

# Causes, experiences and consequences of the impact of chronic heart failure on the person's social dimension: A scoping review

Maddi Olano-Lizarraga PhD, MSc, RN<sup>1,2,3</sup>   | Sara Wallström PhD, RN<sup>4,5</sup> |  
Jesús Martín-Martín PhD, MSc, RN<sup>1,2,3</sup>  | Axel Wolf PhD, RN<sup>4,5</sup>

<sup>1</sup>School of Nursing, Adult Nursing Care, Universidad de Navarra, Pamplona, Spain

<sup>2</sup>Innovation for a Person-Centred Care Research Group (ICCP-UNAV), Universidad de Navarra, Pamplona, Spain

<sup>3</sup>IdiSNA, Navarra Institute for Health Research, Pamplona, Spain

<sup>4</sup>Institute of Health and Care Sciences, Sahlgrenska Academy, University of Gothenburg, Gothenburg, Sweden

<sup>5</sup>University of Gothenburg Centre for Person-Centred Care (GPCC), University of Gothenburg, Gothenburg, Sweden

## Correspondence

Jesús Martín Martín, School of Nursing, Universidad de Navarra, c/Irunlarrea 1, 31008 Pamplona, Navarra, Spain.  
Email: [jmartinm@unav.es](mailto:jmartinm@unav.es)

## Funding information

None declared.

## Abstract

Chronic heart failure (CHF) is a progressive and disabling condition that significantly impacts patients' daily lives. One of its effects is decreased opportunities to participate in social life, leading to reduced social interaction, loneliness, social isolation and lack of social support to continue with their daily life activities. This study aimed to explore the causes, experiences, and consequences of the impact of CHF on the social dimension of the person. According to the Arksey & O'Malley method, a scoping review of the literature was conducted to examine existing knowledge in the area, summarise existing evidence and identify gaps in the literature. The search was conducted in the PubMed, CINAHL, PsychINFO, Scopus, and Web of Science databases from January 2010 to November 2021. Twenty-six articles were identified. The reasons why CHF influences the social dimension of the person were multifactorial and related to physical aspects, sociodemographics, lifestyle changes and the feelings experienced by these patients. Social relationships play a key role, and the benefits of good social relationships and the impact of poor or inadequate social support were identified. Furthermore, the influence of alterations in the social dimension on the CHF patient's clinical outcomes was described. This approach will help to detect and better understand the bidirectional influence that exists in each person between social isolation, relationships, and support life experiences, self-care activities, and morbi-mortality rates. These findings have shown the importance of detecting higher-risk groups and systematically assessing factors related to the social dimension in all patients with CHF.

## KEYWORDS

heart failure, scoping review, social isolation, social support

This is an open access article under the terms of the [Creative Commons Attribution](https://creativecommons.org/licenses/by/4.0/) License, which permits use, distribution and reproduction in any medium, provided the original work is properly cited.

© 2021 The Authors. *Health and Social Care in the Community* published by John Wiley & Sons Ltd.

## 1 | INTRODUCTION

Chronic heart failure (CHF) is a progressive and disabling condition characterised, above all, by shortness of breath, fatigue and oedema in patients (Ponikowski et al., 2016); its prevalence has been steadily increasing over the last three decades (Lippi & Sanchis-Gomar, 2020), and currently, approximately 2% of the world's population is affected, rising to more than 10% in people over 70 years of age (Ponikowski et al., 2016; Virani et al., 2020). Together with its increasing prevalence, what makes this population a priority target for social and healthcare is that, as with other chronic conditions, people with CHF live with a complex situation that significantly affects their quality of life and general well-being (Olano-Lizarraga et al., 2021).

People with CHF, in addition to experiencing severe physical restrictions and rapid and unexpected decompensations, have to deal with complex treatment regimens, strict self-care behaviours and lifestyle changes that have a significant impact on their daily lives (Clark et al., 2014; Müller-Tasch et al., 2018). All of this decreases the opportunities they have to participate in social life, leading them to experience a deterioration of social interaction and loneliness (Chan et al., 2018), social isolation (Robins et al., 2018) and a lack of social support to be able to continue with their daily life activities (Menéndez-Villalva et al., 2015). In fact, social isolation and loneliness have been related to an increased risk of mortality, at the same level as that produced by hypercholesterolaemia, hypertension and tobacco use (Holt-Lunstad et al., 2010; Pantell et al., 2013). In people with CHF, there is also an increased risk of hospitalisation (Korda et al., 2017) and cardiac events (Wu et al., 2013), as well as higher rates of depression (Friedmann et al., 2014), poorer self-care (Fivecoat et al., 2018) and a deterioration in the quality of life and well-being (Olano-Lizarraga et al., 2021). It has been shown that the decline of the social dimension is one of the most negative impacts of the condition on the lives of those with CHF (Leeming et al., 2014).

In the last decade, several studies have been carried out to increase knowledge of the aforementioned phenomena. At this point, it should be noted that the concept 'social dimension' of the person includes the person's social role in the family, social and work dynamics, as well as his or her responsibilities, commitments and relationships (Gordon, 1994). Literature reviews have provided knowledge about the relationship between CHF and people's social dimension through studies of the experience of living with CHF (Gerlich et al., 2012; Hopp et al., 2010; Jeon et al., 2010; Olano-Lizarraga et al., 2016), factors related to the onset of depression (Dekker, 2014; Graven & Grant, 2013), the relationship between social isolation and rehospitalisations (Heidari Gorji et al., 2019) and social aspects related to self-care (Karimi & Clark, 2016; Strachan et al., 2014). However, they all offer a partial view of this situation. It is considered necessary to obtain a broader understanding of the related factors, the antecedents and the consequences on the social dimension to be able to provide a more complete and effective response to this situation. This scoping review aimed to explore the causes, experiences and consequences of the impact of CHF on the social dimension of the person.

### What is known about this topic?

- Chronic heart failure (CHF) is a progressive and disabling condition.
- People have to deal with complex treatments, strict self-care behaviours and lifestyle changes that significantly impact their lives.
- CHF decreases the opportunities to participate in social life, leading to a deterioration of social interaction, loneliness, social isolation and a lack of social support.

### What this paper adds?

- The reasons why CHF influences the social dimension of the person arise from physical aspects, socio-demographics, lifestyles changes and some feelings of the patients.
- Inadequate social support leads to perceptions of lack of confidence, frustration, loneliness, fear and uselessness.
- The impact of CHF on person's social dimension influences the development of depression, risk of readmission and death, emergency department and outpatient visits, self-care behaviours and treatment adherence.

## 2 | MATERIALS AND METHODS

### 2.1 | Design

A scoping review was conducted to examine existing knowledge in the area, summarising existing evidence and identifying gaps in the literature (Arksey & O'Malley, 2005). Scoping reviews can provide a more complete overview of all the research activity related to a topic (Pham et al., 2014). As presented below, the following main steps were carried out: (1) the research question was formulated; (2) the most relevant studies were identified; (3) the studies were selected; (4) the data were analysed; and (5) the results were integrated and synthesised.

### 2.2 | Search methods

The search was conducted in the PubMed, CINAHL, PsychINFO, Scopus and Web of Science databases in January 2021. In addition, snowballing was used to identify other relevant sources. English synonyms for the keywords 'chronic heart failure', 'social life' and 'experience' were used (see Table 1), in addition to MeSH terms for words containing it. The search limits were restricted to publications from January 2010 to November 2021 and those in English and Spanish languages.

The selection criteria listed in Table 2 were applied and allowed for the inclusion of articles that made a significant contribution to the research question.

TABLE 1 Combination of keywords

OR	AND	OR	AND	OR
'heart failure' <sup>a</sup>		'social life'		experience
'cardiac failure'		'social interaction'		perception
Chf		'social relationships'		attitude <sup>a</sup>
'chronic heart failure'		'social relations'		view
'congestive heart failure'		'social life impact'		feeling
		'social network' <sup>a</sup>		qualitative <sup>a</sup>
		'social isolation' <sup>a</sup>		perspective
		Loneliness <sup>a</sup>		'living with'
				assessment

Limits: articles published from January 2010 to November 2021 and language (English and Spanish).

<sup>a</sup>Mesh terms were used for all the concepts that had it.

