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CONCEPT ANALYSIS

Nursing coaching for self-care in heart failure: A concept analysis that includes family support and follow upIsmail Fahmi¹, Yeni Rustina², Bambang Budi Siswanto³, Tuti Herawati⁴, Sutanto Priyo Hastono⁵**Author information**¹ Doctoral Student, Faculty of Nursing, Universitas Indonesia, Indonesia; Poltekkes Kemenkes Jambi, Indonesia² Department of Pediatrics Nursing, Faculty of Nursing, Universitas Indonesia, Indonesia³ Department of Cardiology and Vascular Medicine, Faculty of Medicine, Universitas Indonesia, Indonesia⁴ Department of Medical Surgical Nursing, Faculty of Nursing, Universitas Indonesia, Indonesia⁵ Department of Biostatistics and Population, Faculty of Public Health, Universitas Indonesia, Indonesia

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<https://doi.org/10.31603/jhns.v13i1.14762>**Abstract**

Heart failure (HF) affects over 64 million people globally and is characterized by high post-discharge vulnerability and frequent readmissions. A specific approach is essential to address the complexities of HF management. One such approach is nursing coaching, which integrates family support and follow-up care to improve patient self-care. However, this specific concept remains under-defined and has not been extensively explored within current nursing literature. Therefore, this concept analysis aims to define 'nursing coaching' within the context of HF management, specifically identifying its defining attributes, antecedents, consequences, and empirical referents to guide clinical nursing practice. This concept analysis utilizes the Walker and Avant method to achieve its systematic objectives. To ensure a comprehensive review, multiple electronic databases were searched, including PubMed, the Cochrane Library, CINAHL, Scopus, EMBASE, and ScienceDirect. The search strategy focused on peer-reviewed English-language studies involving *nursing coaching*, *health coaching*, and *heart failure*. Specific inclusion and exclusion criteria were applied to refine the selection, and the entire search and screening process is documented and visualized using a PRISMA flow diagram. Six key attributes were identified as follows patient-centered approach, empowerment and motivation, education and knowledge transfer, behavior change strategies, ongoing support and follow-up, and holistic approach. Antecedents included patient readiness, nurse coaching competency, educational resources, supportive policies, and technology integration; consequences included improved self-care, adherence, quality of life, and reduced avoidable utilization, without implying causality. As a concept analysis, findings clarify nursing coaching in HF and provide an operational definition and referents to inform clinical or community nursing practice design.

Keywords: Concept analysis, heart failure, nursing coaching, patient empowerment, self-care**Introduction**

Global demographic transformations have precipitated a markedly accelerated rate of population aging compared to previous periods (Shreya et al., 2025). Many countries confront challenges arising from this demographic transition, which has engendered a rise in non-communicable diseases such as heart failure (HF) (Bozkurt et al., 2025). HF is a disease with high mortality and readmission rates within months after treatment (Vohra et al., 2024). A study exposed a high prevalence of Stage A and B HF among elderly, with most Stage B patients having an ejection fraction $\geq 50\%$ (Huang et al., 2025). HF affects tens of millions worldwide with a persistent regional burden and high early post-discharge risk (Shu et al., 2025; Tromp et al., 2020). HF in the elderly is primarily caused by chronic hypertension, coronary artery disease, and age-related structural heart changes, often leading to a "multifactorial" condition with multiple comorbidities (Dewaswala et al., 2022). The most common form in older adults is HF with preserved ejection fraction (HFpEF), resulting from stiffening of the heart muscle and decreased filling capacity (Gharagozloo et al., 2024). Recent studies updates document substantial mortality and readmission after an index hospitalization, framing the imperative for structured self-care support and transition management (Salimian et al., 2025). A critical priority for healthcare professionals, particularly nursing staff, is the management of hospital readmissions among patients with HF (Varghese

et al., 2025). These readmission rates serve as a primary clinical indicator and a significant prognostic marker for the progression of the disease.

