

Health Education Needs Patient Diagnosed with Heart Failure

Mariam Alanazi

Alshamli General Hospital, Hail

INTRODUCTION

Heart failure (HF) is a severe, frequent hospitalization and extensive treatment strategies are hallmarks of a progressing clinical condition. One-third to one-half of these hospitalizations are believed to be avoidable (Zaharova, 2019). To enhance patient outcomes and eliminate unnecessary patient recruitment, the SS Consensus Guidelines promote self-care and adherence to treatment regimens. Effective ways to take care of yourself include promoting healthy habits and ongoing monitoring and treatment of symptoms (Rice et al., 2018). Ineffective self-care was explained by the lack of information about specific diseases. Clinicians focus on gaining knowledge by educating patients on how to plan for heart failure to manage this problem (HF-MP).

Patient education has been found to improve patient understanding of heart failure, self-care, and clinical outcomes (Boyde et al., 2018). The study used a range of educational interventions for patients with heart failure. On the other hand, many research approaches consider education not as a stand-alone intervention, but as an integral part of the heart failure management strategy (Bader et al., 2018). Often only a summary of the training material is provided, which is then linked to various post-release follow-up strategies. In addition, the pedagogical theories on which interventions are based are often underestimated, limiting replicability and generalizability (Zaharova, 2019). Although the benefits of patient education have been demonstrated, we have not seen everything we hoped for the variety of studies and the lack of a clear association between teaching method and good patient outcomes are likely to be the cause of conflicting results regarding the effectiveness of educational interventions.

A theoretical framework that conducts research to educate patients about organization, content, and delivery methods provides a more structured approach to developing effective treatments. Adult education or adult pedagogical thinking with a learner-centered approach can be used to provide a theoretical framework for patient education (Boyde et al., 2018). Andragogy, is a collection of assumptions that recognises that learners have varying educational requirements, that they are autonomous in their approach to learning, that they bring prior knowledge and experience to the table, and that their desire and drive to learn are genuine life situation (Bader et al., 2018). The philosophy of adult education encourages students to receive personalized instruction based on their current knowledge and experience, specific requirements and learning styles. According to Frederik and his colleagues, learning through various channels, including face-to-face interviews, written materials, and audiovisual presentations, is very helpful (Boyde et al., 2018). We designed a personalised multimedia learning intervention based on an evaluation of individual learning requirements, verbal

interactions with healthcare experts, and adult learning concepts based on this data, our own pilot study, and adult learning principles, and multimedia patient education resources

Patient Education

The job description of a nurse includes patient education. It has been shown to prevent readmission and hospitalization. Nursing education workshops for patients with heart failure have been found to increase knowledge about the management of this disease (Koehler et al., 2018). When comparing the time nurses spend with patients and other healthcare professionals, nurses tend to be in contact with patients and spend more time with them (Boyde et al., 2018). As a result, it was shown that patient outcomes, such as treatment adherence, contentment, and information comprehension, depend on how nurses build relationships with patients (Zaharova, 2019). In the past, when patients with heart failure were given information, patients were dissatisfied with the fact that doctors did not give clear explanations on how to treat the disease. Randomized controlled trials are the most appropriate form of intervention study (RCT) (Koehler et al., 2018). To this end, we considered randomized controlled trials of nursing education as interventions including readmission, hospital stay, quality of life, and/or cost as endpoints. Normally, patient education is very important. In addition, patients should receive appropriate educational materials before discharge (Paul, 2008) (Zaharova, 2019).

The scope and standards for cardiovascular care published by the American Nurses Association (ANA) emphasize that nurses are responsible for patient education. After a review of 29 studies in an interdisciplinary treatment program, it was found that the inclusion of nurses with sufficient experience in heart failure was beneficial. Cardiac nurses are critical in determining how well a patient is responding to therapy (and making appropriate adjustments) and in preparing the patient and family for self-care after hospital discharge. Patients who received educational interventions before discharge were more likely to weigh themselves, according to a meta-analysis, compared to patients who got normal treatment, they were more likely to follow salt limits and avoid smoking (Bader et al., 2018). Patients who received focused heart failure education before discharge spent less time in the hospital, had lower mortality and better and previous research has shown that patients with heart failure who received professional nursing interventions had fewer readmissions (Boyde et al., 2018).

