]} = 0.03, p = 0.86). \text{Also, there was no significant difference between the high-disruptive and the low-disruptive groups on the State Trait Anxiety Index (33.65 \pm 8.0 \text{ vs } 32.32 \pm 7.33, F_{[1,66]} = 0.44, p = 0.51).}

The total pain scores were higher for those who reported their symptoms as disruptive \( (F_{[1,67]} = 5.37, p < 0.03) \), as were the McGill evaluative and affective scores \( (F_{[1,67]} = 6.82, p < 0.02) \) and \( (F_{[1,67]} = 6.71, p < 0.02) \). These subjects scored higher on the following subscales of the Coping Strategies Questionnaire: diverting attention \( (F_{[1.67]} = 10.71, p < 0.002) \) and catastrophizing \( (F_{[1,67]} = 7.30, p < 0.009) \). The more disruptive group score was higher on the Somatization subscale \( (F_{[1,67]} = 7.56, p < 0.008) \) and was lower on Domestic Environment subscale of the Psychological Adjustment to Illness \( (F_{[1,50]} = 6.69, p < 0.02) \) which indicates this group was not as well adjusted at home as the low-disruptive group.

Hamer et al. (1994) concluded that most patients with a paroxysmal supraventricular arrhythmia were basically well adjusted. They found that anxiety was within normal range as well as depression and other subscales of the Symptom Checklist-90. However, greater than two-thirds of the subjects felt that their symptoms were moderately disruptive to their lives. The more disruptive group also reported more pain. They tended to cope by diverting and catastrophizing, which are strategies not as effective in reducing distress. Hamer et al. (1994) determined that it is the subject’s perception of the illness rather than the illness itself that is disruptive to daily life. They suggested that teaching coping skills and strategies to reduce stress may decrease the
degree of disruptiveness to the patient. This study demonstrated a relationship between the health behavior of ineffective coping and the resulting perceived disruptiveness of the illness in their lives. These issues are germane to the current research that focuses on the relationship between health-promoting behaviors and perceptions of health in an elderly population with the chronic illness of atrial fibrillation.

In 1994, Ferrini et al. studied the relationship between health beliefs and health behaviors in older adults. The purpose of the study was to assess the relationship between health-related beliefs and behavior change in an older, educated population.

The design was descriptive correlational. The participants were part of the Rancho Bernado Heart and Chronic Disease Survey that was an ongoing study to assess lifestyle and chronic disease in educated, upper-middle-class elders. The sample consisted of 1,032 men with an average age of 70.6 years and 1,394 women with an average age of 71.3 years. Subjects completed a mailed questionnaire about health behavior change, health attitudes, and health maintenance practices. The behavioral change data were collected by, first, answering questions about changes in the past 15 years related to salt and fat intake and daily exercise. Secondly, questions about self-help books and dietary changes in the past year were completed. Data on health beliefs were collected by using a modified 1989 Gallup Poll. The subjects agreed or disagreed to five statements related to general health, financial health, motivational health, and confusion about health. Data were analyzed using two-tailed chi-squared tests by gender, then by cohort age group and gender.
Ferrini et al. (1994) compared the genders for frequency of behavior change and found women more likely to have consumed less salt and fat ($p < 0.05$), to have changed diet ($p < 0.01$), and to have read self-help material ($p < 0.001$) than men. The sample was then divided in two age groups for analysis, one 50 to 69 years of age and the other 70 to 89 years of age. The younger group was more likely to have consumed less salt and fat, increased exercise, and changed diet ($p < 0.001$). The inclination remained the same when the age groups were separated by gender. The younger men were more likely to have consumed less salt and fat and changed diet ($p < 0.001$) than the older men. Also, the younger women were more likely to have consumed less salt ($p < 0.01$) and fat ($p < 0.001$), to have increased exercise ($p < 0.001$), and changed diet ($p < 0.01$).

When analyzing the frequency of agreement of health beliefs by gender, Ferrini et al. (1994) found that women tended to report more lack of motivation ($p < 0.01$) and confusion about health habits ($p < 0.05$) than men. The older group also indicated more confusion about health beliefs ($p < 0.001$) and lack of motivation ($p < 0.01$) than the younger group. When the age groups were divided by gender the trends remained similar. The younger men and women indicated more motivation ($p < 0.05$) and less confusion ($p < 0.001$) than older men and women.

Ferrini et al. (1994) found that men and women who agreed that good health practices were important were inversely correlated with those who exercised less ($p < 0.05$). There was also a decreased salt intake in women ($p < 0.01$). Men who agreed that they would spend money on their health consumed less fat ($p < 0.001$), salt ($p < 0.01$), and read more self-help material ($p < 0.001$). Women also had less fat intake
Lack of motivation positively correlated with less exercise in men and women (p < 0.001) and negatively correlated with increased exercise in men (p < 0.01) and women (p < 0.001). Women who reported confusion about what healthy foods to eat were not likely to exercise (p < 0.001) or read self-help material (p < 0.001). Men also were less likely to read self-help material (p < 0.05) when reporting confusion about diet. Confusion about positive health practices correlated with a decrease in exercise in women (p < 0.05). Older women 70-89 years old who agreed personal health practices were important tended to exercise more (p < 0.05).

Ferrini et al. (1994) concluded that women and older respondents were more likely to report confusion about what to do to stay healthy and, as a result, were less likely to make behavioral changes. The sample was, overall, willing to spend money for their health. Those who reported positive health beliefs tended to report positive changes in health behavior, while those who reported confusion about health and motivational problems were not as likely to report positive behavior changes. The differences in health beliefs between the sexes were small. The authors attributed this finding to the higher educational level of these subjects since other studies they reviewed did not agree with this finding.

Ferrini et al. (1994) focused on elders’ health behaviors and how health beliefs affected them. These issues are germane to the current research which sought to further evaluate elders’ health behaviors and perceptions in a population diagnosed with atrial fibrillation.
In 1993, Moore, Newsome, Payne, and Tiansawad investigated the relationship between perception of health and quality of life in the elderly as investigated by nurse researchers. The main purpose of the study was to examine the focus, designs, theoretical bases, statistical methods, and research findings on the relationship between perceptions of health and the quality of life in elders as investigated by nurse researchers during the period from 1987 to 1991. The research questions generated were as follows:

Have nurse researchers recognized the relationship of these variables and designed studies that examine the subject in greater depth?

Have nurse researchers progressed toward theory-generating or theory testing research in relation to quality of life and perceived health?