The readmission among patient with HF increases the burden of health financing among the patients and families (Shahim et al., 2023). Common readmission risk factors include low health literacy, inadequate transitions, multimorbidity/frailty, and limited social support (Niriayo et al., 2024). However, low health literacy and inadequate transition programs are indicators of HF patient readmission (Fabbri et al., 2020). Furthermore, readmission is an essential indicator of the quality of HF care (Baris & Tabit, 2025). The 30-day post-discharge period is widely recognized as a critical window of clinical vulnerability and a key metric for hospital quality (Fischer et al., 2014). Consequently, many nurse-led interventions structure follow-up across 8–12 weeks to monitor for physiological deterioration, reinforce patient education, and stabilize self-care behaviors (Miah et al., 2025). This evidence-based timeframe served as the rationale for adopting a three-month horizon when defining the case studies and empirical referents within this analysis (Jaarsma et al., 2021; Vázquez-Calatayud et al., 2023). Standard HF care includes guideline-directed medical therapy (GDMT), device/advanced therapies, structured patient education, and early post-discharge follow-up (Guleria et al., 2025). The American Heart Association/American College of Cardiology/Heart Failure Society of America (AHA/ACC/HFSA) emphasize the guideline to strengthen self-care and improve outcomes (Heidenreich et al., 2022). In order to optimize the clinical outcomes suggested by these guidelines, adopting a nursing coaching framework serves as a strategic imperative. Educational programs are a strategy to increase independent healthy behavior changes, decision-making, self-monitoring, knowledge, and attitudes (Jasser et al., 2026; Stahlman et al., 2023).

Health coaching is one method of providing education and support that has the potential for implementing advanced practice in effective self-care management education (Zuraida et al., 2022). The success of nursing coaching is determined by the integration of family support and follow-up care to evaluate its ongoing effectiveness. Family support manifests as active participation in cardiac rehabilitation programs, ensuring adherence to complex therapeutic regimens, improving self-care, and facilitating the preparation of heart-healthy nutrition (Popescu et al., 2025). Complementing this, follow-up care is conducted by nurses through home visits and clinical consultations (Lunde et al., 2025). The interactions during follow-up care allow for dialogue between the nurse, the patient, and the family regarding treatment goals and therapeutic adjustments. Furthermore, coaching has emerged as a key focus area in clinical nursing research, highlighting its importance in nursing (Best, 2020; Collins et al., 2018). Although less established than mentorship within the nursing profession, coaching has proven efficacious in enhancing organizational performance and assisting individuals in navigating the balance between professional responsibilities and personal development (Lee et al., 2024). Although coaching and mentoring are frequently used interchangeably, they are distinguished by fundamental conceptual differences. Coaching is primarily process-driven, fostering self-awareness and goal attainment through a rigorous analysis of the individual (Sarroeira et al., 2020). This process triggers deep reflection on one's perspectives, mindsets, and beliefs, ultimately facilitating more sustainable behavioral changes (Sarroeira et al., 2020). Conversely, mentorship is characterized by a relational approach centered on long-term professional growth and holistic learning, whereas coaching prioritizes the realization of specific, mutually agreed-upon objectives (Irby, 2012).

In clinical nursing research, mentoring and coaching are widely used in the context of readmission prevention (Piamjariyakul et al., 2015; Rabbat et al., 2012), low cost (Sales et al., 2013), HF rehabilitation (Frohman et al., 2017), improving self-care (Zuraida et al., 2022), quality of life of patients with HF (Leyser, 2023). However, the conceptual ambiguity between coaching and mentoring carries significant practical implications, as it risks creating confusion within organizational and professional settings (Marcdante & Simpson, 2018; Stokes et al., 2021). Therefore, this study aims to clarify the concept of nursing coaching and ensure its consistent application in both research and clinical practice. Furthermore, this article integrates family support and follow-up care strategies specifically for patients with HF. Integrating nursing coaching with family support and follow-up care is essential for because it addresses the challenges of chronic disease management specifically clinical complexity, social isolation, and physiological deterioration. HF management requires more than simple medication adherence; it demands a total lifestyle transformation that is often leading to patient distress and suboptimal management when attempted in isolation. Through concept analysis, the article strives to clarify definitions, attributes, and relationships with related concepts, reducing misunderstandings and confusion. Building on prior analysis, this article distinguishes nursing coaching from mentoring and education-only approaches by establishing clear definitional boundaries and identifying specific mechanisms such as motivational interviewing and goal setting. This differentiation is critical, as earlier conceptual ambiguity risks conflating relational mentorship with the goal-oriented behavioral changes required for effective clinical care in HF contexts. It is anticipated that the findings of this analysis will serve as an evidence-based touchstone for nursing professionals specializing in the care of patients with HF.