There is also evidence that patients with severe heart failure feel better when they are instructed by trained nurses and their families (Rice et al., 2018). Thus, Cardiovascular nurses must be aware of the difficulties patients have in terms of self-care and treatment adherence, and they must investigate learning techniques that might assist patients in solving these issues. The authors of The Heart Failure Course claim that, roles and the responsibilities of nurses are determined by geographic and state-specific constraints. Other studies, on the other hand, have shown that before nurses depart, they should give high-quality education, but are unable to do so due to lack of time and knowledge (Bader et al., 2018). Nurses with a higher degree, a lot of experience, and who worked in clinical hospitals were the subjects of our research. Our study's most striking conclusion was that nurses' overall comfort scores indicated that they were quite comfortable educating heart failure patients. Daily weight monitoring, water restriction, and signs/symptoms of increasing illness were the areas where respondents felt most at peace (Zaharova, 2019). Alternatively, nurses were the least reassured when it came to providing information about low sodium medications and diets. The purpose and side effects of drug use and difficulties with sexual life were the lowest (Rice et al., 2018). The same applies to training

frequency. To put it another way, the areas in which the nurses felt most at ease were also the ones in which they taught the most (Koehler et al., 2018). Nurses have just a rudimentary awareness of heart failure signs. However, in our own study, we looked at the association indicates that the comfort level of nurses and the frequency of their training depend on the level of their specialization, as well as higher and postgraduate education (Boyde et al., 2018).

Disease Knowledge and Management

Patients may prevent deteriorating symptoms and rehospitalization with proper treatment. Patients who do not taking care of themselves may have the greatest chance of dying a year following discharge (Zaharova, 2019). Self-care compliance by the patient, on the other hand, is challenging and frequently inadequate owing to a variety of factors (Rice et al., 2018). If education is provided at the time of the first diagnosis of heart failure or after any other medical event, it was be ineffective (eg, myocardial infarction) (Koehler et al., 2018). Patients struggle to notice symptoms and react correctly, making it difficult for them to return home. Additional training in a professional context may be different and less successful if it is focused only on information and patients lack confidence in their self-care abilities. Patients must have confidence in their knowledge and abilities, therefore self-efficacy, or trust in one's capacity to care for oneself, is a crucial factor in determining whether or not they were taking care of themselves. Comorbidities, such as depression and cognitive impairment, might make it difficult for patients to actively engage in both direct and indirect heart failure self-management instruction. Patients with heart failure are more likely to experience sadness and cognitive deterioration, with depression affecting 21 to 34 percent of patients and cognitive decline impacting 2575 percent of patients (Zaharova, 2019). They might also have unfavourable outcomes. Patients with heart failure who are depressed have lower levels of physical activity and self-care, which may increase their risk of heart attack (Rice et al., 2018). Patients with cognitive disabilities who are unable to acquire the necessary knowledge and skills for self-care have a comparable impact. Due to cognitive impairment or other factors, poor patient awareness of their health (the capacity to absorb and apply information and manage their own health care) may make self-care challenging. Even if patients are properly educated in accordance with professional norms, a lack of health knowledge might make understanding heart failure hard. About 39% of heart failure patients had poor health awareness, and these patients had a greater risk of morbidity and death during hospitalization (Bader et al., 2018). Patient health awareness may be an essential element to consider in therapy and education since patients with heart failure and self-care need knowledge, and patients with low health awareness are less educated. As the prevalence and expense of heart failure are likely to rise, it is vital to enhance self-management commitment. Sadness, cognitive impairment, illness awareness, and health were all identified as potential predictors of self-care. The American Association of Heart Failure Nurses has recognised cognitive and health literacy as two research objectives since these connections are not fully known. The goal of this study was to evaluate a model that looked at the impact of self-efficacy, depression, illness awareness, and health awareness in heart failure self-management, including cognitive impairment (Rice et al., 2018). The links in the study model was explain the relevance of these factors in the self-help process, suggesting a significant field of intervention research beyond cross-sectional analysis. People with heart failure must often monitor their symptoms, adhere to hydration and dietary restrictions, exercise, adhere to recommended regimens, and seek emergency medical assistance if their symptoms worsen (Koehler et al., 2018). As a consequence, several researchers have looked at ways to assist people with heart failure improve their self-care