What is the link between theory and research in the current work on this topic? (Moore et al., 1993, p. 8)

Nursing was defined as “the diagnosis and treatment of human responses to actual or potential health problems” (Moore et al., 1993, p. 9). Nursing research was defined as a process of investigation or experimentation that includes a statement of purpose, research question or hypothesis, methodology, findings, and conclusions or implications, and contributes to the body of nursing knowledge. Nursing practice research was defined according to the American Nurses Association’s definition as “a systemic investigation of research questions or hypotheses pertaining to assessment of the patient, interventions, or nurse-patient interaction” (p. 9). Quality of life as defined by the Institute of Medicine as a “sense of well-being, level of satisfaction with life, and feeling of worth and self-esteem” (p. 9). Perceived health is an individual’s subjective self-assessment of physical and mental well-being. Gerontological nursing research was considered a qualified study if the subjects were at least 50 years old.
The sample consisted of 17 articles from seven nursing research journals from 1987 to 1991 that met the criteria. The criteria included identifying the article as nursing research, including the phrases “quality of life” and “perception of health”, and the subjects had to be at least 50 years of age. A 32-item instrument, the Nursing Practice Research Analysis Tool, was used for analysis of the articles. Each article was read and scored separately by two different writers. If differences were found between the two writers, they would discuss the difference and if it remained unresolved, then a third writer would be included to read and score the article. Fourteen of the 17 articles were assessment articles and three were intervention-oriented studies. Subjects of 13 studies were male and female and the other four studies had female subjects only. Three of the studies used a nursing theoretical framework, while seven used theory from other disciplines. Half of the theories or models were descriptive and the rest were explanatory. Seven of the studies did not discuss theory, while four did minimally, and four others used theory as a framework, while two actually tested concepts of a model. Theory fitting was found in five of the studies and one tested theory. Eight of the studies used multivariate analysis, six used bivariate analysis, one used univariate analysis, one used qualitative analysis, and one used triangulation. The term quality of life appeared in two articles, while other terms such as “happiness”, “life satisfaction”, and other terms meaning quality of life appeared in the other articles. The term perceived health appeared in seven articles. There were other acceptable indicators of perceived health, both mental and physical, such as perceived physical health, measurements of activities of daily living, and subjective lack of depression to name a few.
Some of the qualitative findings identified by Moore et al. (1993) included perceived health as a significant predictor of a positive outlook, life satisfaction, or self-actualization, mental health as the best predictor of hope and physical health as the best predictor of mental health. A positive or inverse relationship between the variables was demonstrated in seven of the studies. Self-transcendence was correlated with mental health in one study and in another study life satisfaction and perceived health were determined to be good indicators of wellness. Another study found the best predictor of perceived health was retirement attitudes. Physical health and mental health were found to have a strong positive correlation. A negative correlation was demonstrated between developmental resource levels and depression. Self-esteem and depression were negatively correlated, while this same study demonstrated that social support and religious participation were positively correlated to quality of life. In six of the studies, no relationship was shown between perception of health and quality of life. An increased choice and control positively correlated to increased well-being even if health status was decreased. Quality of life was increased with meditation and relaxation skills, yet perceived health was unchanged.

In conclusion, Moore et al. (1993) found a strong positive relationship between perception of health and quality of life in elder samples. Based on these results, Moore et al. suggested that nurses must reflect this knowledge in practice by recognizing the importance of self-perceived health in elder patients. Moore et al. indicated a need for more nursing theory as framework for nursing research. They also recommended more experimental research to develop and test interventions as well as having larger sample
sizes and more randomization to obtain more generalized results. Also, older male
subjects need to be included more in quality of life research. The importance and
significance of the relationship between the perceptions of health and quality of life in the
elderly population parallel the current research that also investigated the relationship
between perceptions of health and quality of life in elders with atrial fibrillation.

Another study on atrial fibrillation by Furberg et al. (1994) used the
Cardiovascular Health Study data to describe the prevalence of atrial fibrillation in
elderly patients. The purpose of the study was to describe the prevalence of atrial
fibrillation, to compare the prevalence among subjects with and without clinical and
subclinical cardiovascular disease, and identify correlates of atrial fibrillation in an
elderly population sample. Atrial fibrillation was defined by electrocardiograph and by
self-report of having been told by a physician that they had atrial fibrillation. A diagnosis
of cardiovascular disease was made by history of any of the following: (a) myocardial
infarction, (b) silent myocardial infarction diagnosed by electrocardiogram, (c) angina,
(d) stroke, (e) transient ischemic attack, (f) congestive heart failure, (g) intermittent
claudication, (h) coronary angioplasty, (i) carotid endarterectomy, and (j) bypass surgery
or angioplasty of arteries in the leg. A diagnosis of subclinical atrial/valvular disease was
made according to abnormal mitral or aortic valve function or abnormal left atrial
dimension. Abnormal left ventricular wall motion or abnormal ejection fraction per
echocardiogram or a left ventricular mass in the 80th percentile by gender was evidence of
subclinical ventricular disease. Ultrasound-defined carotid stenosis, ankle-arm index
<0.9, or gender-specific common or internal carotid mean intimal-medial thickness above
the 80th percentile indicated subclinical atherosclerotic disease. Diabetes was diagnosed by self-report of a previous diagnosis and current use of insulin or oral hypoglycemics, or fasting blood glucose levels ≥ 140 mg/dl or 2-hour post prandial glucose ≥ 200 mg/dl. In subjects not meeting the criteria for diabetes, impaired glucose tolerance was defined as a 2-hour glucose ≥ 140 mg/dl. Hypertension was defined by self-report of a previous diagnosis by a physician and current treatment with antihypertensives.

The sample of the Cardiovascular Health Study included 5,201 men and women who were 65 years of age or older which were obtained from a random sample of subjects chosen from the Health Care Financing Administration Medicare eligibility lists of four communities. The enrolled group was 94.7% Caucasian, 4.7% African American, and 0.6% other ethnic groups. The subjects answered standard questionnaires about personal habits, hospitalizations, and past medical history. Twelve-hour fasting blood glucose levels were drawn on all subjects and a 75 gram oral glucose load was given to the nondiabetic subjects with subsequent two-hour blood glucose levels drawn. Blood pressures were measured after the subjects had been seated for five minutes with measurements taken in the right arm and then in the supine position on both arms and legs. The resulting ratios were used as indicators of peripheral arterial disease. Twelve-lead resting electrocardiograms were recorded on all participants using a recorder that stored the data electronically. The data were then transmitted daily to the electrocardiography reading center for analysis.

Furberg et al. (1994) discovered that 4.8% of the women and 6.2% of the men had atrial fibrillation. The prevalence of atrial fibrillation increasing with age was only
significant in women ($p<0.0001$). Clinical diseases included congestive heart failure, stroke, myocardial infarction, angina, or valvular heart disease. Subclinical disease included atrial/valvular disease, ventricular disease, and atherosclerotic disease. Women with clinical disease had a total incidence of 8.7% of atrial fibrillation which accounted for 54% of the atrial fibrillation cases, while subclinical disease had an incidence rate of 4.5% and accounted for 40% of the cases and those with no disease had an incidence rate of 1.1% and accounted for 6% of the atrial fibrillation. Men with clinical disease had an incidence of 9.4% and accounted for 60% of the atrial fibrillation, while those with subclinical disease had an incidence rate of 4.7% and accounted for 31% of the cases and those with no disease had a 2.7% incidence rate and accounted for 9% of the atrial fibrillation. Atrial fibrillation was significantly correlated with increasing age ($p<0.05$), male gender ($p<0.05$), history of myocardial infarction ($p<0.05$), congestive heart failure ($p<0.05$), valvular heart disease ($p<0.05$), stroke ($p<0.05$), and angina ($p<0.05$). However, after multivariate analysis, only congestive heart failure, age, valvular heart disease, and stroke were significantly associated with atrial fibrillation ($p<0.05$). Subclinical diseases that showed significant univariate relationships with atrial fibrillation ($p<0.05$) included mitral stenosis, aortic regurgitation, large left atrial dimension, abnormal ejection fraction, abnormal left ventricular wall motion, and left ventricular mass. However, after multivariate analysis, only mitral stenosis, aortic regurgitation, and large left atrial dimension showed independent associations with atrial fibrillation ($p<0.05$). Significant univariate relationships were demonstrated between hypertension, diabetes, and fasting
glucose and atrial fibrillation. After multivariate analysis, only hypertension remained a
significant independent risk factor \( p<0.05 \).