Method

The development of this concept analysis followed the methodological framework established by Walker and Avant (Walker & Avant, 2013). The method consists of the following eight stages as follows selecting a concept, determining the purposes of analysis, identifying of all uses of the concept, determining of the defining attributes, identifying a model case, identifying additional case, identifying antecedents and consequences, and defining empirical referent. This method was selected due to its structured and pragmatic approach, which is particularly useful for clarifying complex and practice-based concepts such as coaching in nursing. Walker and Avant's method provides a clear pathway for identifying defining attributes, related concepts, antecedents, and consequences (Walker & Avant, 2005). This approach enables the development of a precise operational definition to support future interventions and instrument construction in HF nursing. Although self-care is positioned as the central behavioral target within nursing coaching, it aligns with HF guidelines that emphasize patient engagement in weight monitoring, medication adherence, dietary control, and symptom recognition. It is essential to acknowledge that many patients with HF are unable to enact self-care independently due to physical limitations, cognitive decline, or emotional distress (Turrise et al., 2025). Therefore, self-care in HF cannot be understood as an isolated individual effort (Riegel et al., 2022). Instead, nursing coaching is conceptualized as patient-centered while intentionally integrating family or informal caregivers when needed (Leyser, 2023). Family involvement is not treated as a separate entity from self-care; rather, it is an extension of the self-care process. It serves as a vital mechanism through which self-care behaviors are supported, delegated, or shared between the patient and their support system. This perspective explains why attributes such as ongoing support, follow-up, and holistic care are included in the analysis. At first glance, these elements may seem peripheral to self-care. However, behavioral change literature in chronic illness demonstrates that self-care is not a one-time acquisition of knowledge, but a sustained process requiring continuous reinforcement, monitoring, emotional support, and adaptation (Schlicher et al., 2025; Patil et al., 2024; Audulv et al., 2025).

The quality appraisal in the article was performed by considering study objectives, research methodology, participants, results and recommendations to be applied in the coaching nursing in HF. Design-specific quality assessments were accomplished on all integrated studies. Each article was assessed in its entirety to acknowledge how nursing coaching was applied and related to similar concepts in HF contexts. If a paper appeared to fit with our search criteria, we perused the abstract, then regarded the entire contents. Articles not addressing HF were discarded during screening. All articles were evaluated to identify accepted knowledge regarding the concept. The researchers worked independently and discussed their findings to consensus. To ensure methodological transparency, a PRISMA flow diagram was used to depict the literature identification, screening, and inclusion process, reinforcing the rigor of the evidence base underpinning the concept analysis. During the search process, the authors determined the inclusion and exclusion criteria. The inclusion criteria included English article, discussed coaching, discussed nursing coaching, discussed health coaching, involved patients with HF, full-text articles, and published in peer-reviewed journals. In contrast, theses and dissertations were excluded from the search. The keywords were *nursing coaching*, *health coaching*, and *heart failure*. The authors also used a dictionary and thesaurus as additional sources of literature. The literature search encompassed articles published over a 15-year period, spanning from 2009 to 2024.

A systematic literature search was performed across PubMed, the Cochrane Library, CINAHL, Scopus, EMBASE, and ScienceDirect, initially yielding 1,245 records. An additional 18 articles were identified through manual screening of reference lists, resulting in a total of 1,263 citations. Following the removal of 331 duplicates, 932 records underwent title and abstract screening. Of these, 756 were excluded for failing to meet the inclusion criteria related to nursing coaching or HF. Subsequently, 176 full-text articles were assessed for eligibility; 132 were excluded due to a lack of conceptual clarity, the presence of non-nursing-led interventions, mixed populations lacking subgroup data, or insufficient intervention descriptions. Ultimately, 44 studies met all criteria and were included in the final concept analysis (Figure 1).

Results

Selecting a concept

In the development of concept analysis, the first stage involves selecting a concept (Walker & Avant, 2013). The phase involved examining the general definition of *coaching* through a literature search. As detailed in the preceding sections, a comprehensive query across multiple electronic databases was completed, yielding a selection of articles for formal analysis. Furthermore, the clinical rationale behind the scene of this concept analysis development was established in the earlier chapters of the article.