### 2.3 | Search outcomes

One researcher (MOL) carried out the database searches after reaching a consensus with the rest of the research team on the search strategy. Two researchers MOL and JMM independently screened the articles according to title and abstract based on the selection criteria described at the beginning. Both the divergences in the selection and the articles that would go on to the in-depth reading phase were agreed upon by the research team. Thus, of the 594 eligible articles, 46 were read in depth (see [Figure 1](#)).

Two researchers (MOL and JMM) carried out an in-depth reading of the 46 preselected articles, excluding several of them for the reasons presented in [Figure 1](#). Finally, the other two researchers of the team (SW and AW) corroborated the inclusion of the 26 final studies in the review. The complete selection process is presented in [Figure 1](#) and was carried out based on the Preferred Reporting Items for Systematic reviews and Meta-analysis extension for Scoping Reviews (PRISMA-ScR) guidelines (Tricco et al., 2018).

### 2.4 | Data abstraction and synthesis

First, the following data were extracted: the authors, the country in which the study was carried out and the year of publication; the objective of the study; the methodology used; the sample; and the

main results of the articles. Subsequently, a thematic synthesis of the data was carried out based on the method proposed by Dixon-Wood et al. (2005) for the synthesis of qualitative and quantitative evidence. Two researchers (MOL and JMM) first summarised the evidence for each selected study and coded it under broad thematic headings. Then, the results of all studies were compared, identifying common themes and creating higher-order categories. Later, the evidence collected under each theme was summarised, and several subthemes were identified. Finally, the similarities and differences between the results comprising each theme and subtheme were identified. This process was then reviewed and discussed by the entire research team, which resulted in reconfiguring the themes and further summarising the results.

## 3 | RESULTS

First, the characteristics of the selected studies will be described. Then, the results of the thematic analysis of the literature will be presented. The reasons why CHF influences the social dimension of the person will be identified. The role of social relationships in the lives of people with CHF will be shown and, finally, the influence of disturbances in the social dimension of the person with CHF on their clinical health outcomes will be described. [Figure 2](#) shows a representation of the main findings of this study.

TABLE 2 Selection criteria

Inclusion criteria	Exclusion criteria
<ul style="list-style-type: none"> <li>• Studies in which the sample was composed of people with CHF</li> <li>• Addressed people's experience of social life, social roles, social support or social relationships</li> </ul>	<ul style="list-style-type: none"> <li>• Studies focussing on polypathological older patients where the specific influence of the CHF on the situation cannot be determined.</li> <li>• Studies focussing on the experience of people with other cardiac conditions (atrial fibrillation, transplant recipients, myocardial infarction, Takotsubo cardiomyopathy, etc.)</li> <li>• Studies focussing on informal caregivers and healthcare professionals</li> <li>• Studies focussing on the experience of people of a particular culture or ethnicity</li> <li>• Studies exploring other phenomena around CHF, such as self-care, self-management, adherence to diet or treatment, physical activity, economic costs, thirst, etc.</li> <li>• Patients with mechanical circulatory support</li> <li>• Development and validation of scales</li> </ul>

FIGURE 1 PRISMA 2009 flow diagram

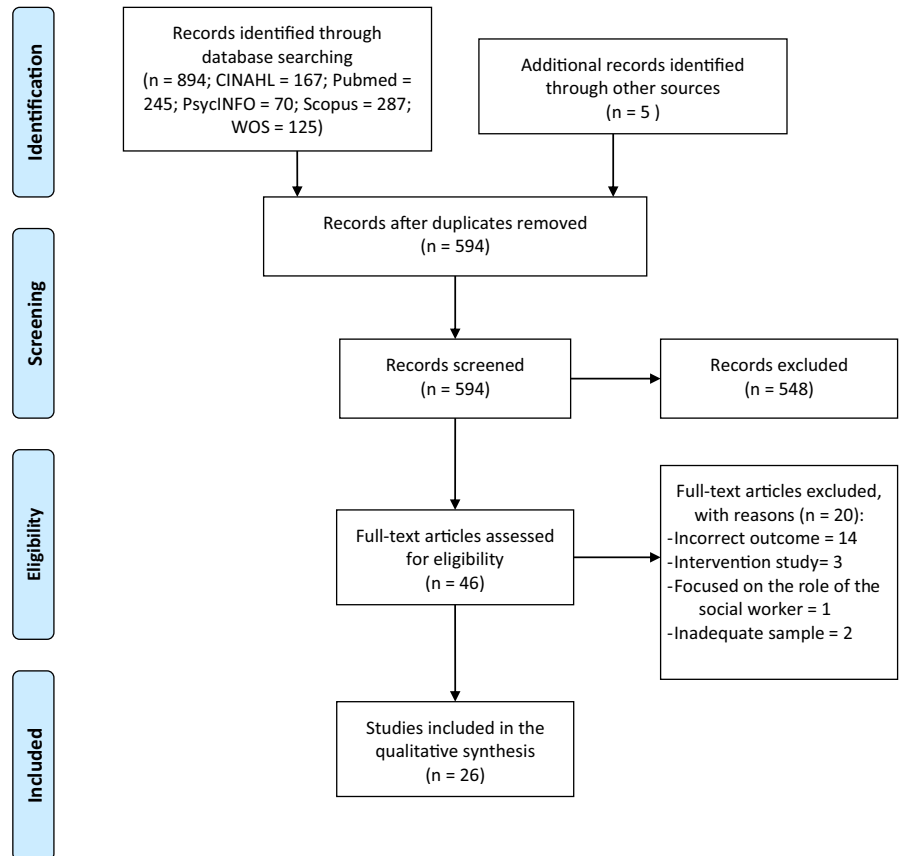
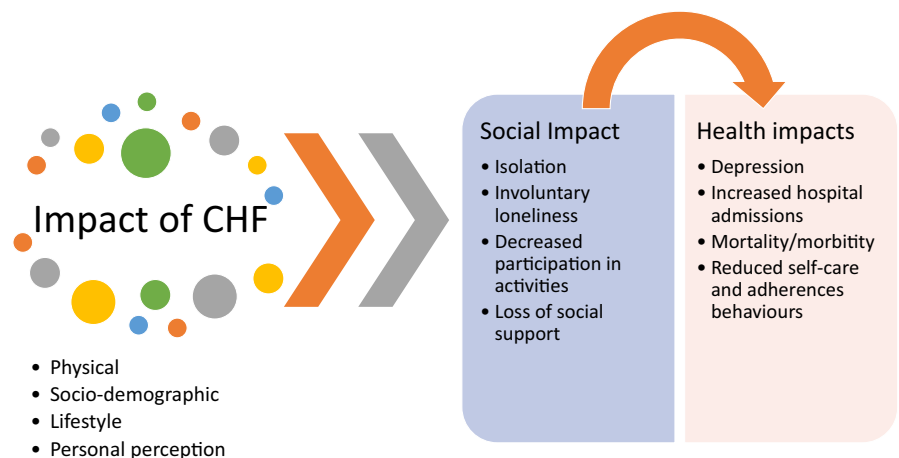


FIGURE 2 Summary of results



### 3.1 | Study characteristics

Twenty-four articles were identified that responded to the objective of this scoping review to explore the causes, experiences and consequences of the impact of CHF on the social dimension of people with the condition. Details of the selected articles are presented in Table 3.

Six studies were conducted in the USA (Dekker, 2014; Graven & Grant, 2013; Hopp et al., 2010; Manemann et al., 2018; Pavlovic et al., 2021; Sacco et al., 2014), four in Sweden (Allemann et al., 2018; Årestedt et al., 2013; Pihl et al., 2011; Sundin et al., 2010), three in the UK (Fry et al., 2016; Leeming et al., 2014; Mahoney-Davies et al., 2017), three in Spain (Olan-Lizarraga

et al., 2016, 2020, 2021), two in Canada (Karimi & Clark, 2016; Strachan et al., 2014) and one in Germany (Gerlich et al., 2012), Iran (Heidari Gorji et al., 2019), Australia (Jeon et al., 2010), Poland (Obieglo et al., 2016), Italy (Paturzo et al., 2016), Greece (Polikandrioti et al., 2019), Japan (Saito et al., 2019) and China (Zhu et al., 2021).