Furberg et al. (1994) concluded that atrial fibrillation was strongly associated with
independent factors such as congestive heart failure, valvular heart failure, and stroke.
Atrial fibrillation also was associated with some subclinical heart diseases, especially
atrial/valvular disease. Atrial fibrillation was very rare in the absence of clinical or
subclinical heart disease. Hypertension was one of the most common predictors of atrial
fibrillation.

Furberg et al. (1994) demonstrated the rarity of atrial fibrillation when not in the
presence of heart disease. The modifiable risk factors of clinical and subclinical
cardiovascular diseases such as hypertension, congestive heart failure, stroke, and angina
can be modified through health promotion. The current study investigates the health
beliefs and health behaviors and their relationship in the elderly population with atrial
fibrillation to develop guidelines for practice to prevent or treat atrial fibrillation through
health promotion and to treat the client more holistically by observing their health beliefs.

A study by Whittle and Goldenberg (1996) investigated functional health status
and instrumental activities of daily living (IADL) in the noninstitutionalized elderly. The
purpose of their research was to determine any relationship between functional health
status and dependencies in IADLs in the elderly. The research questions that guided the
study were as follows.

What is the relationship between IADL dependence and: 1) health status variables
(physical functioning, role limitations, social functioning, mental health/emotional
well-being, energy/fatigue, pain, and health perception)? 2) specific medical
conditions (such as arthritis, heart disease, chronic lung disease)? 3) vision or hearing impairment (sensory-perceptual capacity)? 4) demographic characteristics of age, gender, education, and living arrangements? (Whittle & Goldenberg, 1996, p. 222)

A descriptive correlational design was employed in the study. The sample was one of convenience and consisted of 47 subjects who ranged in age from 70 to 93 and were noninstitutionalized. Most of the subjects were female and widowed. Chronic conditions included arthritis, angina, hypertension, and chronic lung problems.

Instrumentation included a demographic questionnaire, the Multidimensional Functional Assessment Questionnaire Instrumental Activities of Daily Living Scale (MFAQ/IADL) and the Health Status Questionnaire (HSQ). The MFAQ/IADL assesses, by self-report, the ability to use the telephone, shopping, preparing meals, housekeeping, taking medication, handling finances, and transportation without help, with some help, or unable to perform task. The HSQ measures eight concepts of health: (a) physical functioning, (b) role limitations attributed to physical or emotional problems, (c) social functioning, (d) mental health/emotional well-being, (e) energy/fatigue, (f) pain, and (g) health perception. The higher the score obtained, the higher the level of functioning of the respondent.

The statistical package for the Social Sciences programs was used to perform the statistical analysis. The relationship between functional health status and performance of the IADLs were tested using inferential statistics. Whittle and Goldenberg (1996) found that for IADL dependency, approximately 39% of the elder subjects were dependent in the area of housekeeping and about 15% were dependent in the area of transportation.
More than 85% of all subjects were independent in all IADLs except housekeeping. Means for the HSQ were lower than expected for the variables of pain, role limitations related to physical health problems, and mental health/emotional well-being, while health perception was higher than expected in a healthy population. The physical functioning, social functioning, and energy/fatigue level means were representative of healthy population scores.

The researchers determined that for question one subjects reported a significant decrease \((p=0.009)\) when they compared present health status to health status of one year ago. Also, IADL dependency was significantly associated with physical functioning \((p=0.001)\), role limitations attributed to physical problems \((p=0.001)\), social functioning \((p=0.01)\), energy/fatigue \((p=0.01)\), pain \((p=0.01)\), and health perception \((p=0.001)\). Better social functioning significantly correlated with less fatigue and pain, better mental health, better perception of health, and fewer role limitations. Better physical functioning significantly correlated with less pain, fatigue, fewer role limitations, and better social functioning. Positive health perceptions also correlated well with better social functioning, better mental health, increased energy levels, fewer role limitations, and emotional well-being.

For question two, of the medical conditions associated with IADL dependency, only stroke was significantly correlated to IADL dependency of transportation \((p=0.02)\) and housekeeping \((p=0.012)\), and for question three, no significant relationship emerged between IADL dependency and hearing or visual impairments possibly due to access of hearing aids and eyeglasses as needed under the Canadian health care system.
The results to question four were obtained using Pearson’s r. A significant relationship existed between increased age and housekeeping dependency ($p = 0.001$). The older the subjects, the more dependent they were for housekeeping assistance.

Whittle and Goldenberg (1996) concluded that social functioning, physical functioning, and health perceptions were significantly related to IADL dependency. Elderly people become more dependent in the areas of housekeeping, shopping, and transportation as health perception and functional status decline. Increasing age and the number of medical conditions did not affect the subjects’ level of independence. These results were relevant to the current study that further explored the relationship between the perceptions of health and quality of life in elders with atrial fibrillation.

Summary

The reviewed articles were germane to the current research that further evaluated the relationship among health promoting behaviors, health perceptions, and quality of life in elders with atrial fibrillation. According to Furberg et al. (1994), approximately 5% of women and 6% of men have atrial fibrillation. This determination corroborated other studies’ findings that atrial fibrillation is most commonly present in the company of clinical or subclinical cardiovascular disease. Without clinical or subclinical heart disease, the incidence of atrial fibrillation has been a mere 1.1%. Several modifiable independent risk factors for atrial fibrillation, including valvular disease, congestive heart failure, diabetes, and hypertension, were well established by Benjamin et al. (1994).

Other researchers focused on perceptions of health, quality of life, and health behavior. In 1994, Ferrini et al. established a relationship between health beliefs and
health behavior change in the older adult and subsequently suggested initiating health promotion campaigns to reduce confusion about health behaviors. Hamer et al. (1994) determined that the perception of illness is more disruptive than the illness itself, and as a result, suggested that teaching health-promoting skills such as coping and stress reduction might improve their perception of health. In 1993, Moore et al. found a strong positive relationship between perceptions of health and quality of life in the elderly. A few years later, Whittle and Goldenberg (1996) concluded that health perception was a significant factor in the elderly maintaining independence. These studies support the current study’s endeavor to develop a better understanding of how perceptions of health, health-promoting behaviors, and quality of life are interrelated. A better understanding of the relationship among these variables could be a basis for improved care in the nurse practitioner practice.
Chapter III

The Method

The purpose of this study was to determine the relationship among perceptions of health, health promoting behaviors, and quality of life in elders with a diagnosis of atrial fibrillation. This chapter identifies how the variables of interest were studied. The design of the study, the setting, the population, the methods of data collection, the instrumentation, the procedures, and the methods of data analysis are detailed.

Design of the Study

A descriptive correlational design was used to determine and describe the relationship among the variables of interest including health-promoting behaviors, perceptions of health, and quality of life in elders with atrial fibrillation. According to Polit and Hungler (1995), the main purpose of descriptive correlational research is to describe the relationship between variables without inferring a cause and effect relationship. No variables were manipulated in this study. Intervening variables may have included situational factors such as state of physical and mental well-being and the degree of honesty of the subjects. Controlled variables included age and diagnoses.

Setting

The proposed sites for data collection were an internal medicine clinic and a family medical clinic located in a small college town in rural Mississippi. However, there
were insufficient numbers of patients who met the subject criteria at the family clinic. Difficulty in locating qualified subjects resulted in the addition of two more collection sites, a cardiac rehabilitation program and a small community clinic. All three sites were located in rural Mississippi.