Determining the purposes of analysis

The second step involves determining the purposes of the analysis (Walker & Avant, 2013). This concept analysis aims to define *nursing coaching* within the context of HF management, specifically identifying its defining attributes, antecedents, consequences, and empirical referents to guide clinical nursing practice. The analysis also integrated the concept of family support and follow-up care.

Identifying of all uses of the concept

The third step is identifying of all uses of the concept (Walker & Avant, 2013). According to the Cambridge Dictionary (online version), the word *coaching* refers to the act of giving special classes in sports, a school subject, or a work-related activity, especially to one person or a small group (Cambridge Dictionary, 2019). Additionally, the International Coach Federation (ICF) defines *coaching* as a partnering with clients in a thought-provoking and creative process that inspires them to maximize their personal and professional potential (International Coach Federation, 2025). Meanwhile in nursing context, coaching more focuses on health promotion and education including supporting self-care (Oksman et al., 2017; Vázquez-Calatayud et al., 2023). Furthermore, health coaching is a specialized form of training designed for individuals seeking guidance to maintain their health and implement sustainable lifestyle changes (Suleta & Davis, 2025; Newman & McDowell, 2016). Furthermore, the concept of health coaching is derived from the principles of motivational interviewing to support patients with chronic diseases (Simmons & Wolever, 2013). For instance, optimizing self-care practice, enhancing self-confidence, improving decision-making skills, and managing cognitive, emotional or social situations.

When this concept is applied within the context of HF, it involves a holistic and patient-centered approach where nurses empower individuals to manage their condition effectively (Preventive Cardiovascular Nurses Association [PCNA], 2024). Based on the previous definition, self-care becomes the primary focus of nursing coaching in the context of HF (Riegel et al., 2020; Riegel et al., 2024; Vázquez-Calatayud et al., 2023; Zuraida et al., 2022). Therefore, nursing coaching in HF is a holistic, patient-centered intervention designed to facilitate self-care by integrating education with motivational and behavioral change techniques. The process encompasses follow-up care and family engagement to strengthen shared decision-making and enhance the patient's capacity to cope with physical, emotional, and social challenges. The concept of family has strong relevance in the context of self-care for patients with HF. In this article, the author utilizes the conceptual framework developed by Grey et al. (2006). The study adopts this framework to guide its analysis. The concept emphasizes that self-care is not solely an individual responsibility but rather the result of a dynamic interaction between individual and family factors in the self-management process of chronic illness (Dunbar et al., 2008). Hospital readmissions are a major problem in patients with HF, most often occurring within 30 days of treatment. Nurses contribute significantly to follow-up care, as diligent monitoring of a patient's clinical status remains a critical factor in reducing readmission rates (Marques et al., 2022).

Determining of the defining attributes

The subsequent step involves identifying the defining attributes associated with the concept under analysis (Walker & Avant, 2013). Attributes are defined by trying to show the group of attributes that are most often associated with the concept and that allow the study of broader insights into the concept (Walker & Avant, 2013). This concept analysis obtained six main attributes as follows patient-centered approach, empowerment and motivation, education and knowledge transfer, behavior change strategies, ongoing support and follow-up, and holistic approach (**Table 1**). Patient-centered approach is an essential attribute of nurse coaching for patients with HF, focusing on individualized care and decision-making according to patient needs. A study highlighted the importance of a patient-centered approach in improving adherence by addressing patient preferences and values (Allen et al., 2011). In addition, other study has shown that nursing interventions improved self-care and prevented readmissions of HF (Piamjariyakul et al., 2013; Vale et al., 2003). A patient-centered nursing approach is also thought to promote empowerment, increase self-efficacy, and improve quality of life (Vázquez-Calatayud et al., 2023). Empowerment and motivation are the second attributes. A literature discusses that motivational interviewing improves self-care behaviors and adherence to HF treatments (Chen et al., 2018; Creber et al., 2016). Structured information programs also effectively empower patients, improve self-management skills, and reduce readmissions (Cui et al., 2019). Also, nursing interventions have shown positive effects on self-care behaviors, care dependency, and quality of life (Köberich et al., 2015).