The included studies consisted of six cross-sectional studies (Allemann et al., 2018; Årestedt et al., 2013; Manemann et al., 2018; Obieglo et al., 2016; Polikandrioti et al., 2019; Saito et al., 2019; Zhu et al., 2021), seven literature reviews (Dekker, 2014; Graven & Grant, 2013; Jeon et al., 2010; Karimi & Clark, 2016; Olan-Lizarraga et al., 2016; Pavlovic et al., 2021; Strachan et al., 2014), five hermeneutic phenomenological studies (Olan-Lizarraga et al., 2020,

TABLE 3 Summary of selected articles

Author, year, country	Aim	Methods	Sample	Main results
Allemand et al. (2018), Sweden	To explore factors related to perceived social support in a large cohort of individuals with HF living with an ICD.	Cross-sectional study	N = 1550 patients (303 female and 1247 male) Mean age = 67.3 years	<ul style="list-style-type: none"> <li>One in 5 patients with HF living with an ICD reported low/medium perceived levels of social support.</li> <li>Cohabiting was the greatest predictor of high perceived level of social support.</li> </ul>
Årestedt et al. (2013), Sweden	(1) To describe social support in older patients with chronic heart failure in relation to gender. (2) To investigate if age, gender, cohabitation, perceived financial situation and disease severity are associated with social support. (3) To investigate if social support is associated with HRQoL after controlling for age, gender and disease severity.	Cross-sectional study	N = 649 patients (163 female and 186 male) Mean age = 79.1 years	<ul style="list-style-type: none"> <li>Being a man, living alone, perceiving a problematic financial situation and high disease severity (NYHA) were associated with lower levels of social support.</li> <li>Age was not associated with social support.</li> <li>Social support was generally associated with HRQoL, in particular the emotional dimensions.</li> </ul>
Dekker (2014), USA	To review qualitative findings about patient perspectives of contributing factors, associated symptoms, consequences and self-care strategies used for depressive symptoms in HF.	Qualitative literature review	30 studies	<ul style="list-style-type: none"> <li>Perceived consequences of depressive symptoms included hopelessness, despair, impaired social relationships and a decreased ability to engage in HF self-care.</li> <li>Recommended management strategies consisted of enhanced social support and cognitive strategies.</li> </ul>
Fry et al. (2016), UK	To use secondary analysis to interrogate a qualitative data set to explore the experiences of patients living with heart failure.	Ethnographic study	N = 11 patients (7 female and 4 male) Mean age = 71.2 years	The experiences of patients living with heart failure: (1) The impact of illness on everyday life, (2) The role of family and friends in providing support, (3) Relationships with health professionals, (4) Managing multiple illnesses and (5) Access to healthcare.
Gerlich et al. (2012), Germany	To explore the needs of older patients with advanced heart failure and their experiences with healthcare delivery in Germany.	Qualitative longitudinal research	N = 12 patients (6 female and 6 male) Age = 73–94 years	<p>Three main categories with several subcategories emerged:</p> <ol style="list-style-type: none"> <li>Understanding of illness and prognosis: Information needs; Source of information and Dealing with prognosis.</li> <li>Healthcare services: Hospitals; In the community and Finances.</li> <li>Social life: Social activities and Communication about illness with family, friends and neighbours.</li> </ol>
Graven and Grant (2013), USA	To (1) examine recent literature regarding the impact of social support on depressive symptoms in individuals with HF, (2) synthesise findings across those studies, (3) assess potential areas of future research regarding social support and (4) identify implications for nursing practice.	Integrative review	15 studies	<ul style="list-style-type: none"> <li>11 studies found social support to prevent or reduce depressive symptoms.</li> <li>Emotional and tangible support as coping resources or strategies, the perceived availability of or satisfaction with support and social networks, and assistance with problem solving positively influenced depressive symptoms.</li> </ul>

TABLE 3 (Continued)

Author, year, country	Aim	Methods	Sample	Main results
Heidari Gorji et al. (2019), Iran	To what extent social isolation can affect the hospital readmission rate for heart failure patients?	Meta-analysis	13 studies	<ul style="list-style-type: none"> <li>Social isolation was associated with a 55% greater risk of hospital readmission in patients with HF.</li> <li>No significant difference in the rate of hospital readmission between perceived and objective social isolation.</li> </ul>
Jeon et al. (2010), Australia	To develop a wide-ranging understanding of what is known about the patient experience of CHF based on narrative accounts of firsthand experience by patients or indirect experience by health professionals or family carers.	Narrative review of qualitative studies	30 studies	<p>Core concepts and Sub-concepts:</p> <ol style="list-style-type: none"> <li>Impact of CHF on everyday life: Social isolation; Living in fear; and Losing a sense of control.</li> <li>Common patterns of coping strategies: Sharing experiences; and Being flexible to changing circumstances.</li> <li>Factors influencing self-care and/or the provision of good care: Knowledge; Health Services—availability and access; Health Services—continuity and quality of care; Co-morbidity; and Personal Relationships.</li> </ol>
Karimi and Clark, (2016), Canada	To bring research findings regarding the influence of patients' values on HF self-care.	Mixed-methods systematic review	54 studies	<p>Three themes:</p> <ol style="list-style-type: none"> <li>The effects of HF influenced which values the patients prioritised.</li> <li>Values influenced HF self-care behaviors.</li> <li>Self-care behaviors influenced the values patients prioritised.</li> </ol>
Leeming et al. (2014), UK	To explore the impact of advanced heart failure on other aspects of the patients' lives	Secondary analysis of interview data generated for a qualitative longitudinal study	18 interviews (12 interviews with patients and their family carers, and 6 with GPs)	<p>Three key themes:</p> <ol style="list-style-type: none"> <li>Social isolation.</li> <li>Psychological issues and coping strategies.</li> <li>Existential concerns.</li> </ol> <ul style="list-style-type: none"> <li>Participants were more concerned about their mood, anxiety, quality of life and social functioning at present compared with before the onset of heart failure.</li> <li>Themes present in the interview data: Changes to self and others; Emotional reactions; Thoughts about death; Expectations for the future; and Hospital experiences.</li> </ul>
Mahoney-Davies et al. (2017), UK	To understand the emotional and psychological experiences of heart failure patients in a busy NHS service and make recommendations for how best to support this population.	Mixed methods approach	10 patients (4 female and 6 male) Age = 47–75 years	<ul style="list-style-type: none"> <li>Participants were more concerned about their mood, anxiety, quality of life and social functioning at present compared with before the onset of heart failure.</li> <li>Themes present in the interview data: Changes to self and others; Emotional reactions; Thoughts about death; Expectations for the future; and Hospital experiences.</li> </ul>
Manemann et al. (2018), USA	To determine, among patients with HF, whether perceived social isolation is associated with death and healthcare use, including hospitalisations, emergency department (ED) visits and outpatient visits.	Cross-sectional study	1,681 patients (783 female and 898 male) Mean age = 73 years	<ul style="list-style-type: none"> <li>High perceived social isolation is associated with an increased risk of death, hospitalisations, ED visits and outpatient visits.</li> </ul>

(Continues)

TABLE 3 (Continued)

Author, year, country	Aim	Methods	Sample	Main results
Obieglo et al. (2016), Poland	To analyse an association between acceptance of illness and quality of life in a large group of individuals with at least a 6-month history of heart failure.	Cross-sectional study	100 patients (32 female and 68 male) Mean age = 63.2 years	<ul style="list-style-type: none"> <li>Patients presenting with low levels of acceptance of illness scored significantly higher on the energy, pain, emotional reaction, sleep, social isolation and mobility.</li> <li>Acceptance of illness was the only independent predictor of quality of life in all the NHP domains: energy, emotional reactions, sleep, social isolation and mobility.</li> <li>Divorce was associated with higher social isolation scores.</li> </ul>
Olano-Lizarraga et al. (2016), Spain	To determine, from a systematic literature review, the experience of living with heart failure and to propose some practice guidelines and research questions	Qualitative meta-synthesis of the literature	25 studies	<p>Three main themes:</p> <ol style="list-style-type: none"> <li>The beginning of the process.</li> <li>Its effect on the person: The effects on the physical, emotional, social and spiritual dimension.</li> <li>How to live with HF: Adjustment and coping strategies; The support of their immediate environment; and Professional support.</li> </ol>
Olano-Lizarraga et al. (2020), Spain	To explore the perception of normality in life experienced by patients with chronic heart failure	Hermeneutic phenomenological study	20 patients (12 female and 8 male) Age = 65–89 years	<p>Four main themes:</p> <ol style="list-style-type: none"> <li>Accepting my new situation.</li> <li>Experiencing satisfaction with life.</li> <li>Continuing with my family, social and work roles.</li> <li>Hiding my illness from others.</li> </ol>
Olano-Lizarraga et al. (2021), Spain	To understand the meaning of living with CHF from the patient's perspective	Hermeneutic phenomenological study	20 patients (12 female and 8 male) Age = 65–89 years	<p>Six main themes:</p> <ol style="list-style-type: none"> <li>Living with CHF involves a profound change in the person.</li> <li>The person living with CHF has to accept their situation.</li> <li>The person with CHF needs to feel that their life is normal and demonstrate it to others.</li> <li>The person with CHF needs to have hope.</li> <li>Having CHF makes the person continuously aware of the possibility of dying.</li> <li>The person with CHF feels that it negatively influences their close environment.</li> </ol>