The internal medicine clinic was located in a small college town and was a busy 10-room facility in which the primary care providers saw between 90 and 110 clients a day. The general clientele were fairly evenly split between the middle- to upper-class and the lower-socioeconomic-class. The age of the population ranged from age 16 through 100+ years. Patients were treated for a variety of diagnoses, with most of the elderly having comorbidity. Clients were referred from nearby family practices and many were walk-ins. Two internists, a gastroenterologist, and a family nurse practitioner were the primary healthcare providers in this clinic.

The cardiac rehab program was in a hospital-owned fitness center approximately 250 feet from the hospital. The hospital was located in a small college town. The cardiac rehab program had about 70 clients enrolled and the ages ranged from 48 to 89 and was staffed with a registered nurse and an assistant. It was equipped with cardiovascular intensive equipment such as treadmills, stationary bicycles, and air dynes. Cardiac monitoring equipment was available to monitor clients while they exercise or before and after they exercise. The nurse was certified in Advanced Cardiac Life Support and the necessary equipment was kept in the exercise room.

The last site was a small community clinic located about 13 miles from the nearest town. It was a busy 8-room facility in which primary care providers saw 70
clients a day. The majority of the clientele were of the lower-socioeconomic-class.

Clientele ranged in age from infant through the geriatric population. There were a wide variety of diagnoses, with many of the elderly having comorbidity. Two family nurse practitioners and one medical doctor were the primary healthcare providers at this facility.

Population/Sample

The proposed population was elders age 55 to 65 of either gender who had a diagnosis of atrial fibrillation for at least one year, controlled coexisting chronic illnesses, and a creatinine level of less than two. However, due to the difficulty in locating qualified subjects, the age range was redefined to include subjects between the ages of 55 to 75. Continued difficulty in locating subjects forced the researcher to extend the age to 77 years of age. Also, for the same reason, the period of time since the date of diagnosis was shortened from one year to four months. A creatinine level was not attainable on all subjects because charts were not available on subjects contacted at the rehab program. Therefore, this criterion also was dropped. The final inclusion criteria were age 55 to 77 of either gender, diagnosis of atrial fibrillation for at least four months, and coexisting chronic illnesses controlled.

The sample was one of convenience and included elders who met the inclusion criteria, agreed to participate in the study, and were clients of the participating clinics or cardiac rehab program. The target sample size was 50. The actual sample was 18.

Instrumentation

The instruments used to measure variables of interest were a researcher developed Demographic Data Sheet (see Appendix A), a researcher developed Chart Audit Sheet
(see Appendix B), the researcher developed Demographic Data Sheet II (see Appendix C), the Health Perceptions Questionnaire (see Appendix D), and the Health-Promoting Lifestyle Profile II (see Appendix E). A letter to the authors of the Health-Promoting Lifestyle Profile II was sent (see Appendix F), and permission forms were subsequently received. Permission was granted December 8, 1997 to use the Health-Promoting Lifestyle Profile II (see Appendix G).

The Demographic Data Sheet was used to gather information regarding age, sex, race, education, marital status, and the quality of life information. A 100-millimeter visual analog scale on the Demographic Data Sheet measured perceived quality of life between the limits of extremely poor and excellent. It was scored by percentile. The Chart Audit Sheet was used to gather information regarding diagnosis of atrial fibrillation, and coexisting illnesses with treatment. The Demographic Data Sheet II was used to gather data when a chart audit was not possible as it required additional information, such as first diagnosis with atrial fibrillation, medications presently taking, and a list of coexisting health problems. It too included the visual analog for quality of life assessment.

The Health Perceptions Questionnaire (Ware, 1976) is a self-administered, 32-item questionnaire that provides information about health beliefs. It consists of a 5-point response scale that ranges from 1, assigned to definitely false, to 5, assigned to definitely true. Responses are summed and scores can range from 32 to 160. The higher the score, the more positive the health beliefs, and the lower the score, the more negative the health beliefs. Two of the first field test populations were used to estimate the reliabilities of the
individual items. They were estimated by test-retest correlation and the results ranged from 0.19 to 0.77 with the majority falling between 0.4 and 0.6. Reliability of the scales and subscales was estimated by internal consistency reliability coefficients and results ranged from 0.45 to 0.92 (Ware, 1976). The questionnaire was retyped in larger print and copied on light peach paper to facilitate reading for the elders.

The Health-Promoting Lifestyle Profile II (S. N. Walker, personal communication, December 8, 1997) is a self-administered, 52-item instrument that measures health-promoting behavior. A 4-point response format measures the frequency of health behavior in the areas of health responsibility, physical activity, nutrition, spiritual growth, interpersonal relations, and stress management. The responses are as follows: N for never, S for sometimes, O for often, and R for routinely. For scoring purposes, four points are given to routinely (R), three points are given to often (O), two points are given to sometimes (S), and one point is given to never (N). A score for each of the six areas of health is obtained by calculating a mean for the responses of the subscale items. An overall score is obtained by calculating a mean of the scores to all the responses. The higher the score, the more the respondents participated in health-promoting behavior, and the lower the score, the less they participated in health-promoting behavior. The validity scores are not presently available on this revised instrument. However, the Cronbach’s alphas which are a measure of reliability are as follows: health responsibility (.861), physical activity (.850), nutrition (.800), spiritual growth (.864), interpersonal relations (.872), stress management (.793), and total Health-Promoting Lifestyle Profile II (.943; S. N. Walker, personal communication, December 8,
The questionnaire was retyped in larger print and copied on light peach paper to facilitate reading by the elders.

Data Collection

Permission to conduct this study was obtained from the Mississippi University for Women Committee on Use of Human Subjects in Experimentation (see Appendix H). Permission to conduct the study at the clinical sites was obtained by written consent from the doctors and nurse practitioners at those settings (see Appendix I). Also, permission was obtained from the hospital administrator to conduct research in the cardiac rehab program (see Appendix J). Appointments were made with the clinics and the cardiac rehab program for data collection times. Prospective subjects were contacted in the exam rooms and in the exercise room of the rehab program. Consent was obtained (see Appendix K) from elders who met the criteria for study inclusion after an explanation of the study had been given. The researcher assured anonymity and the consent forms were kept separate from the instruments. The researcher administered the instruments to the elders in the exam rooms. While the subject was completing the instruments, the researcher audited the chart, if available, for required information in the same room with the subject. This allowed the investigator to be able to assist a subject with filling out the questionnaire if needed. The type of assistance given included reading the instructions, reading questions, or reading responses. If the chart was not audited in the room, then the investigator periodically checked on the subject to monitor progress as well as assist in any way necessary to facilitate his/her completing the questionnaire. Participants completed the Demographic Data Sheet or the Demographic Data Sheet II, the Health-
Promoting Lifestyle Profile II, and the Health Perceptions Questionnaire, and the researcher completed the Chart Audit Sheet when applicable. A number was assigned each subject and that number was put on each of the questionnaires and audit sheet and left off of the consent form to assure anonymity. The completed instruments were kept in the researcher’s home.

Data Analysis

Descriptive statistics of means, frequencies, and percentages were used to determine the relationships among the variables of health perceptions, quality of life, and health behaviors in elders with atrial fibrillation. Demographic variables and other variables of interest such as number of medications and comorbidity were also included in the analysis. Scores were determined for the subscales of the Health-Promoting Lifestyle Profile II as well as for the entire instrument. Scores for the Health Perceptions Questionnaire and the quality of life visual analog scales were also determined. Scores were subsequently compared to each other for correlation. The product-moment correlation coefficient was appropriate to test the hypotheses and to evaluate the research question because the variables were of interval and ratio measurements.
Chapter IV

The Findings

The purpose of this descriptive study was to determine the relationship among the variables of health-promoting behaviors, perceptions of health, and quality of life in elders with atrial fibrillation to establish a basis for development of guidelines for nurse practitioners in practice. Data were gathered through the use of researcher developed Demographic Data Sheet, Chart Audit Sheet, and Demographic Data Sheet II, the Health Perceptions Questionnaire, and the Health Promoting Lifestyle Profile II. The Demographic Data Sheet and the Demographic Data Sheet II contained a 100-millimeter visual analog scale to measure quality of life. A description of the sample and results of data analysis are presented in this chapter.