Education and knowledge transfer are other attributes that play an essential role in coaching. A study shown that educational programs improve self-care behaviors, reduce dependency on care, and improve quality of life (Köberich et al., 2015). Nurse-led telephone-based and telemonitoring interventions have also been found to positively impact patient

adherence, knowledge retention, and readmission prevention (Oliveira et al., 2017; Mizukawa et al., 2019). In addition, telerehabilitation programs that combine multiple educational strategies shown long-term benefits such as improving outcomes and reducing readmissions (Piotrowicz et al., 2020). Behavior change strategies are essential to coaching programs for patient with HF. Implementing health education based on behavior change theory has improved self-efficacy and self-management (Yu et al., 2019). In addition, motivational interviewing and goal-setting techniques emerged as practical approaches to facilitate behavior change in patients with cardiovascular disease (Chen et al., 2018). HF coaching programs should incorporate specific strategies to promote healthier lifestyles, ensure adherence to treatment, and facilitate symptom management (Lainscak et al., 2011).

Ongoing support and follow-up are also essential attributes of nursing coaching. Follow-up via telephone monitoring, telehealth interventions, and scheduled check-ups improved knowledge, self-care, and quality of life (Chen et al., 2018; Oliveira et al., 2017). In addition, a structured follow-up program allows for early detection of complications, thus reducing the readmissions (Köberich et al., 2015). A holistic approach to nursing coaching emphasizes comprehensive care that addresses physical, emotional, and social aspects (Piotrowicz et al., 2020). An integrative program combining telemonitoring, health education, and ongoing support has been shown to enhance the quality of life and prevent readmission in patient with HF (Boisvert et al., 2015). Nurse-led coaching can improve well-being and reduce risk factors through individualized care plans and holistic care (Stanulewicz et al., 2019). Furthermore, a nurse-led intervention combining comprehensive education and support strategies has significantly improved self-care in heart failure patients (Piotrowicz et al., 2020).

Table 1. Defining attributes of nursing coaching in HF.

Attributes	Clusters	References
Patient-centered approach	Individualized care, interventions, personalized training, patient preferences, shared decision making	Allen et al., 2011; Piamjariyakul et al., 2013; Vale et al., 2003; Vázquez-Calatayud et al., 2023
Empowerment and motivation	Patient empowerment, motivational interviewing, increased self-efficacy, facilitation of behavioral change	Chen et al., 2018; Creber et al., 2016; Cui et al., 2019; Köberich et al., 2015
Education and knowledge transfer	Health education, patient teaching, knowledge dissemination, information sharing, educational interventions	Oliveira et al., 2017; Köberich et al., 2015; Mizukawa et al., 2019; Piotrowicz et al., 2020
Behavioral change strategies	Behavior modification, habit formation, compliance strategies, lifestyle interventions, compliance enhancement	Chen et al., 2018; Lainscak et al., 2011; Yu et al., 2019
Ongoing support and follow-up	Ongoing support, regular follow-up, ongoing monitoring, telehealth interventions, long-term engagement	Chen et al., 2018; Oliveira et al., 2017; Köberich et al., 2015
Holistic approach	Comprehensive care, biopsychosocial model, holistic care, integrative health, multidisciplinary approach	Boisvert et al., 2015; Piotrowicz et al., 2020; Stanulewicz et al., 2019

Identifying a model case

In concept analysis, a model case is a narrative that illustrates how all defining attributes of a concept function in practice (Walker & Avant, 2013). These cases can be real or fictional, provided they accurately represent the essential components of the concept. The following examples are fictional but designed to reflect clinical scenarios of HF care.

Mrs. A, a 65-year-old woman with Heart Failure with Reduced Ejection Fraction (HFrEF) (New York Heart Association Class [NYHA] III), is discharged after stabilization from an acute exacerbation. A nurse conducts a values-based discussion to identify her personal goals, co-creates a daily weight monitoring and diuretic adjustment plan, and collaborates to set individualized sodium limits (patient-centered approach). Motivational interviewing techniques

uncover barriers to adherence and help set progressive, achievable goals (empowerment and motivation). The nurse uses teach-back to reinforce understanding of symptom zones and response actions (education and knowledge transfer). A structured action plan using implementation intentions supports consistent medication and weight routines (behavioral change strategies). Scheduled follow-up includes a day-3 phone call, week-2 clinic visit, and weight-triggered telemonitoring alerts with rapid nursing responses (continuing support and follow-up). Recognizing emotional and social strain, the daughter is involved in pillbox setup and meal planning, while social support services are offered as needed (holistic and family integration). The care plan is iteratively refined over a 90-day period based on clinical monitoring.