TABLE 3 (Continued)

Author, year, country	Aim	Methods	Sample	Main results
Paturzo et al. (2016), Italy	To describe the lived experience of adults with HF	Hermeneutic phenomenological study	30 patients (10 female and 20 male) Age = 48–86 years	Seven themes: 1. Important life changes. 2. Social isolation caused by the illness. 3. Anger and resignation associated with the disease. 4. Relief from spirituality. 5. Will to live. 6. Uncertainty about the future. 7. The inescapability of disease and death.
Pavlovic et al. (2021), USA	To synthesise existing literature on fatigue in HF through a systematic literature review guided by the biopsychosocial model of health	Systematic review	33 studies (female sex was 42.7% in quantitative studies and 47.4% in qualitative studies) Age = 64.8 years across (quantitative studies), 70.4 years (qualitative studies), and 81.0 years (mixed methods study).	<ul style="list-style-type: none"> <li>Biological and psychological factors associated with fatigue: New York Heart Association functional class, haemoglobin level, history of stroke and depression.</li> <li>Social factors related to fatigue: social roles, relationship strain, and loneliness and isolation.</li> <li>Few non-pharmacologic interventions have been tested by show some promise for alleviating fatigue in HF.</li> <li>Conflicting evidence related to the prognostic implications of fatigue.</li> </ul>
Pihl et al. (2011), Sweden	To describe how patients suffering from chronic heart failure conceived their physical limitations in daily life activities	Phenomenographic approach	15 patients (5 female and 10 male) Mean age = 76 years	<p>Main themes:</p> <ol style="list-style-type: none"> <li>Need of finding practical solutions in daily life.</li> <li>Having realistic expectations about the future.</li> <li>Not believing in one's own ability.</li> <li>Losing one's social role in daily life.</li> </ol>
Polikandrioti et al. (2019), Greece	To assess levels of fatigue in HF outpatients and the associated factors, as well as to explore the correlation between fatigue and QoL	Cross-sectional study	130 patients (47 female and 83 male) Age = 82.3% over 60 years	<p>Total fatigue was statistically significantly associated with NYHA stage, confidence to acknowledge health deteriorations, decrease in appetite, dyspnoea at night, oedema in lower limbs, relation with health professionals, and whether patients had limited daily activities, social contacts, and if they had financial worries. Finally, as the score of fatigue increased, so the QoL score also increased.</p>
Pratt Hopp et al. (2010), USA	To systematically review the literature relating to the lived experience of HF and to identify common themes identified in this literature	Systematic review	15 studies (59 female and 111 male) Age = 38–100 years	<p>2 domains:</p> <ol style="list-style-type: none"> <li>Challenges related to HF: Challenges in working with the formal healthcare system; Life disruption; Social isolation; Symptoms associated with HF; and Uncertainty about life with HF.</li> <li>Coping with HF challenges: Management of the condition; Dealing with the dying process; and Social support.</li> </ol>

(Continues)



TABLE 3 (Continued)

Author, year, country	Aim	Methods	Sample	Main results
Sacco et al. (2014), USA	To explore the experiences of people living with advanced heart failure (HF) to determine the extent to which (1) psychosocial resources relevant to HF patients were qualitatively reported, and (2) to determine the extent to which psychosocial resources were correlates of subsequent well-being as assessed by validated quantitative measures.	Mixed methods approach	111 patients (44 female and 67 male)	<ul style="list-style-type: none"> <li>Patients reported many psychosocial resources, particularly positive meaning, religion/spirituality, social support and medical resources.</li> <li>Social support was related to higher anxiety about death three months later.</li> </ul>
Saito et al. (2019), Japan	To investigate the prevalence of social isolation in patients with heart failure and whether it is associated with rehospitalisation	Cross-sectional study	148 patients (73 female and 75 male) Age = 75–86 years	<ul style="list-style-type: none"> <li>Heart failure rehospitalisation occurred within 90 days, and the heart failure rehospitalisation rate was significantly higher in the social isolation group.</li> <li>Social isolation was one of the strongest predictors of heart failure rehospitalisation, showing larger effects than living alone, being unemployed and other established risk factors.</li> </ul>
Strachan et al. (2014), Canada	To identify the main contextual factors and processes that influence patients' self-care of heart failure	Qualitative systematic review	45 studies	<p>Six main types of contextual factors were found to influence HF self-care in the studies:</p> <ul style="list-style-type: none"> <li>Caregivers; Social networks and social support; Place; Finances and financial capacity; Work and occupation; and HF support groups and programmes.</li> </ul>
Sundin et al. (2010), Sweden	To illuminate the meanings of support as experienced by elderly women with chronic heart failure.	Hermeneutic phenomenological study	5 female patients	<p>Two themes:</p> <ol style="list-style-type: none"> <li>Feeling confident means support: Enjoying freedom and independence; and Being confirmed mediates safety.</li> <li>Feeling abandoned: Suffering from dependency of others; Longing for sharing; and Feeling neglected in care.</li> </ol>
Zhu et al. (2021), China	To investigate the association of living alone with clinical outcomes in patients with HFpEF	Cross-sectional study within a randomised clinical trial	3103 patients (1527 female) Age = 72 years	<ul style="list-style-type: none"> <li>The prevalence rate of living alone was 25.2%.</li> <li>Living alone was related to a greater risk of any hospitalisation after adjustment for confounders.</li> <li>Each year increase in age, female sex, non-White race, NYHA functional classes III and IV, dyslipidaemia, and chronic obstructive pulmonary disease were predictors for living alone.</li> </ul>

2021; Paturzo et al., 2016; Pihl et al., 2011; Sundin et al., 2010), two mixed methods studies (Mahoney-Davies et al., 2017; Sacco et al., 2014), two qualitative longitudinal studies (Gerlich et al., 2012; Leeming et al., 2014), one ethnography (Fry et al., 2016) and one meta-analysis (Heidari Gorji et al., 2019).

### 3.2 | Why CHF influences the social dimension of patients

There are multiple reasons why CHF impacts the social dimension of people with the condition. There are causes related to the physical impact of the disease, influenced by sociodemographic aspects, derived from changes in lifestyles, and related to the feelings experienced by these patients.

#### 3.2.1 | Related to the physical impact of the illness

CHF-related breathlessness and fatigue induce an inability, or lessened ability, to participate in social events and to maintain a social life; it also limits relationships outside the immediate family (Gerlich et al., 2012; Mahoney-Davies et al., 2017; Pavlovic et al., 2021; Pihl et al., 2011; Polikandrioti et al., 2019). This situation leads patients to develop a perception of social isolation and imprisonment in their own home (Jeon et al., 2010; Leeming et al., 2014; Paturzo et al., 2016). Furthermore, the unpredictable course of this disease means that they do not know if they will be able to attend planned social events (Jeon et al., 2010; Leeming et al., 2014; Mahoney-Davies et al., 2017). This diminishes the person's self-confidence and reduces their comfort zone to that of their own home (Leeming et al., 2014). Increased severity of the disease also impacts the availability and adequacy of social integration or participation in social groups (Årestedt et al., 2013), social recognition, that is, the way one is seen by others (Karimi & Clark, 2016) and the position in society experienced by people with CHF (Karimi & Clark, 2016; Pihl et al., 2011).