Description of Sample

The convenience sample \((N=18)\) consisted of subjects who met the criteria of being between the ages of 55 and 77, a diagnosis of atrial fibrillation for at least four months, and control of coexisting illnesses. The sample ranged in age from 55 to 77 years with a mean age of 69.44. Eight (44.4%) of the participants were female and 10 (55.6%) were male. Fourteen (77.8%) of the subjects were White and four (22.2%) were Black. Fourteen (77.8%) were married, two (11.1%) were widowed, one (5.6%) was divorced, and one (5.6%) was single. Education varied among the subjects. Five (27.8%) of the
subjects had less than a high school education, four (22.2%) had a high school education, four (22.2%) had less than a bachelor's degree, one had a bachelor's degree (5.6%), and four (22.2%) had graduate degrees. Only two (11.1%) did not have a coexisting illness, while eight (44.4%) had single comorbidity and eight (44.4%) had multiple comorbidity.

Table 1 illustrates summary of the most common diagnoses.

Table 1

<table>
<thead>
<tr>
<th>Diagnosis</th>
<th>Single Comorbidity</th>
<th>Multiple Comorbidity</th>
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</thead>
<tbody>
<tr>
<td>Hypertension</td>
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<td>5</td>
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<tr>
<td>Congestive heart failure</td>
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<td>2</td>
</tr>
<tr>
<td>Post myocardial infarction</td>
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<td>1</td>
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<td>Diabetes Mellitus</td>
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<td>Hyperthyroidism</td>
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<tr>
<td>Benign prostatic hypertrophy</td>
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<td>2</td>
</tr>
<tr>
<td>COPD(^a)</td>
<td>1</td>
<td>1</td>
</tr>
</tbody>
</table>

\(^a\)COPD = chronic obstructive pulmonary disease
The number of different medications each subject was taking ranged from 1 to 9. Four (22.2%) were taking four or less medications, while the remaining 14 (77.8%) were taking five or more medications. Thirteen (72.2%) subjects took Coumadin, while Lanoxin was second, with 10 (55.6%) subjects taking this medication. Other medications taken were ACE inhibitors (n=8, 44.4%), anti-inflammatories except aspirin (n=8, 44.4%), diuretics (n=7, 38.9%), beta-blockers (n=6, 33.3%), aspirin (n=5, 27.8%), and nitrates (n=5, 27.8%).

Results of Data Analysis

Hypothesis number one was as follows: Health-promoting behaviors of elders with atrial fibrillation will positively correlate to perceptions of health. The directional hypothesis was rejected as there was no significant correlation (r(13)=.199, p=.514) between health-promoting behaviors and perceptions of health among elders with atrial fibrillation.

Hypothesis number two was as follows: Health-promoting behaviors of elders with atrial fibrillation will positively correlate to perceptions of quality of life. A strong relationship (r(13)=.833, p<.001) between health-promoting behaviors and quality of life in elders emerged, thus the directional hypothesis was accepted. Table 2 illustrates how quality of life correlated with the subscales of the Health-Promoting Lifestyle II.
Table 2

Health-Promoting Lifestyle II Subscales and Quality of Life Using Pearson Product Moment Coefficient

<table>
<thead>
<tr>
<th>Subscales</th>
<th>n</th>
<th>r</th>
<th>p</th>
</tr>
</thead>
<tbody>
<tr>
<td>Interpersonal relationship</td>
<td>17a</td>
<td>.374</td>
<td>.139</td>
</tr>
<tr>
<td>Nutrition</td>
<td>17a</td>
<td>.537*</td>
<td>.026</td>
</tr>
<tr>
<td>Physical Activity</td>
<td>17a</td>
<td>.449</td>
<td>.070</td>
</tr>
<tr>
<td>Spiritual Growth</td>
<td>17a</td>
<td>.508*</td>
<td>.038</td>
</tr>
<tr>
<td>Stress Management</td>
<td>17a</td>
<td>.247</td>
<td>.339</td>
</tr>
<tr>
<td>Health Responsibility</td>
<td>16a</td>
<td>.644*</td>
<td>.007</td>
</tr>
</tbody>
</table>

Note. * = significant @ > .05; a=the number of subjects varied due to missing data.

The research question was as follows: What is the relationship between perceptions of health and quality of life in elders with atrial fibrillation? Since no significant relationship (r(18)= -.303, p=.221) emerged, the researcher determined that no significant relationship existed between the perceptions of health and quality of life in elders with atrial fibrillation.

Additional Findings

The researcher was interested in determining if demographic information correlated with the quality of life scores, the Perceptions of Health scores, and the Health-
Promoting Lifestyle II scores. Significant relationships were noted when the demographic data (age, race, education, marital status, gender) were correlated with the scores of the Health Perception Questionnaire, the Health Promoting Lifestyle II, and the Quality of Life visual analog. Males perceived health more negatively than did female subjects ($r(18) = -0.493, p=0.038$). Also, married individuals had better stress management skills ($r(17) = 0.510, p=0.036$). Additional relationships were noted when the subscales of the Health-Promoting Lifestyle II were correlated among themselves. Spiritual growth was positively correlated with stress management ($r(16) = 0.641, p=0.007$) and increased spiritual growth as a health-promoting lifestyle significantly correlated with better nutritional behaviors ($r(16) = 0.631, p=0.009$) in elders with atrial fibrillation.
Chapter V

The Outcomes

Atrial fibrillation is the most common arrhythmia that affects elders. It greatly increases the risk of stroke and can be disabling due to the symptoms. Health behavior affects survival and disability in elders with chronic illnesses. In order to better serve the elderly population with the diagnosis of atrial fibrillation, nurse practitioners must have a better understanding of health perceptions, health-promoting behaviors, and quality of life in this population.

The purpose of this descriptive correlational study was to determine the relationships among the variables of health perceptions, health-promoting behaviors, and quality of life in elders with atrial fibrillation. Data were gathered with a researcher developed Demographic Data Sheet, Chart Audit Sheet, and Demographic Data Sheet II as well as with the Health Perceptions Questionnaire and the Health Promoting Lifestyle Profile II. The Demographic Data Sheet and the Demographic Data Sheet II contained a 100-millimeter visual analog scale to measure quality of life. Pender’s Health Promotion Model served as the theoretical framework and Stevenson’s theory of Developmental Tasks for the Four Stages of Adulthood also was utilized. Data were collected from patients served by a cardiac rehabilitation program, an internal medicine clinic, and a small community clinic located in rural Mississippi. The Pearson Product-Moment
Correlation and descriptive statistics were used to analyze the data. This chapter presents a discussion of the findings and the conclusions, implications, and recommendations that resulted from these findings.

Summary of Findings

The sample population (N=18) ranged in age from 55 to 77 years with a mean age of 69.44 years. Most of the subjects (55.6%) were male, White (77.8%), and married (77.8%). Education was varied with 50.0% of the subjects having a high school education or less. Only two (11.1%) subjects did not have a coexisting illness, and 77.8% took five or more medications.