Identifying additional case

The additional cases included borderline and contrary cases. The borderline case contains most of the defining attributes of the concepts being examined (Walker & Avant, 2013). The following is the case:

Mr. B, a 60-year-old patient with chronic heart failure, was discharged from the hospital with only an educational booklet and a single follow-up call from a nurse (education and limited knowledge transfer). Although this provided basic education, the transfer of knowledge remained limited. While he was encouraged to practice self-care, there was a lack of structured motivational engagement, resulting in only partial empowerment (partial empowerment). A follow-up visit was scheduled; however, it was not supported by active monitoring or tailored interventions, leading to fragmented continuing care (limited continuing follow-up). Due to this lack of consistent support, Mr. B struggled to adhere to daily weight monitoring and dietary restrictions. Consequently, his condition deteriorated, eventually resulting in a preventable hospital readmission.

Lastly, the additional case is a contrary case, representing a scenario where the defining attributes of the concept are entirely absent (Walker & Avant, 2013). This serves to contrast with the previous examples and clarify the boundaries of the concept by illustrating what it is not. The following is the case:

Mrs. C, a 58-year-old patient, was discharged with only a medication list and no formal education, resulting in a complete absence of knowledge transfer (no knowledge transfer). There was no discussion regarding her personal health goals (lack of patient-centeredness), nor were there any empowerment strategies or behavioral coaching provided to support her recovery (absence of all key attributes). Furthermore, the plan included no structured follow-up or symptom monitoring. Due to this lack of understanding and support, Mrs. C failed to recognize worsening symptoms, leading to a delay in seeking care and a rapid hospital readmission shortly after discharge.

Identifying antecedents and consequences

Antecedents are events or related events that must occur or exist before an idea or concept is realized (Walker & Avant, 2013). Patient readiness, nurse coaching competence, educational resources, supportive policies, and telehealth or monitoring capacity set the conditions for effective coaching encounters and continuity (Chen et al., 2018; Creber et al., 2016; Cui et al., 2019; Oliveira et al., 2017; Köberich et al., 2015). Patients with HF readiness for self-care involves the patient's willingness to engage in self-management strategies, adherence to prescribed treatments, and motivation to adopt behavioral changes (Chen et al., 2018). Without patient willingness, coaching interventions may not be effective. Nurses' coaching competency is also essential, as nurses must have skills in motivational interviewing, behavioral change strategies, and patient-centered communication to facilitate self-care (Creber et al., 2016). Furthermore, educational resources such as structured HF education programs, information booklets, and telehealth interventions should be available to support coaching (Cui et al., 2019). Supportive healthcare policies play a critical role by enabling continuity of care, multidisciplinary collaboration, and resource allocation for long-term patient follow-up (Oliveira et al., 2017). In addition, integrating technology can strengthen the effectiveness of coaching including remote monitoring and telehealth platforms (Köberich et al., 2015).

Consequences are the incidents occurring as a direct effect of the concept being implemented (Walker & Avant, 2013). The consequences included improved self-care and adherence, greater confidence and quality of life, and fewer preventable acute care encounters; these are described as conceptual outcomes, not causal trial effects. Several studies shown that coaching by nurses improves self-care in patients with HF (Chen et al., 2018; Creber et al., 2016; Oliveira et al., 2017; Köberich et al., 2015). Research shows that providing self-care education alongside sequential telephone follow-ups by nurses over three months effectively enhances self-care (Köberich et al., 2015). Another study explained that patients with HF who received four motivational interviewing sessions, followed by telephone follow-up at

2, 4, and 8 weeks after hospital discharge, effectively improved self-care (Chen et al., 2018). In addition, conventional management in the form of three visits (initial, second, and fourth month) combined with telephone monitoring by nurses was effective in improving knowledge and self-care in the fourth month (Oliveira et al., 2017). Another study corroborated these findings, demonstrating that patients who received one home visit and three to four follow-up calls from a nurse over a 90-day period showed higher self-care scores compared to those receiving standard care (Creber et al., 2016).