#### 3.2.2 | Related to sociodemographic aspects

It has been shown that people living alone have low/medium levels of perceived social support (Allemann et al., 2018), lower levels of social support (Årestedt et al., 2013) and higher social isolation (Saito et al., 2019). Regarding marital status, unmarried patients have higher rates of moderate/high perceived social isolation (Manemann et al., 2018), especially divorced people (Obieglo et al., 2016). There is controversy about how age and gender influence this. Some studies indicate that people who are younger and female have lower/medium levels of perceived social support (Allemann et al., 2018) and moderate/higher perceived social isolation (Manemann et al., 2018). However, others note that age showed no significant association with social support (Årestedt et al., 2013), or even that people over

60 experience higher levels of social isolation (Obieglo et al., 2016). Other studies show that being male is associated with lower levels of social support (Årestedt et al., 2013) and that women present more emotional support (Strachan et al., 2014).

#### 3.2.3 | Related to lifestyle changes

Most patients with CHF need to adopt new lifestyles and adhere to new medication regimens, which increases their social isolation (Jeon et al., 2010; Leeming et al., 2014; Olano-Lizarraga et al., 2021). Meeting their self-care needs, such as dietary restrictions, reduces participation in social events (Karimi & Clark, 2016) and limits the opportunities to socialise with friends and family, making those with CHF feel misunderstood and disrespected (Jeon et al., 2010). Similarly, taking medication, especially diuretics, decreases patients' ability to participate in recreational and leisure activities and prevents people from leaving their homes and socialising, which increases their social isolation (Jeon et al., 2010; Leeming et al., 2014; Strachan et al., 2014). When patients have to leave work prematurely, they lose interpersonal relationships and status in society (Olano-Lizarraga et al., 2016, 2020), contributing to more intense feelings of social isolation (Saito et al., 2019).

#### 3.2.4 | Related to feelings

People with CHF who feel less control over their heart condition perceive low/medium levels of social support (Allemann et al., 2018). Feeling fearful that something bad will happen or about being a burden to family caregivers, contribute to the experience of social isolation (Jeon et al., 2010; Olano-Lizarraga et al., 2021). An altered self-image (Leeming et al., 2014; Olano-Lizarraga et al., 2021), a lack of confidence (Leeming et al., 2014) and a poor acceptance of the illness are also associated with greater social isolation (Obieglo et al., 2016). The impact that CHF has on patients' relationships and social roles leads them to feelings of uncertainty, sadness, frustration, low self-esteem, loss of autonomy, dependence and social isolation, among others (Olano-Lizarraga et al., 2021). Patients also experience a sense of loss due to their inability to carry out activities that previously were enjoyable and valuable to them (Mahoney-Davies et al., 2017). All of this contributes to a state of loneliness (Hopp et al., 2010; Olano-Lizarraga et al., 2016) and causes deep discomfort, making it difficult to perceive normality in their lives (Olano-Lizarraga et al., 2020). Those who suffer from social isolation also lose the meaning and purpose of their lives (Leeming et al., 2014).

### 3.3 | The role of social relations

People with CHF receive social support mainly from family members and friends (Allemann et al., 2018; Fry et al., 2016; Sacco et al., 2014),

although housekeepers, hired caregivers, neighbours (14, 18) and health professionals (Sacco et al., 2014) are also mentioned. The following is a description of the benefits of having adequate social relationships for people with CHF, as well as the impact on them if they do not have sufficient social support.

### 3.3.1 | Benefits of having social relations

Having good social support promotes the psychosocial well-being of patients with CHF (Olan-Lizarraga et al., 2021), helping them overcome social isolation and maintain their quality of life (Strachan et al., 2014). This interaction makes them feel loved and allows them to express their thoughts and feelings (Dekker, 2014; Strachan et al., 2014; Sundin et al., 2010). It means not being alone, abandoned or forgotten and brings them a sense of being safe and secure (Sundin et al., 2010). This positive social support helps them cope with negative emotions and serves as a buffer against the stress associated with CHF (Dekker, 2014), therefore preventing depressive symptoms (Graven & Grant, 2013). It helps them accept the diagnosis of heart failure more quickly and to regain some normality (Fry et al., 2016; Olan-Lizarraga et al., 2016; Strachan et al., 2014), as well as giving meaning to their lives (Sacco et al., 2014).

Family and friends also play a key role in supporting them in managing their illness (Fry et al., 2016; Graven & Grant, 2013), mainly to reinforce self-care, follow treatment, manage symptoms and attend medical visits (Olan-Lizarraga et al., 2016) as well as to allowing them to continue with daily activities, such as shopping, dressing, cleaning, preparing food, performing household tasks, going for walks and accessing transportation (Jeon et al., 2010; Olan-Lizarraga et al., 2021). Socialising made participants forget about their fatigue symptoms during the interactions (Pavlovic et al., 2021). It also allows them to stay socially connected to the world, even if in a limited way (Hopp et al., 2010). All this gives them a sense of validation, relief, comfort and camaraderie, as well as permits overcoming social isolation (Jeon et al., 2010).

### 3.3.2 | When there is a lack of or inadequate social support

A significant number of patients with CHF report that they have 'very' limited social contact (Polikandrioti et al., 2019) and scarce social support (Dekker, 2014; Fry et al., 2016). This makes them feel concerned and lacking in confidence when facing the illness (Fry et al., 2016; Sundin et al., 2010), as well as abandoned, let down and/or isolated (Jeon et al., 2010; Olan-Lizarraga et al., 2016). Some of them even prefer to stay in the hospital, where they feel accompanied and can avoid the loneliness they feel at home (Paturzo et al., 2016).

Although some patients have this support, they report difficulties sharing their fears, worries and symptoms with their family and

friends, as they do not want to become a burden (Dekker, 2014; Hopp et al., 2010; Olan-Lizarraga et al., 2021). When this happens, the communication tends to be brief and concrete, and they try to play the role of a strong person (Gerlich et al., 2012; Sundin et al., 2010). Similarly, Olan-Lizarraga et al. (2021) stated that there are people with CHF who think that disclosing their disease could negatively influence their social relationships because of the social stigma associated with the condition.

Changes occurring in their roles and relationships cause patients to feel negative emotions such as guilt, anxiety, frustration, uncertainty, fear, loneliness and uselessness (Jeon et al., 2010; Pavlovic et al., 2021; Sundin et al., 2010). Patients felt guilt and anxiety about being a burden to others, and dependency caused frustration, uncertainty and fear of inadequate support provision. Some patients experienced being misunderstood by friends and family who did not appreciate the severity of their condition, which was interpreted as a potentially negative effect on patient quality of life (Jeon et al., 2010). Sometimes family members fostered dependency by "doing too much" for patients, which could lead them to lower adherence to self-care in relation to diet or activity (Strachan et al., 2014).

### 3.4 | The influence of alterations in the social dimension on the CHF patient's clinical outcomes

Aspects related to the social dimension of people with CHF influence several of the health outcomes of individuals, such as the development of depression, risk of readmission, death, emergency department visits and outpatient visits, and self-care behaviours and treatment adherence.

The level of social support available to people with CHF is significantly associated with their quality of life (Allemann et al., 2018; Årestedt et al., 2013), especially in the emotional dimensions (Årestedt et al., 2013). Hence, participants with low/medium levels of perceived social support notice a lower level of control, feel they have less help in relation to their heart condition and experience more symptoms of anxiety and depression (Allemann et al., 2018). People with moderate/high perceived social isolation are more likely to have depression (Manemann et al., 2018). Depression is negatively related to the quantity and degree of satisfaction with social supports (Graven & Grant, 2013). For patients experiencing depressive symptoms, the emotional, physical and financial support provided by family and friends helps them cope, manage and reduce these symptoms (Dekker, 2014; Graven & Grant, 2013).

Regarding the influence of the social dimension of people with CHF on the risk of hospital readmission, it is seen that people with high perceived social isolation have almost a 76% higher risk (Manemann et al., 2018) and a 2.5 times greater likelihood (Saito et al., 2019) of being readmitted; it should be taken into account that almost 50% of these patients report having social isolation (Saito et al., 2019). The study by Heidari Gorji et al. (2019) reports that having a poor social

network and low perceived social support are also associated with an increased risk of hospital readmission by 87%–98% and 50%–89%, respectively. Living alone is another strong predictor for readmission in patients with CHF (Manemann et al., 2018; Zhu et al., 2021), with 37% and 91% higher odds for 30-day and 90-day readmissions, respectively (Manemann et al., 2018). There is even an increased risk of death (>3 times) (Manemann et al., 2018; Zhu et al., 2021), emergency room visits (70%) and outpatient visits in patients with high perceived social isolation (Manemann et al., 2018).