The first directional hypothesis, which stated that health-promoting behaviors of elders with atrial fibrillation will positively correlate to perceptions of health, was rejected as no significant relationship emerged (p=.514) between the variables. In the second directional hypothesis, which stated that health-promoting behaviors of elders with atrial fibrillation will positively correlate to perceptions of quality of life, the researcher determined a positive correlation (p<.001). The research question was to determine the relationship between perceptions of health and quality of life in elders with atrial fibrillation. No significant relationship existed between perceptions of health and quality of life (p=.221).

The researcher noted numerous additional findings. Males perceived health more negatively than did female subjects (p=.038). Also, married individuals had better stress management skills (p=.036). Quality of life positively correlated with health responsibility (p=.007), nutrition (p=.026), and spiritual growth (p=.038). Additionally,
spiritual growth positively correlated with stress management ($p = .007$) and better nutritional behavior ($p = .009$) in elders with atrial fibrillation.

**Discussion**

No other studies were found that explored the relationship between health-promoting behaviors and perceptions of health, thus, the current findings can neither be supported nor refuted. Several explanations may have attributed to the non-significant correlation between these two variables. First, the sample composition and size may not have been representative of the population. For example, the male subjects, who tended to have poorer perceptions of health, made up 55% of the sample, perhaps resulting in negative influence on the relationship between health-promoting behaviors and perceptions of health. Age may have been a factor as people tend to think "the older I get the worse my health". In spite of the researcher's efforts to limit age in the sample, the mean age was 69.44 years. Due to recruitment difficulties (non-randomization) and time constraints (two months), the sample size remained small.

Other explanations for health-promoting behaviors and perceptions of health not correlating may have been that 78% of the subjects were taking five or more medications and 89% had comorbidity. It could be postulated that these subjects viewed their health more poorly because they were taking numerous medications or because they had multiple illnesses. The researcher also must consider that these elders may not have had a specific cue to engage in health-promoting behaviors such as being informed by their primary care provider that they needed to be exercising or eating low fat food (Pender, 1987). Finally, the researcher assumes that some subjects with a good perception of
health did not feel they needed to participate in health-promoting behaviors, while those with poor perceptions of health may have believed they needed to increase health-promoting behaviors such as improving diet or increasing exercise. On the other hand, perhaps, the results are accurate and do reflect that these variables are not significantly related in this population.

A strong relationship \( (p < 0.001) \) existed between the variables of health-promoting behaviors and quality of life in elders with atrial fibrillation. One supposition for this result may be that subjects who participate in health-promoting behaviors feel better about themselves, are more active, and more involved in self-care, such as eating nutritious foods and getting adequate exercise. Seventy-eight percent of the subjects were married which may have allowed for increased support at home in areas such as nutrition and stress management which positively impacted perceptions of quality of life. Spiritual growth correlated with stress management, good nutrition, and quality of life. Therefore, the researcher postulates that spiritual desire may be a cue to increase health-promoting behaviors, thus increasing quality of life. These subjects may have viewed age as a positive cue, regardless of their stated health status, because of the prospect of having grandchildren, seeing more of their family, and retiring or preparing for retirement (Pender, 1987). This explanation also supports the theory of tasks of positive development in older adults by Stevenson (Bellack & Edlund, 1992).

The results of no significant relationship between perceptions of health and quality of life in this sample may have been indicative of elders who do not see their illness, or perception of health, as affecting their quality of life. Many elders have had a
high level of disability and yet regard themselves as having a good quality of life. Hamer et al. (1994) found that it is the perception of the illness rather than the illness itself that is disruptive to the client indicating that the coping skills of the client may need refining. The current finding is partly refuted by Moore et al. (1993), who found a strong positive relationship between perceptions of health and quality of life in an elderly population. The Moore et al. study was a meta-analysis of 17 research articles between 1987 and 1991 with subjects at least 50 years of age. Four of the 17 articles focused on women only, while the other 13 articles focused on men and women. The sample composition again should be noted since the current study found that men tended to have lower health perceptions. However, this researcher is mindful of the fact that six of the studies in the meta-analysis showed no relationship between perceptions of health and quality of life, and a positive or inverse relationship was demonstrated in seven of the other studies. Moore et al. recommended further research involving more older male subjects as well as larger sample sizes and more randomization.

Another study by Whittle and Goldenberg (1996) concluded that health perception was a significant factor in the elderly for maintaining independence. Quality of life was not addressed by Whittle and Goldenberg, and it cannot be assumed that because independence is lost or decreased that quality of life is lessened. An increase in leisure time and having adapted to aging and retirement may help explain why quality of life increases, yet health perceptions may decrease due to aging, taking several medications, or having multiple illnesses. This explanation would support Stevenson’s tasks of development which are important for personal growth (Bellack & Edlund, 1992).
Limitations

Two study limitations were noted. The sample size was small, not culturally diverse, and may not have been representative of the target population. There were other additional confounding variables noted. However, the sample was well represented by each gender with near equal representation. Nearly 33% of the sample was African American which is close to the 33% strata for Mississippi. The sample was selected from three clinically isolated sites, so there was no sample contamination. Also, having three sites increased the generalizability of the study (Polit & Hungler, 1995).

Time constraint was a major factor in limiting data collection. This resulted in only 18 subjects being secured for the study. Failure to reject the null hypothesis is many times the result of a sample size that is too small (Polit & Hungler, 1995). The time constraint forced the researcher to redefine the criteria of subjects for admission to the study. However, the researcher believes that the data secured is valid and could be used as pilot information and the beginning of the basis for improving family nurse practitioner practice in elders with atrial fibrillation.

Conclusions

In this study, the relationships among the variables of health perception, health behaviors, and quality of life were determined. Hypothesis number one determined that health-promoting behaviors and perceptions of health in elders with atrial fibrillation were not significantly correlated. This finding was neither supported nor refuted by previous studies. Hypothesis number two determined that health-promoting behaviors and quality of life were strongly positively correlated in elders with atrial fibrillation.
"Health promotion consists of activities directed toward increasing the level of well being" (Pender, 1987, p. 4). The research question determined that perceptions of health and quality of life in elders with atrial fibrillation were not significantly correlated. This finding was refuted by Moore et al. (1993) who found a strong relationship between perceptions of health and quality of life in elders.

Implications for Nursing

The results of this study have many implications for nursing in the areas of practice, education, and research. In practice, nurse practitioners cannot assume that elders with atrial fibrillation who have a poor perception of health also have a poor quality of life. Therefore, there should be a separate evaluation of quality of life and perception of health for an accurate health assessment of the client. An evaluation of the client’s health perceptions also may reveal the likelihood of participation in health-promoting behaviors (Pender, 1987).

Nurse practitioners also must evaluate the health perceptions of elders and identify barriers to health-promoting behaviors so that barriers can be eliminated and the client will be able to participate in health-promoting behaviors (Pender, 1987). Nurse practitioners, using Stevenson’s model for task development, also need to determine where the older client is developmentally. This information will allow for realistic goal setting for task achievement in each individual client.

Faculty of nurse practitioner programs should incorporate health perceptions and health-promoting behaviors content and focus on issues such as age, gender, and diagnoses related to quality of life. This information would better equip new nurse
practitioners in caring for elders with atrial fibrillation in a holistic manner. "Frequently, old patterns of behavior must be extinguished and new patterns of behavior learned to enhance health and well-being" (Pender, 1987, p. 59). Therefore, nurse practitioners should immediately begin educating clients to practice positive health behaviors as this may directly affect quality of life in a positive manner.