In addition to improving self-care, coaching programs conducted by nurses have also been identified as being able to prevent readmissions. A structured education program was given to patients with HF during hospitalization and after discharge showed improvements in medication adherence, dietary modification, social support, and symptom management. The program was also associated with a significant decrease in readmission rates (Cui et al., 2019). Other studies also explain that the Collaborative Management (CM) approach through telemonitoring initiated by nurses has been shown to improve quality of life, self-efficacy, and self-care and reduce readmission rates (Mizukawa et al., 2019). The Hybrid Comprehensive Telerehabilitation (HCTR) program that includes telecare, telerehabilitation, and remote monitoring for 9 weeks is effective in increasing peak oxygen consumption and quality of life in patients with HF (Piotrowicz et al., 2020). Antecedents, attributes, and consequences were presented in the figure to help visualize the concept (**Figure 1**).

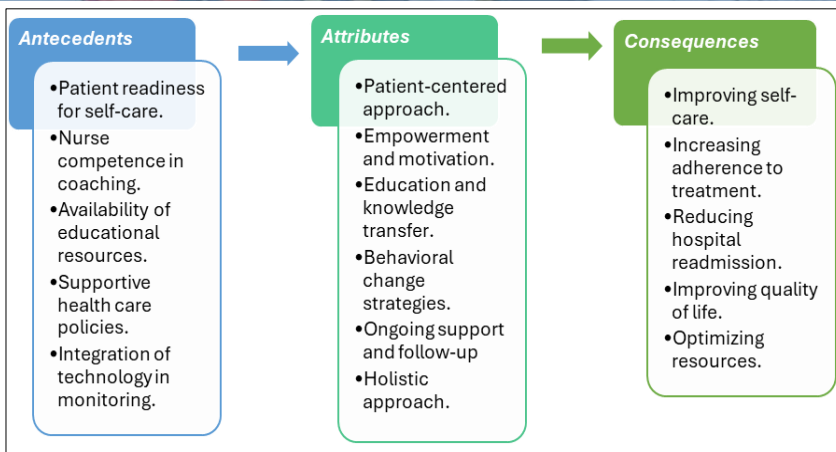


Figure 1. Antecedents, attributes, and consequences.

Defining empirical referent

Empirical referents are observable phenomena in association with the defining or critical attributes of the concept (Walker & Avant, 2013). The referent provides objective methods for evaluating the effectiveness of nursing interventions. The Community Outreach and Cardiovascular Health (COACH) Trial demonstrated the effectiveness of a nurse-led coaching program in reducing cardiovascular disease risk through a structured approach involving nurse practitioners and community health workers (Allen et al., 2011). The Self-Care of Heart Failure Index (SCHFI) can be used to measure self-care behaviors in patients with HF, including symptom monitoring, adherence to the care plan, and early intervention when symptoms worsen (Boisvert et al., 2015; Lainscak et al., 2011). The motivational interviewing approach to nursing coaching for behavior change has been validated in studies such as the MITI-HF Randomized Controlled Trial (Creber et al., 2016; Chen et al., 2018). The CONTACT-Patient-Centred Care Questionnaire was used to assess how nurses implement patient-centered care (Kenis et al., 2022). The Patient Continuity of Care Questionnaire can measure the continuity of nursing in cardiovascular cases (Säfstrom et al., 2020). Capabilities of Nurse Educators (CONE) describes how nurses educate patients (McAllister & Flynn, 2016). The Health Behavior and Stages of Change Questionnaire (HBSCQ) assesses health promotion strategies in behavioral change (Gonzalez-Ramirez et al., 2017). The Caregiver Contributions to Self-Care of Heart Failure Index (CC-SCHFI) is a valid and reliable instrument used to measure family support in patients with HF (Vellone et al., 2020). However, there is limited research explaining the tools or instruments to evaluate the effectiveness of nursing coaching specifically for patients with HF.