abilities. The majority of the studies took place at big tertiary institutions in metropolitan regions, where multidisciplinary teams ran referral clinics or nurse practitioners conducted interventions (Zaharova, 2019). Because rural individuals have lower household budgets than urban residents and have limited access to expert treatment, patients with heart failure in rural regions need simple remedies that may be implemented with less resources (Rice et al., 2018).
Aim of the Study The purpose of this study was identifying the health educational needs of patients with HF. Findings from this study was be used to improve patient education and to promote positive

METHOD

Design

This study used a cross-sectional descriptive design.

Setting

This study carried out in three critical care units at the King Abd Aziz hospital university, in Jeddah, KSA. The outpatient clinics provide services daily to around 150 patients with heart failure. The service entails blood investigation, and medication.

Subjects

A convenience sample of patients in outpatient clinic who accept to participate in this investigation were recruited in the study.

Sample Size Calculation

Based on Cohen, West and Aiken (2003)' sample power calculation, the minimum required sample size for a multiple regression study, with the desired probability level of (0.05), and a minimum of 10 predictors in the model, small effect size of (0.05), and the statistical power level of (0.8), the required sample size is 307.

Inclusion Criteria

1. Adult person aged 18 years or more of both sexes.
2. Diagnosed with heart failure.
3. Able to read and write (Arabic or English).

Exclusion Criteria

1. Persons who have cognitive deficit.

Outcome Measures

Two tools were utilized to collect data pertinent to this study.

Self-Care Heart Failure Index Tool

This tool included two parts:

Participants Sociodemographic Data

This part included participants' age, gender, level of education, occupation, marital status and illness duration.

Self-Care Heart Failure Index Questionnaire

The Outpatient Heart Failure Learning Needs Inventory (OHFLNI) was developed for this study and was used as the data collection instrument. The OHFLNI is a direct modification of Wehby and Brenner's (1999). Two items that were specific to inpatients were deleted and six items were modified to reflect the needs of an outpatient sample. All other items are original to the HFLNI. The OHFLNI contains 46 closed response items and 1 open-ended question covering 8 educational topic areas as recommended by the Agency for Health Care Policy and Research (1994) for HF patient education: prognosis, diet, activity, medications, signs and symptoms, risk factors, psychological factors (stress, support systems, emotional response to illness), and general HF information. Subjects were asked to rate each item from not important to very important on a five-point Likert scale. Permission to use and modify instrumentation was obtained from Gerard and Peterson (1984), Hagenoff et al. (1994), and Wehby and Brenner (1999).

Data Collection

This study was conducted through three phases: preparation, implementation, and evaluation phases.

Preparation Phase

- An ethical approval was obtained from the Research Ethics Committee of the King Abd Aziz hospital university
- Permission to conduct the study was obtained from the responsible authorities of the study setting after providing them with an explanation of the aim of the study.
- Data collection tools was translated into Arabic version by an expert translator
- To ensure the validity of translation, back translation technique was used.
- The translated version of the tools was reviewed by an expert in the areas of critical care nursing and medicine.
- The reliability of data collection tools was assessed using Cronbach's Alpha test.

Implementation Phase

- Eligible patients were approached by the primary investigator to inform them about the study and invite them to participate.
- Participants' socio-demographic data and their patients' health relevant data were collected after obtaining an informed consent.
- The specific tools were used to assess the study outcomes.

Evaluation Phase

- Evaluation of the collected data were done by using appropriate statistical tests.