According to the study of Karimi & Clark (2016), some patients with CHF feel they have a social obligation to others and to society. Therefore, some place responsibilities such as caring for children or grandchildren, working or supporting the family above their self-care activities. In an attempt to maintain these roles, they may ignore their symptoms and delay seeking help, even delaying hospitalisation. For example, a patient might prioritise his or her socialisation or participation in leisure activities by attending a social event, such as a restaurant dinner, leading to a lack of adherence to the prescribed diet or fluid restriction (Strachan et al., 2014). Or a patient may stop taking diuretics to meet friends or go to work, knowing that these decisions could result in a deterioration of health and a worsening of symptoms. It appears that these decisions may stem from a desire to maintain some gender work roles, pleasure activities, social recognition (avoiding being judged by others) and independence (Karimi & Clark, 2016). It has been found that having higher levels of social support improves adherence to recommendations and self-care (Strachan et al., 2014).

## 4 | DISCUSSION

This scoping review has allowed us to increase our understanding of the relationship between CHF and the social dimension of people with the condition, identifying the causes, experiences and consequences of this phenomenon. Our findings suggest that the impact of CHF on the social sphere of the person depends on multiple factors, including reasons related to the nature of the illness, personal aspects such as age, gender and marital status, changes in lifestyles and the feelings of the patients themselves. In addition, the review also explores the roles of social relationships in the lives of these patients, pointing out both the benefits of having adequate social support and the experiences associated with inadequate or non-existent support. Finally, the findings show the influence that the social dimension of the person with CHF has on several health outcomes, such as the development of depression, the risk of hospitalisation and death, the frequency of emergency and office visits, and the development of self-care habits and treatment adherence.

The analysis of the impact of the social dimension on health outcomes is perhaps the most relevant result of the present scoping review. As noted in our study, other authors have shown that restrictions on social participation, limited social activities and social isolation are linked to an increase in depressive symptoms in elderly people (Choi, 2020). Douglas et al. (2017) also studied the effect of

social participation in the elderly, identifying social support and the sense of social cohesion with the community that most favour social involvement, which in turn is a key indicator of successful ageing and is related to mortality, morbidity and quality of life. Our review also shows evidence of the impact of the social aspects of the person with CHF on mortality. This was also pointed out by other authors, who stated that social isolation (Cantarero-Prieto et al., 2018; Holt-Lunstad et al., 2015) and loneliness are associated with an increased risk of premature death and greater cardiovascular morbidity and mortality (Holt-Lunstad et al., 2010; Valtorta et al., 2016). According to Valtorta et al. (2016), three main pathways have been identified through which social relationships can affect health: behavioural, psychological and physiological mechanisms. Health risk behaviours associated with loneliness and social isolation include physical inactivity and smoking. Loneliness is linked to lower self-esteem and limited use of active coping methods, while social isolation predicts decreased self-efficacy. Feeling lonely or socially isolated is associated with poor immune functioning and higher blood pressure.

Our findings also highlighted that the adoption of new lifestyles, adherence to treatment and premature cessation of work are among the causes that have severely impacted the social dimension of people with CHF. Increasing compliance with treatment is pivotal, as less than 50% of patients adhere to self-care (Chew et al., 2021), which has been suggested to be the origin of 40% of CHF admissions (Van Der Wal et al., 2010). A literature review conducted by Chan et al. (2018) pointed to the possible interference with socialisation in people with CHF as one of the main barriers to maintaining adherence to a low-salt diet. More broadly, the study by Sedlar et al. (2017) described that social habits and values (especially the importance of work and food preferences) are among the factors that most affect self-care decision-making in patients with CHF. Thus, along the lines of our study, other investigators have seen that a person's habits are important facilitators for medication adherence and self-monitoring (Jaarsma et al., 2017). However, there may also be factors related to lifestyle, such as following a healthy diet, that could also be perceived as helping to maintain traditions and connections with family/friends, so their modification may not be so easy (Jaarsma et al., 2017). As in our study, others also found that continuing to work provides people with numerous social interactions and is an important part of their lives (Abdi et al., 2019; Sedlar et al., 2017), as well as a factor affecting motivation for self-care (Sedlar et al., 2017). All these results support, on the one hand, the need to study how to combine the maintenance of social relationships with adherence to healthy lifestyles in people with CHF and, on the other hand, the importance of maintaining work activities in patients who wish to do so, adapting both the time of dedication and the type of activity to each situation.

The impact of the social dimension on self-care activities of those with CHF constitutes, in certain situations, supports (social support) and in others, a barrier, for socialisation. As in this study, the study by Graven et al. (2018) found that the greater the social support available, the better CHF patients maintain their self-care and self-management habits. Siabani et al. (2013) also showed that

people who have a supportive environment and opportunities to share their problems and participate in social activities manifest better self-care. Similar results were also identified in other chronic populations, such as COPD, demonstrating the benefit of social support in depression, anxiety and psychological stress and an improvement in self-care and self-efficacy (Barton et al., 2015). Something similar was seen in people with diabetes mellitus, showing that social support acts as a buffer, reducing the negative effects of depression on self-care, including insulin use (Beverly et al., 2021).

This review has shown a disparity of results regarding the influence of age and gender on the social dimension of people with CHF; while some studies confirm that the impact is greater in young women, others present opposite findings or even a lack of statistical significance. These findings may suggest that factors impacting social dimensions, such as social isolation and involuntary loneliness, are pivotal to identify, regardless of age or gender. Understanding this in greater depth could help identify the groups at greatest risk and thus act in a preventive and/or early manner. Supporting one of these results, Steptoe et al. (2013) and Cantarero-Prieto et al. (2018) stated that social isolation increases the risk of developing chronic diseases in the elderly (>50 years), since several events occur at the same time during this life stage, such as a decrease in financial resources, mobility problems and the death of relatives. Other studies also concluded that there is a greater presence of social isolation (Ponikowski et al., 2016) and higher mortality associated with social factors in persons with CHF with advanced age (Checa et al., 2019). Regarding the influence of gender, the literature is not as clear, while some authors have found that it is not a significant factor in the development of social isolation (Cantarero-Prieto et al., 2018), others have shown that being a woman protects against mortality associated with social risks (Checa et al., 2019). This could be clarified, in part, through the study by Yang et al. (2013), who found that when reviewing evidence about sex differences in social relationships and support received, the results are not conclusive; however, there seem to be differences in the physiological response to the rupture of social ties, with women reacting with less psychological distress and physical deterioration than men. Either way, professionals should be attentive to the gender differences that may exist when assessing this aspect.

Overall, the results of the present study suggest the need to take more account of the social variables of people with CHF to reduce the observed impact. One way to improve this situation could be to include family and friends in the care process so that they can learn more about the patient's experience and achieve their collaboration. In addition, support groups led by professionals, peer support or volunteer services could be designed (Årestedt et al., 2013), together with the activation of community social services (Manemann et al., 2018). However, despite promising strategies to improve social relationships, such as technology applications, video calls, mindfulness, tai chi and meditation, interventions to reduce the social isolation of people with CHF remain scarce (Heidari Gorji et al., 2019; Saito et al., 2019). It should be known in depth what the social impact of the illness is on each patient and their family and what their

experience is to help them define new social, family and work roles, providing a more optimistic and less frustrating perspective of their situation based on their capabilities and wishes (Olano-Lizarraga et al., 2016).