Discussion

The finding of the concept analysis has potential implications for nursing knowledge and practice in the care of patients with HF. It is interesting to discuss that coaching is an evidence-based approach that focuses on improving self-care, therapy adherence, and preventing complications by empowering patients' responsibilities (Best, 2020). The model emphasizes educational and motivational approaches to increase patient awareness and care (Chen et al., 2018). In clinical practice, nursing coaching can improve the quality of interactions between nurses and patients. Furthermore, nurses can utilize motivational interviewing techniques to encourage patients' self-care skills, reduce readmission rates, and improve quality of life (Chen et al., 2018). In addition, coaching promotes effective communication and an empathy, allowing nurses to provide extra care (Piamjariyakul et al., 2013). Implementing this concept facilitates a deeper

understanding of the disease process, thereby facilitating the shared decision-making process regarding their therapeutic regimen. The findings of the attributes in the conceptual analysis emphasize the integration of various patient well-being strategies. The term "integrative" refers to a holistic approach that focuses on the ability of the individual and patient to build trust and confidence. The main themes of this theory are patient-centered care, health promotion, and holistic care (Moore et al., 2022). Thus, the relationship between the nurse as a coach and the client is one of equals, with the client considered the expert in their own self-control and the coach acting as a guide who will accompany the change process (Dossey & Hess, 2013).

Conclusion

The concept analysis reveals that nursing coaching for patient with HF is characterized by six defining attributes: a patient-centered approach, empowerment and motivation, education and knowledge transfer, behavior change strategies, ongoing support and follow-up, and a holistic approach. With synthesizing these core elements, the analysis highlights that the systematic implementation of nursing coaching acts as a powerful catalyst for positive patient outcomes. Specifically, it enhances self-care behaviors and optimizes medication adherence, which are critical for the long-term stabilization of chronic cardiac conditions. Furthermore, there is an opportunity for clinical educators to explore more modern teaching strategies to improve patient self-efficacy and self-care in future studies. This comprehensive support model enhances the quality of life for those living with HF. Additionally, it serves a systemic function by reducing hospital readmission rates and promoting sustainable health outcomes across the care continuum.

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AI statements

This article is the original work of the authors, developed through a comprehensive literature review. The use of AI was strictly limited to grammatical corrections.

Author's declaration

Ismail Fahmi contributed to the conception and design of the study, conducted literature review, performed data analysis, drafted the initial manuscript, and managed the overall coordination of the manuscript preparation. Yeni Rustina provided guidance in concept development, supervised the analysis process, reviewed and edited the manuscript critically for important intellectual content. Bambang Budi Siswanto offered expert clinical insights related to heart failure, assisted in interpreting findings from a clinical perspective, and reviewed the final draft for accuracy and relevance. Tuti Herawati contributed to the refinement of the concept analysis method, participated in manuscript editing, and ensured consistency with nursing theory and practice.

Availability of data and materials

All data and materials supporting the findings of this concept analysis are documented within the article and its included reference list. Reasonable requests for additional data can be directed to the corresponding author.

Competing interests

All authors declare no conflict of interest.

Ethical clearance

As this concept analysis did not involve human participants, formal ethical clearance was not required. Furthermore, the case examples provided including the model, borderline, and contrary cases are hypothetical constructs rather than actual clinical cases. These scenarios were developed to facilitate a clearer understanding and contextualization of the 'nursing coaching' concept.

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Publishers and journal's note

This concept analysis is relevant to clinical nursing practice within the population of patient with HF. The findings of this article offer practical utility for hospital settings and specialized cardiac clinics. Furthermore, the use of the Walker and Avant methodology is appropriate, as it provides a systematic framework for concept development via utilizing illustrative case examples to facilitate an understanding of the nursing coaching model.

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Authors' insight

Key points

- The article provides a definition of nursing coaching distinguishing it from general health coaching by emphasizing nursing-specific competencies and clinical judgment in HF management.
- A central finding is that self-care is not an isolated patient activity; rather, it is a collaborative process integrating family support for treatment adherence at home.
- The analysis identifies that for coaching to be effective in reducing readmissions, it must extend beyond the hospital walls, providing a safety during the period immediately following discharge.

Emerging nursing avenues

- How does nursing coaching differ from traditional patient education in the context of HF management both in clinical and community setting?
- What specific role does family support play as a defining attribute in nursing coaching among patient with HF in this article?
- In what ways does the integration of follow-up care address the post-discharge vulnerability period for patients with HF?

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