Data Analysis

Data were analyzed by using the Statistical Package for the Social Sciences (SPSS, version 24. IBM). Descriptive statistics were used to summarize and describe the learning needs and sociodemographic data of the participants. Pearson product moment correlation coefficient was utilized to assess relationships between learning needs and sociodemographic and health history data. The level of significance was set at $p < 0.05$ for the statistical data.

Ethical Considerations

An ethical approval was obtained from the Research Ethics Committee. The primary investigator sought an ethical approval from the Institutional Review Board after providing complete explanation of the aim and nature of the study. Written informed consent was obtained from the study samples after providing them with details about the nature of the study, benefits and risks. They were informed that participation in the study is voluntary, and they have the right to withdraw without any responsibility. Moreover, they were assured that their data were coded, and their personal information was kept confidential. There was no link between their personal information and published data.

RESULTS

Socio-demographic Characteristics the Study Sample

148 completed questionnaires were received. A scan be noted from Table 1, just over the study sample who responded to the survey females (57.4%) and the least proportion was males (42.6%). Additionally, the majority (66.20%) were aged less than 51 years old years, and 33.8% were aged more than 50 years old. It is apparent from this table that more than half of the study participants were married (56.1%) and 34.5% were single. Additionally, 52.7% of the respondent had attained bachelor's degree of education compared to 23% obtained a secondary education level whilst 24.3% had an obtained secondary level or less. Moreover, 41.9% of the study participants had job and 23% of the participants were students compared to 17.6% either were unemployed or retired. Approximately, 45.9% of the study responded had a salary less than 5000 SAR monthly and only 14.2% receive a salary of 10000 SAR monthly or more. From this data, we can see that the 70%of the participants had acute diagnosis of heart failure disease, less than five years compared to 30% of patients have been diagnosed with heart failure for more than five years.

Table 1: Demographic Characteristics of The Study Participants

Characteristics	Frequency	%
<u>Gender</u>		
Male	63	42.6%
Female	85	57.4%
<u>Age</u>		
18 -30 years	50	33.8%
31-50 years	48	32.4%
>51 years	50	33.8%
<u>Marital Status</u>		
Single	51	34.5%
Married	83	56.1%
Widow	2	%1.30
Divorced	12	8.1%
<u>Education Qualification</u>		
Primary	19	12.8%
Intermediate	17	11.5%
Secondary	34	23.0%
University	78	52.7%
<u>Occupation</u>		
Unemployed	26	17.6%

Employed	88	41.9%
Student	34	%23.0
Retired	26	%17.6
Monthly Salary		
<5000 SAR	68	%45.9
5000 – 10000 SAR	59	%39.9
>10000 SAR	21	%14.2
Duration of diagnosis in heart failure		
< 1 year	66	44.6%
1 -5 years	37	25.0%
5 -10 years	22	14.9%
>10 years	23	%15.5

Table 2: The Results of Study Participants to the Leaning Needs Scale

Rank	Item	Not important	Slight important	Important	Medium Importance	Very important	Mean	SD
1	why I am short of breath.	18	30	25	35	40	3.88	0.33
2	what the heart looks like and how it works.	20	18	20	49	31	3.82	0.39
3	what causes heart failure.	3	30	15	51	39	3.81	0.38
4	what happens when someone has heart failure.	23	20	25	36	44	3.76	0.43
5	if my heart failure can be cured.	8	15	25	44	56	3.75	0.59
6	if any other tests will need to be done and why.	8	12	22	54	52	3.74	0.45
7	where my family can go to learn CPR	13	20	25	38	52	3.74	0.55
8	the normal emotional response to heaving a chronic illness.	20	20	28	52	30	3.73	0.45
9	the importance of talking to someone about my fears, feeling, and thoughts	3	35	23	48	39	3.71	0.47
10	what effect stress has on my heart.	11	11	26	43	51	3.68	0.47
11	what I can do to reduce stress.	11	22	25	43	47	3.68	0.47
12	what support groups are available.	21	23	22	47	35	3.64	0.53
13	which factors may have contributed to the onset of my heart disease?	18	30	25	42	34	3.63	0.58
14	how these factors affect the heart.	15	12	34	49	38	3.60	0.55