The current study illuminates the lack of research in the areas of quality of life, health perceptions, and health behaviors in elders with atrial fibrillation. The researcher found no direct study of the quality of life in elders with atrial fibrillation resulting in a lack of concrete information to better improve quality of care. No known concrete methods or standardized tools were found to assess quality of life in this population. Nurse practitioners can begin the process of improving outcomes or preventing atrial fibrillation by implementing practice based research that targets the elderly population at risk for developing this disease or at risk for complications of this disease.

Recommendations

Based on the findings of this study, the following recommendations are made:

Research:

1. Replication of the study with a larger sample size and an increased collection time.

2. Replication of the study to compare a younger elder group and an older elder group.
3. Replication of the study to determine the impact of demographic variables such as gender, marital status, and comorbidity on quality of life, health perceptions, and health behaviors.

Practice:

1. Incorporation of a developmental theorist into practice specific to the elder population to determine realistic goal setting for task achievements.

2. Assessment of baseline information for elders with atrial fibrillation reflecting health perceptions, quality of life, and health-promoting behaviors to set realistic goals for plans of care.

3. Determination of health perceptions and other cognitive perceptual factors to determine the likelihood of responding to a cue to action (education by the nurse practitioner; Pender, 1987).
References


APPENDIX A

DEMOGRAPHIC DATA SHEET
DEMOGRAPHIC DATA SHEET

1. Age: _____  

2. Check One: _____ male _____ female

3. Check One: _____ black _____ white _____ other (specify) _________

4. Check One: _____ Married
   _____ Separated
   _____ Divorced
   _____ Widowed
   _____ Single
   _____ Other (specify)

5. Check One: Highest level of education completed
   _____ Less than high school
   _____ High School
   _____ Less than Bachelor’s Degree
   _____ Bachelor’s Degree
   _____ Graduate Degree

Please mark with a single (X) on the line where you rate your quality of life.

Quality of life:

Poor •----------------------------------------------------------• Excellent
APPENDIX B

CHART AUDIT SHEET
<table>
<thead>
<tr>
<th>CHART AUDIT SHEET</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>A. Date of diagnosis of atrial fibrillation:</strong> ____________________</td>
</tr>
<tr>
<td><strong>B. Creatinine level:</strong> ____</td>
</tr>
<tr>
<td><strong>C. Coexisting illnesses</strong></td>
</tr>
<tr>
<td>1)</td>
</tr>
<tr>
<td>2)</td>
</tr>
<tr>
<td>3)</td>
</tr>
<tr>
<td>4)</td>
</tr>
<tr>
<td>5)</td>
</tr>
<tr>
<td><strong>D. List of current medications.</strong></td>
</tr>
<tr>
<td></td>
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<tr>
<td></td>
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<tr>
<td></td>
</tr>
</tbody>
</table>


APPENDIX C

DEMOGRAPHIC DATA SHEET II
DEMOGRAPHIC DATA SHEET II

1. Age: ____

2. Check One: ____ male  ____ female

3. Check One: ____ black  ____ white  ____ other (specify) _____________

4. Check One: ____ Married  
   ____ Separated  
   ____ Divorced  
   ____ Widowed  
   ____ Single  
   ____ Other (specify)  

5. Check One: Highest level of education completed  
   ____ Less than high school  
   ____ High School  
   ____ Less than Bachelor's Degree  
   ____ Bachelor's Degree  
   ____ Graduate Degree  

6. First diagnosed with atrial fibrillation: ________

7. List all medications you are presently taking:  
   __________________________  
   __________________________  
   __________________________  

8. What other health problems do you have? Please list:  
   __________________________  
   __________________________  
   __________________________

Please mark with a single ( X ) on the line where you rate your quality of life.

Quality of life:  
   ___ Poor  ___ Excellent
APPENDIX D

HEALTH PERCEPTIONS QUESTIONNAIRE
Health Perceptions Questionnaire

Please read each of the following statements and then check one of the numbers on each line to indicate whether the statement is TRUE or FALSE for you.

There are no right or wrong answers.

If a statement is definitely true for you, circle 5.
If it is mostly true for you, circle 4.
If you don't know whether it is true or false, circle 3.
If it is mostly false for you, circle 2.
If it is definitely false for you, circle 1.

Some of the statements may look or seem like others, but each statement is different and should be rated by itself.

1. According to the doctor I've seen, my health is now excellent. 5 4 3 2 1
2. I try to avoid letting illness interfere with my life. 5 4 3 2 1
3. I seem to get sick a little easier than other people. 5 4 3 2 1
4. I feel better now than I ever have before. 5 4 3 2 1
5. I will probably be sick a lot in the future. 5 4 3 2 1
6. I never worry about my health. 5 4 3 2 1
7. Most people get sick a little easier than I do. 5 4 3 2 1
8. I don’t like to go to the doctor. 5 4 3 2 1
9. I am somewhat ill. 5 4 3 2 1
10. In the future, I expect to have better health than other people I know. 5 4 3 2 1
11. I was so sick once I thought I might die. 5 4 3 2 1
12. I’m not as healthy now as I used to be. 5 4 3 2 1
13. I worry about my health more than other people worry about their health. 5 4 3 2 1
14. When I’m sick, I try to just keep going as usual. 5 4 3 2 1
15. My body seems to resist illness very well. 5 4 3 2 1
16. Getting sick once in a while is part of my life. 5 4 3 2 1
17. I’m as healthy as anybody I know. 5 4 3 2 1
18. I think my health will be worse in the future than it is now. 5 4 3 2 1
19. I've never had an illness that lasted a long period of time.  
20. Others seem more concerned about their health than I am about mine.  
21. When I'm sick, I try to keep it to myself.  
22. My health is excellent.  
23. I expect to have a very healthy life.  
24. My health is a concern in my life.  
25. I accept that sometimes I'm just going to be sick.  
26. I have been feeling bad lately.  
27. It doesn't bother me to go to a doctor.  
28. I have never been seriously ill.  
29. When there is something going around, I usually catch it.  
30. Doctors say that I am now in poor health.  
31. When I think I am getting sick, I fight it.  
32. I feel about as good now as I ever have.
APPENDIX E

LIFESTYLE PROFILE II
Lifestyle Profile II

Directions: This questionnaire contains statements about your present way of life of personal habits. Please respond to each item as accurately as possible, and try not to skip any item. Indicate the frequency with which you engage in each behavior by circling:

N for never, S for sometimes, O for often, R for routinely

1. Discuss my problems and concerns with people close to me.

2. Choose a diet low in fat, saturated fat, and cholesterol.

3. Report any unusual signs or symptoms to a physician or other health professional.

4. Follow a planned exercise program.

5. Get enough sleep.

6. Fell I am growing and changing in positive ways.

7. Praise other people easily for their achievements.

8. Limit use of sugars and food containing sugar (sweets).

9. Read or watch TV programs about improving health.

10. Exercise vigorously for 20 or more minutes at least three times a week (such as brisk walking, bicycling, aerobic dancing, using a stair climber).