However, most of the current care models for people with CHF do not contemplate the attention of their social dimension in a specific way (Comín-Colet et al., 2016; Takeda et al., 2012), even though they are predominantly based on the Chronic Care Model (CCM) proposed by Wagner et al. (2001). One way to lead the change in this healthcare paradigm would be to promote a person-centred health approach (Donaldson & Rutter, 2017; Pronovost et al., 2018). When healthcare is provided with person-centred care as a framework, personal experiences, life stories, family, environment and the goals and desires that each person has are taken into account when planning health-related aspects (Ekman et al., 2011). The subjectivity of each person, how people are integrated into their environment, what their strengths and weaknesses are, their plans for the future, and their rights should be considered. Patients' needs are recognised, but above all, they are seen as having capabilities, resources and expert knowledge about their daily lives, goals and motivations (Britten et al., 2020). Moreover, care is cocreated between the patient, the family and professionals, thus allowing active decision-making by all those involved in the process. Specifically, the application of the University of Gothenburg Centre for Person-Centred Care (GPCC) framework has been shown to have a positive impact in several clinical trials with people with CHF, with an impact on the length of hospital stays and the ability to carry out activities of daily living (Ekman et al., 2012), self-efficacy in caregiving (Fors et al., 2018), healthcare costs (Hansson et al., 2016) and treatment adherence (Markgren et al., 2019), among others. For all these reasons, it would be considered appropriate and necessary to design an intervention to reduce the impact that CHF has on the social dimension of the person based on this person-centred care approach.

## 4.1 | Limitations

There are a number of limitations and strengths of this review. The analysis of the results was performed through journal publications and not using the original data of the studies, so some of the information may have been lost. In addition, it should be noted that the methodological quality of the studies included in the review was not analysed because it is not considered a reason for exclusion in this type of review (Arksey & O'Malley, 2005; Pham et al., 2014), but it may have affected, in some way, the synthesis and validity of the results.

Nevertheless, it should be noted that this study has followed a rigorous process of search, selection and synthesis, agreed on first among peers and then with the entire research team. In addition, it offers a complete perspective on the topic for the first time in the literature. Our scoping review is based on evidence from 26 scientific studies (five cross-sectional studies, six literature reviews, five hermeneutic phenomenological studies, two mixed methods

studies, two qualitative longitudinal studies, one ethnography and one meta-analysis), of which 16 are original studies. Fourteen of the latter were carried out in various geographical areas of Europe: countries located in the north, centre, south and east of the continent ( $n = 2570$ ). Thus, it is reasonable to assume that the results of this review are transferable to the European adult CHF population.

## 5 | CONCLUSIONS

This scoping review has yielded comprehensive knowledge that helps to understand, in a single study, the origin, experiences and consequences of the impact experienced by people with CHF on their social dimension. It has shown the importance of detecting higher risk groups and systematically assessing factors related to the social sphere in all patients with CHF. This will help detect and better understand the bidirectional influence that exists in each person between social isolation, social relationships and social support, life experiences, self-care activities and morbidity and mortality rates. This, in turn, will be the starting point for the cocreation of interventions that address this situation from a person-centred perspective.

## 6 | RELEVANCE TO CLINICAL PRACTICE

The knowledge provided by this review will help health professionals to be more aware that social disruption involves both negative experiences associated with a lack of adequate social support and a negative impact on readmission and death rates, medical visits, development of depression, self-care behaviours and treatment adherence. These findings have shown the importance of detecting higher-risk groups and systematically assessing factors related to the social dimension in all patients with CHF. This review will also serve as a starting point to define the focus of future interventions.

### CONFLICT OF INTEREST

No conflicts of interest have been declared by the authors.

### AUTHOR CONTRIBUTIONS

Olano-Lizarraga, M contributed to conceptualization, methodology, validation, formal analysis, investigation, writing—original draft, writing—review & editing.

Wallström, S: contributed to conceptualization, methodology, validation, formal analysis, investigation, writing—original draft.

Martín-Martín, J contributed to conceptualization, methodology, validation, formal analysis, investigation, writing—Original Draft.

Wolf, A contributed to conceptualization, methodology, validation, formal analysis, investigation, writing—original draft.

### DATA AVAILABILITY STATEMENT

The data that support the findings of this study are available from the corresponding author upon reasonable request.

### ORCID

Maddi Olano-Lizarraga  <https://orcid.org/0000-0002-8354-8367>

### TWITTER

Maddi Olano-Lizarraga  @MaddiOlano

Jesús Martín-Martín  @jemartmart

### REFERENCES

- Abdi, S., Spann, A., Borilovic, J., de Witte, L., & Hawley, M. (2019). Understanding the care and support needs of older people: A scoping review and categorisation using the WHO international classification of functioning, disability and health framework (ICF). *BMC Geriatrics*, 19, 195–210. <https://doi.org/10.1186/s12877-019-1189-9>
- Allemann, H., Strömberg, A., & Thylén, I. (2018). Perceived social support in persons with heart failure living with an implantable cardioverter defibrillator. *Journal of Cardiovascular Nursing*, 33(6), E1–E8. <https://doi.org/10.1097/JCN.0000000000000523>
- Årestedt, K., Saveman, B.-I., Johansson, P., & Blomqvist, K. (2013). Social support and its association with health-related quality of life among older patients with chronic heart failure. *European Journal of Cardiovascular Nursing*, 12(1), 69–77. <https://doi.org/10.1177/1474515111432997>
- Arksey, H., & O'Malley, L. (2005). Scoping studies: Towards a methodological framework. *International Journal of Social Research Methodology: Theory and Practice*, 8(1), 19–32. <https://doi.org/10.1080/1364557032000119616>
- Barton, C., Effing, T. W., & Cafarella, P. (2015). Social support and social networks in COPD: A scoping review. *COPD: Journal of Chronic Obstructive Pulmonary Disease*, 12(6), 690–702. <https://doi.org/10.3109/15412555.2015.1008691>
- Beverly, E. A., Ritholz, M. D., & Dhanyamraju, K. (2021). The buffering effect of social support on diabetes distress and depressive symptoms in adults with Type 1 and Type 2 diabetes. *Diabetic Medicine*, 38(4), 1–10. <https://doi.org/10.1111/dme.14472>
- Britten, N., Ekman, I., Naldemirci, Ö., Javinger, M., Hedman, H., & Wolf, A. (2020). Learning from Gothenburg model of person centred healthcare. *The BMJ*, 370, 1–6. <https://doi.org/10.1136/bmj.m2738>
- Cantarero-Prieto, D., Pascual-Sáez, M., & Blázquez-Fernández, C. (2018). Social isolation and multiple chronic diseases after age 50: A European macro-regional analysis. *PLoS One*, 13(10), 1–12. <https://doi.org/10.1371/journal.pone.0205062>
- Chan, A. (2018). An integrative review: Adherence barriers to a low-salt diet in culturally diverse heart failure adults. *Australian Journal of Advanced Nursing*, 36(1), 37–47. <https://search.ebscohost.com/login.aspx?direct=true&db=c8h&AN=131905848&lang=es&site=ehost-live&scope=site>
- Chan, A., Kinsman, L., Elmer, S., & Khanam, M. (2018). An integrative review: Adherence barriers to a low-salt diet in culturally diverse heart failure adults. *Australian Journal of Advanced Nursing*, 36(1), 37–47.
- Checa, C., Abellana, R., Verdú-Rotellar, J. M., Berenguera, A., Domingo, M., Calero, E., & Pérez, M. A. M. (2019). Social risk and mortality: A cohort study in patients with advanced heart failure. *Journal of Cardiovascular Nursing*, 34(1), E8–E15. <https://doi.org/10.1097/JCN.0000000000000538>
- Chew, H. S. J., Sim, K. L. D., Choi, K. C., & Chair, S. Y. (2021). Effectiveness of a nurse-led temporal self-regulation theory-based program on heart failure self-care: A randomized controlled trial. *International Journal of Nursing Studies*, 115, 103872. <https://doi.org/10.1016/j.ijnurstu.2021.103872>
- Choi, S. (2020). The effects of social participation restriction on psychological distress among older adults with chronic illness.