15	what I can do to improve my heart function	7	30	15	45	51	3.56	0.63
16	general rules about taking medications.	20	20	25	36	47	3.54	0.67
16	why I am taking each medication.	17	12	20	54	44	3.51	0.74
17	what side -effects of each medication are.	8	11	40	41	47	3.49	0.55
18	what to do if I have problems with medications.	11	10	25	48	52	3.37	0.71
19	why I am short of breath.	17	15	26	44	46	3.37	0.71
20	how to adapt to taking medication every day.	11	35	23	40	47	3.36	0.93
21	general rules about eating.	11	16	26	38	56	3.32	0.76
22	how diet affects my heart disease.	11	17	23	50	47	3.64	0.53
23	what the words sodium, salt, and NACL mean.	12	36	25	36	40	3.28	0.91
24	what my diet restrictions are, if any.	11	16	34	29	58	3.26	0.77
25	how to adapt the recommended diet to my lifestyle.	7	17	15	58	51	3.17	0.97
26	what fluid restrictions mean and which fluids should be included.	12	16	33	40	47	3.10	0.92
27	how to adapt the recommended fluid restriction to my lifestyle.	9	12	13	60	51	3.06	1.12
28	why daily weight is so important.	8	11	40	41	47	2.98	0.89
29	how to adapt daily weights to my lifestyle.	11	10	16	48	61	2.98	0.95
30	how alcohol effects the heart.	17	15	26	44	46	2.95	0.77
31	why I may not be able to do as much physically as I could before developing heart failure.	11	27	15	48	55	2.92	1.13
32	general guidelines for physical activity.	11	16	14	38	68	2.92	0.86
33	what my physical activity restrictions are, if any.	11	8	23	59	47	2.90	0.86
34	how to tell if I can increase my activity.	18	16	15	55	44	2.89	0.85
35	when I can engage in sexual activity.	12	36	14	47	40	2.79	0.96

36	how significant my heart failure is?	11	16	27	36	58	2.78	1.30
37	what advanced directives are.	7	17	11	58	55	2.77	1.04
38	what my long-term life expectancy is.	7	12	33	44	52	2.47	1.11
39	what can happen if I do not follow my doctor's recommendation.	9	7	18	52	59	2.46	1.23
40	what my quality of life is expected to be.	8	11	28	53	47	2.45	1.15
41	what advice should be given to my family in the event of an emergency outside of the hospital.	7	13	20	45	61	2.28	1.08
42	what symptoms are caused by heart failure.	17	20	21	44	46	2.27	1.18
43	What are the signs and symptoms of worsening heart failure?	16	17	20	44	95	2.25	1.15
44	what I should do if symptoms worsen.	11	16	14	38	68	2.24	0.94
45	when to call the doctor.	11	14	17	59	47	1.87	0.78
46	the signs and symptoms of other heart problem	11	23	19	56	40	1.54	0.34
47	What are the websites to take information from them about heart failure	11	27	15	48	55	1.34	0.28
48	What are the contact numbers for me in case of any emergency?	11	10	20	51	55	1.27	0.30
49	What are the electronic health programs approved by the Ministry of Health, which can know my health status and developments in it?	11	8	35	59	35	1.15	0.27

Table 3: The Relationship between Sociodemographic Data and The Leaning Needs

Characteristics	Prognosis	Diet	Activity	Medications	Signs and Symptoms	Risk Factors	Psychological Factor
Gender							
Male	0.34*	-0.37*	0.41*	-0.43*	0.07	0.44*	0.34*
Age							
18 -30 years	-0.41*	0.28*	0.33*	0.03	0.10	-0.37*	0.12
Marital Status							
Single	0.03	0.27*	0.52*	-0.34*	0.11	0.04	0.11
Education Qualification							

Primary	0.10	-0.35*	-0.37*	0.21	0.09	0.07	0.10
Occupation							
Unemployed	0.43*	-0.43*	-0.29*	-0.42*	0.11	0.10	-0.33*
Monthly Salary							
<5000 SAR	0.42*	0.33*	0.35*	-0.38*	0.14	0.14	-0.42*
Duration of diagnosis in heart failure							
< 1 year	0.48*	0.26*	-0.40*	0.04	0.15	0.13	-0.32*