11. Take some time for relaxation each day.

12. Believe that my life has purpose.

13. Maintain meaningful and fulfilling relationships with others.

14. Eat 6-11 servings of bread, cereal, rice, and pasta.
15. Question health professionals in order to understand their instructions.
16. Take part in light to moderate physical activity (such as sustained walking 30-4 minutes 5 or more times a week).
17. Accept those things in my life which I cannot change.
18. Look forward to the future.
19. Spend time with close friends.
20. Eat 2-4 servings of fruit each day.
21. Get a second opinion when I question my health care provider's advice.
22. Take part in leisure-time (recreational) physical activities (such as swimming, dancing, bicycling).
23. Concentrate on pleasant thoughts at bedtime.
24. Feel content and at peace with myself.
25. Find it easy to show concern, love and warmth to others.
26. Eat 3-5 servings of vegetables each day.
27. Discuss my health concerns with health professionals.
28. Do stretching exercises at least 3 times per week.
29. Use specific methods to control my stress.
30. Work toward long-term goals in my life.
31. Touch and am touched by people I care about.
32. Eat 2-3 servings of milk, yogurt, or cheese each day.
33. Inspect my body at least monthly for physical changes/danger signs.

34. Get exercise during usual daily activities (such as walking during lunch, using stairs instead of elevators, parking car away from destination and walking).

35. Balance time between work and play.

36. Find each day interesting and challenging.

37. Find ways to meet my needs for intimacy.

38. Eat only 2-3 servings from the meat, poultry, fish, dried beans, eggs, and nuts group each day.

39. Ask for information from health professionals about how to take good care of myself.

40. Check my pulse rate when exercising.

41. Practice relaxation or meditation for 15-20 minutes daily.

42. Am aware of what is important to me in my life.

43. Get support from a network of caring people.

44. Read labels to identify nutrients, fats, and sodium content in packaged food.

45. Attend educational programs on personal health care.

46. Reach my target heart rate when exercising.

47. Pace myself to prevent tiredness.

48. Feel connected with some force greater than myself.
49. Settle conflicts with others through discussion and compromise.

50. Eat breakfast.

51. Seek guidance or counseling when necessary.

52. Expose myself to new experiences and challenges.
APPENDIX F

LETTER REQUESTING PERMISSION TO USE HEALTH PROMOTING LIFESTYLE PROFILE II
Dear Ms. Walker,

I am writing a request for consent to use your Health Promoting Lifestyle II instrument in my research. I am assessing health promoting behaviors of elders with a diagnosis of atrial fibrillation to see how it correlates with their perceptions of health and quality of life. I am currently pursuing a MSN in the Family Nurse Practitioner Program at Mississippi University for Women.

Thank you for your time.

Sincerely,

Eric W. Smith, RN, BSN
APPENDIX G

LETTER OF APPROVAL FOR USE OF HEALTH PROMOTING LIFESTYLE PROFILE II
PERMISSION FORM

I plan to use the Health-Promoting Lifestyle Profile II in a research or evaluation project entitled:

The Relationship between Health-Promoting Behaviors and Perceptions of Health and Quality of Life in Older Adults with HIV Infection

I am enclosing a check for ten dollars ($10.00) payable to the University of Nebraska Medical Center College of Nursing.

Print Name

Signature

Position

Mailing Address

2408 A NW 63rd St

STARVILLE, IA 52394

Permission is granted to the above investigator to copy and use the Health-Promoting Lifestyle Profile II for non-commercial data collection purposes such as research or evaluation projects provided that content is not altered in any way and the copyright/permission statement at the end is retained. The instrument may be reproduced in the appendix of a thesis, dissertation or research grant proposal without further permission. Reproduction for any other purpose, including the publication of study results, is prohibited without specific permission.

Susan Noble Walker

Date

Please send two signed copies of this page to: Susan Noble Walker, Ed.D., R.N., F.A.A.N.
University of Nebraska Medical Center
College of Nursing
600 South 42nd Street
Omaha, Nebraska 68198-5330
APPENDIX H

LETTER OF APPROVAL FROM MISSISSIPPI UNIVERSITY FOR WOMEN
ON USE OF HUMAN SUBJECTS IN EXPERIMENTATION
February 23, 1998

Mr. Eric W. Smith
C/o Graduate Program in Nursing
Campus

Dear Mr. Smith:

I am pleased to inform you that the members of the Committee on Human Subjects in Experimentation have approved your proposed research as submitted.

I wish you much success in your research.

Sincerely,

Susan Kupisch, Ph.D.
Vice President
for Academic Affairs

SK: wr

cc: Mr. Jim Davidson
Dr. Mary Pat Curtis
Dr.:

I am a registered nurse and a graduate student at the Mississippi University for Women in Columbus, Mississippi currently pursuing a Master of Science in Nursing with a specialty as a Family Nurse Practitioner. I would like to request permission to obtain a portion of the information needed for my research from your clinic. The title of my study is "The Relationship between Health-Promoting Behaviors and Perceptions of Health and Quality of Life in Elders with Atrial Fibrillation". The research will help health professionals gain a better insight into improving health-promoting behaviors in elders with atrial fibrillation.

A Demographic Data Sheet, a 52-item questionnaire about lifestyle and health behaviors, and a 32-item questionnaire about perceptions of health will be administered to elders who meet the criteria. Also, a chart review to obtain demographic data and clinical information will be performed on each eligible elder.

I would like your written permission to conduct this research in your clinic. All information obtained in this study will be confidential and used solely for the purpose of the study. No names will be used and participation will be voluntary on behalf of the client and they may withdraw from the study at anytime. I would like to begin collecting data in May 1998. I will be in touch about setting appointments for dates of data collection. A summary will be sent to you after completion of the study if you wish. Thank you for considering my request.

Sincerely,

Eric W. Smith
Physician's Agreement Concerning Research Study

Title of Research:
The Relationship between Health Promoting Behaviors and Perceptions of Health and Quality of Life in Elders with Atrial Fibrillation

Study explained to:

Name of Physician

Name of Clinic

I grant consent for the patients of this clinic and a review of their medical records to be used in this study. This will be dependent on the patient's consent.

Date

Physician's Signature

Investigator's Signature
APPENDIX J

CONSENT FOR DATA COLLECTION IN CARDIAC REHAB
DATE: 5-19-98
TO: Mr. Kelly/CEO
FROM: Elizabeth Varco, RN
RE: Research in Cardiac Rehab

Eric Smith is a graduate student at Mississippi University for Women. He would like to perform a research study on health behaviors, perceptions of health, and quality of life in people with a diagnosis of atrial fibrillation. The participants will sign a consent form and patient confidentiality will be maintained. The research study consists of filling out a health perception survey.

Dr. Ben Sanford is the medical director of cardiac rehab and has given his permission. I have discussed this with Mr. Hilton and he requested that I also obtain your permission to proceed.

May we have your permission to proceed with this research project in our out-patient cardiac rehab program.

Sincerely,

Elizabeth Varco, RN

Do we have a policy and procedure to follow in these circumstances?

Confidentiality is paramount. Otherwise, OK.
APPENDIX K

SUBJECT CONSENT FOR PARTICIPATION
Consent for Participation

My name is Eric Smith. I am a registered nurse and a Graduate student at the Mississippi University for Women. I am conducting a research study on health behaviors, perceptions of health, and quality of life in people with atrial fibrillation. This information will serve to assist healthcare professionals in rendering the best care to people with a diagnosis of atrial fibrillation.

Participation in this study will require you to answer questions on the Health Perceptions Questionnaire and the Lifestyle Profile II that will take approximately 20 to 30 minutes. Information will be obtained from your chart to assist with the study. Whether or not you participate in this study will in no way affect your treatment. All answers and information will remain confidential. No names will appear on the questionnaires. You may withdraw from the study at anytime prior to analysis of the data. The questionnaires will be destroyed at the end of the study. I would appreciate your contribution to this study.

Sincerely,

Eric Smith

I have read or been read the Consent for Participation and do agree to participate in this study.

____________________  ______________________
date                  signature of participant