The results of correlation analysis indicates that male patients had better prognosis of disease compared with female patients ($r = 0.34$; $p < 0.05$) and there is statistically significant relationship between male patient and risk factor as well as psychological factors. However, male patients are negatively correlated with diet and medication adherence ($p < 0.05$). In addition, patients aged between 18-30 years is statistically significant correlated with diet, activity ($p < 0.05$). however, it is negatively related with prognosis and risk factor. The results also demonstrated that single patients are significantly correlated with diet and activity and negatively correlated with medication. Patients with low education level seemed to have less activity and diet adherence. The occupation status is negatively correlated with diet, activity, medication and psychological factor. Low socioeconomic status is positively correlated with prognosis, diet and activity ($p < 0.05$) and negatively correlated with medication and psychological factors ($p < 0.05$). less disease chronicity is positively correlated with prognosis and diet and negatively correlated with activity and psychological factors, as described in Table 3.

DISCUSSION

The objective of this study was to better understand the educational demands of heart failure patients and compare them to healthcare professionals' aspirations. The findings indicated parallels and discrepancies in patient and healthcare professional assessments of educational demands. In general, both groups were in a similar position when it came to analysing learning requirements. Heart failure patients want to know about the meds they're taking, and when educators are included, their signs and symptoms improve. Medical practitioners also make an effort to educate as many individuals as possible about the same issues that patients face. Our findings are in line with earlier research on the educational demands of heart failure patients. Koehler et al. (2018) The educational requirements of heart failure patients and nurses were investigated, and it was shown that drugs and indications and symptoms were reasonably popular subjects among both groups.(Koehler et al., 2018) In the same way,(Jaarsma et al., 2021).

For in patients with heart failure, questions on the signs and symptoms of heart failure are considered a fundamental educational need and (Anderson & Marrs, 2018) Prove that medication information is the most critical information for patients with heart failure before they are discharged from the hospital. Understanding drugs has a big influence on heart failure patients' treatment adherence, which has a big impact on their health.(Fung et al., 2018).Reduced symptoms are one of the key aims of HF therapy(McDonald et al., 2021). As a result, crucial drugs and information regarding signs and symptoms are important issues for heart failure patients and healthcare providers. Healthcare personnel were more worried about

diet than patients in this study(Gupta & Wood, 2019). Patients with heart failure showed much worse diet-related outcomes than health care professionals.

A study came upon anything similar(Yu et al., 2018). Diet-related educational concerns are undervalued in heart failure patients. Furthermore, heart failure patients and healthcare experts in this study held opposing viewpoints on a number of issues, including fluid restriction, alcohol intake, and daily body weight. In individuals with heart failure, however, they are regarded an important aspect of self-healing (Greene et al., 2021; Yu et al., 2018).

The major aims of heart failure therapy are to remove or at least lessen the symptoms of heart failure (such as venous congestion) as well as to diminish or eliminate variables that contribute to the disease's development. Limiting salt and water consumption is especially crucial in this scenario to avoid venous congestion and its associated signs and symptoms(Chrysohoou et al., 2022). Heart failure patients may have entrenched dietary patterns that are difficult to modify. Patients with heart failure may find it challenging to stick to their restricted fluid consumption, with just 60% indicating that they adhere to their fluid limits(Chew et al., 2019).

Some people may be unaware of the strong link between fluid retention and heart failure clinical symptoms. Even if the patient understands the need of diet, daily self-control can assist(Chew et al., 2019). Clinicians must first assess patients' level of knowledge before training them and providing tailored treatment based on their particular learning needs to enhance self-management in HF. While medical knowledge and expertise are essential, it is also critical to assess how they may be applied effectively in the real lives of patients with heart failure. Whereas the two groups agreed on the general order of educational needs, there were substantial disparities in the order of particular things that heart failure patients and healthcare professionals regarded necessary.

Patients want to know about their illness or hospital treatment, yet many find communicating with healthcare personnel challenging(Fawaz et al., 2018). Patients do not always express all of their concerns because they are afraid that healthcare providers would respond in an inappropriate manner, such as by disregarding them (Maffoni et al., 2019). Patients may believe doctors are providing them with excessive or erroneous information(Maffoni et al., 2019). Healthcare practitioners, on the other hand, frequently believe that patients are unaware of their duties. As a result, poor communication can be a substantial barrier to individuals with receiving appropriate therapy(Magnani et al., 2018).

Previous studies have indicated that one-on-one and one-on-one training for nurses can help patients improve their coping abilities(Dineen-Griffin et al., 2019). Through engagement with healthcare providers and general clinical care, patient-centered education that targets the patient's greatest learning requirements can promote patient confidence and well-being. Furthermore, past study has demonstrated that a patient's level of education or other medical issues might affect their communication with healthcare providers and treatment choices(Dineen-Griffin et al., 2019). As a result, well-designed methods to promote communication between heart failure patients and healthcare providers are required, taking into consideration the patients' actual educational requirements. Furthermore, patient-centered instructional materials should be designed to give practical counsel that is suited to each individual's situation and preferences.

This research contains a number of flaws. First, the sample is tiny and convenient, so it cannot represent the entire population, and generalization is restricted. Comparisons between nurses and doctors were challenging due to the limited sample size of healthcare workers, which might erode trust in the findings. Future research will benefit from combining the perspectives of diverse health practitioners. Second, in this study, Cronbach's alpha HFPLNI is 0.98, which is a significantly high number. Prioritizing each item might be difficult because most people have similar reactions to most items. Using answer scales with more than five points or enabling participants to assess different categories might help researchers come up with clearer scores and priorities for future studies. **Conclusions** The training requirements and goals of heart failure patients and healthcare providers have some commonalities and some substantial disparities. Health insurers must examine the real educational requirements and knowledge levels of heart failure patients and give in-depth and practical patient-centered education in order to apply an effective strategy to successful self-management of patients throughout their lives. Interim treatment for adults with heart failure lowers mortality and improves quality of life. Due to a lack of data, the effect on emotional stress is equivocal, emphasizing the need for more study.(Li et al., 2021)

The influence of hospitalisation on heart failure patients has been widely researched. The first hospitalisation in the HF process has been highlighted as a turning point because it frequently leads to readmission and is linked with a considerable increase in mortality (Rice, Say, and Betihavas, 2018). Furthermore, despite conservative therapy, the dismal prognosis of hospitalized heart failure patients did not improve [40]. These factors, together with the high financial cost of hospitalisation, provide an ideal setting for evaluating hospitalisation management strategies, decreasing recruitment rates and thereby cutting expenses. Despite the fact that nurses play an important part in overall SS care and are frequently teachers, further study on the influence of nursing education on hospitalisation is needed. Education and training are two techniques for patient empowerment.(Rice et al., 2018)

We present information and ideas for future research, as well as policy and practise implications, based on the findings of this study. It also highlights the therapeutic value and relevance of educational activities. Given this, the role of nurse has a significant practical impact. The value of nurses in providing comprehensive heart failure treatment has been shown (Rice et al., 2018). Nurses are ideally positioned to assess patient knowledge, educational requirements, and overcome learning obstacles by reviewing educational content as required, in addition to delivering care.

Nurse-led education enables patients to have access to knowledge and engage actively in their health care. Patient education and follow-up, both over the phone and in person, improved patient outcomes and decreased hospitalizations and readmissions, according to the research. Nurses are ideally positioned to assess patient knowledge, educational requirements, and overcome learning obstacles by reviewing educational content as required, in addition to delivering care. Nurse-led education enables patients to have access to knowledge and engage actively in their health care. Patient education and follow-up, both over the phone and in person, improved patient outcomes and decreased hospitalizations and readmissions, according to the research nurses play a vital role in the treatment of patients with heart failure in general and applying their skills and knowledge in patient education can help patients with heart failure improve their clinical and functional outcomes.

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