- Journal of Gerontological Social Work*, 63(8), 850–863. <https://doi.org/10.1080/01634372.2020.1830217>
- Clark, A. M., Spaling, M., Harkness, K., Spiers, J., Strachan, P. H., Thompson, D. R., & Currie, K. (2014). Determinants of effective heart failure self-care: A systematic review of patients' and caregivers' perceptions. *Heart*, 100(9), 716–721. <https://doi.org/10.1136/heartjnl-2013-304852>
- Comín-Colet, J., Enjuanes, C., Lupón, J., Cainzos-Achirica, M., Badosa, N., & Verdú, J. M. (2016). Transitions of care between acute and chronic heart failure: Critical steps in the design of a multidisciplinary care model for the prevention of rehospitalization. *Revista Española De Cardiología (English Edition)*, 69(10), 951–961. <https://doi.org/10.1016/j.rec.2016.05.001>
- Dekker, R. L. (2014). Patient perspectives about depressive symptoms in heart failure: A review of the qualitative literature. *The Journal of Cardiovascular Nursing*, 29(1), E9–E15. <https://doi.org/10.1097/JCN.0b013e318273a5d6>
- Dixon-Woods, M., Agarwal, S., Jones, D., Young, B., & Sutton, A. (2005). Synthesising qualitative and quantitative evidence: A review of possible methods. *Journal of Health Services Research and Policy*, 10(1), 45–53. <https://doi.org/10.1258/1355819052801804>
- Donaldson, L., & Rutter, P. (2017). Healthier fairer safer. In L. Donaldson (Ed.), *The global health journey 2007–2017*. World Health Organization.
- Douglas, H., Georgiou, A., & Westbrook, J. (2017). Social participation as an indicator of successful aging: An overview of concepts and their associations with health. *Australian Health Review*, 41(4), 455–462. <https://doi.org/10.1071/AH16038>
- Ekman, I., Swedberg, K., Taft, C., Lindseth, A., Norberg, A., Brink, E., Carlsson, J., Dahlin-Ivanoff, S., Johansson, I. L., Kjellgren, K., Lidén, E., Öhlén, J., Olsson, L. E., Rosén, H., Rydmark, M., & Sunnerhagen, K. S. (2011). Person-centered care—Ready for prime time. *European Journal of Cardiovascular Nursing*, 10(4), 248–251. <https://doi.org/10.1016/j.ejcnurse.2011.06.008>
- Ekman, I., Wolf, A., Olsson, L. E., Taft, C., Dudas, K., Schaufelberger, M., & Swedberg, K. (2012). Effects of person-centred care in patients with chronic heart failure: The PCC-HF study. *European Heart Journal*, 33(9), 1112–1119. <https://doi.org/10.1093/eurheartj/ehr306>
- Fivecoat, H. C., Sayers, S. L., & Riegel, B. (2018). Social support predicts self-care confidence in patients with heart failure. *European Journal of Cardiovascular Nursing*, 17(7), 598–604. <https://doi.org/10.1177/1474515118762800>
- Fors, A., Blanck, E., Ali, L., Ekberg-Jansson, A., Fu, M., Kjellberg, I. L., Mäkitalo, Å., Swedberg, K., Taft, C., & Ekman, I. (2018). Effects of a person-centred telephone-support in patients with chronic obstructive pulmonary disease and/or chronic heart failure—A randomized controlled trial. *PLoS One*, 13(8), 1–12. <https://doi.org/10.1371/journal.pone.0203031>
- Friedmann, E., Son, H., Thomas, S. A., Chapa, D. W., & Lee, H. J. (2014). Poor social support is associated with increases in depression but not anxiety over 2 years in heart failure outpatients. *Journal of Cardiovascular Nursing*, 29(1), 20–28. <https://doi.org/10.1097/JCN.0b013e318276fa07>
- Fry, M., McLachlan, S., Purdy, S., Sanders, T., Kadam, U. T., & Chew-Graham, C. A. (2016). The implications of living with heart failure: The impact on everyday life, family support, co-morbidities and access to healthcare: A secondary qualitative analysis. *BMC Family Practice*, 17(1), 139. <https://doi.org/10.1186/s12875-016-0537-5>
- Gerlich, M. G., Klindtworth, K., Oster, P., Pfisterer, M., Hager, K., & Schneider, N. (2012). “Who is going to explain it to me so that I understand?” Health care needs and experiences of older patients with advanced heart failure. *European Journal of Ageing*, 9(4), 297–303. <https://doi.org/10.1007/s10433-012-0244-6>
- Gordon, M. (1994). *Nursing diagnosis: Process and application*, 3rd ed. Mosby.
- Graven, L. J., Gordon, G., Keltner, J. G., Abbott, L., & Bahorski, J. (2018). Efficacy of a social support and problem-solving intervention on heart failure self-care: A pilot study. *Patient Education and Counseling*, 101(2), 266–275. <https://doi.org/10.1016/j.pec.2017.09.008>
- Graven, L. J., & Grant, J. (2013). The impact of social support on depressive symptoms in individuals with heart failure: Update and review. *Journal of Cardiovascular Nursing*, 28(5), 429–443. <https://doi.org/10.1097/JCN.0b013e3182578b9d>
- Hansson, E., Ekman, I., Swedberg, K., Wolf, A., Dudas, K., Ehlers, L., & Olsson, L. E. (2016). Person-centred care for patients with chronic heart failure—A cost-utility analysis. *European Journal of Cardiovascular Nursing*, 15(4), 276–284. <https://doi.org/10.1177/1474515114567035>
- Heidari Gorji, M. A., Fatahian, A., & Farsavian, A. (2019). The impact of perceived and objective social isolation on hospital readmission in patients with heart failure: A systematic review and meta-analysis of observational studies. *General Hospital Psychiatry*, 60, 27–36. <https://doi.org/10.1016/j.genhosppsy.2019.07.002>
- Holt-Lunstad, J., Smith, T. B., Baker, M., Harris, T., & Stephenson, D. (2015). Loneliness and social isolation as risk factors for mortality: A meta-analytic review. *Perspectives on Psychological Science*, 10(2), 227–237. <https://doi.org/10.1177/1745691614568352>
- Holt-Lunstad, J., Smith, T. B., & Layton, J. B. (2010). Social relationships and mortality risk: A meta-analytic review. *PLoS Medicine*, 7(7), e1000316. <https://doi.org/10.1371/journal.pmed.1000316>
- Hopp, F. P., Thornton, N., & Martin, L. (2010). The lived experience of heart failure at the end of life: A systematic literature review. *Health & Social Work*, 35(2), 109–117. <https://doi.org/10.1093/hsw/35.2.109>
- Jaarsma, T., Cameron, J., Riegel, B., & Stromberg, A. (2017). Factors related to self-care in heart failure patients according to the middle-range theory of self-care of chronic illness: A literature update. *Current Heart Failure Reports*, 14(2), 71–77. <https://doi.org/10.1007/s11897-017-0324-1>
- Jeon, Y.-H., Kraus, S. G., Jowsey, T., Glasgow, N. J., (2010). The experience of living with chronic heart failure: A narrative review of qualitative studies. *BMC Health Services Research*, 10(77), 1–9. <https://doi.org/10.1186/1472-6963-10-77>
- Karimi, M., & Clark, A. M. (2016). How do patients' values influence heart failure self-care decision-making?: A mixed-methods systematic review. *International Journal of Nursing Studies*, 59, 89–104. <https://doi.org/10.1016/j.ijnurstu.2016.03.010>
- Korda, R. J., Du, W., Day, C., Page, K., Macdonald, P. S., & Banks, E. (2017). Variation in readmission and mortality following hospitalisation with a diagnosis of heart failure: Prospective cohort study using linked data. *BMC Health Services Research*, 17(1), 1–18. <https://doi.org/10.1186/s12913-017-2152-0>
- Leeming, A., Murray, S. A., & Kendall, M. (2014). The impact of advanced heart failure on social, psychological and existential aspects and personhood. *European Journal of Cardiovascular Nursing*, 13(2), 162–167. <https://doi.org/10.1177/1474515114520771>
- Lippi, G., & Sanchis-Gomar, F. (2020). Global epidemiology and future trends of heart failure. *AME Medical Journal*, 5, 15. <https://doi.org/10.21037/amj.2020.03.03>
- Mahoney-Davies, G., Davis, C., Glen, C., Clifton, C., & Salkovskis, P. M. (2017). Examining the emotional and psychological experiences of people with heart failure. *British Journal of Cardiac Nursing*, 12(4), 192–198. <https://doi.org/10.12968/bjca.2017.12.4.192>
- Manemann, S. M., Chamberlain, A. M., Roger, V. L., Griffin, J. M., Boyd, C. M., Cudjoe, T. K. M., Jensen, D., Weston, S. A., Fabbri, M., Jiang, R., Jiang, R., & Rutten, L. J. F. (2018). Perceived social isolation and outcomes in patients with heart failure. *Journal of the American Heart Association*, 7(11), 1–7. <https://doi.org/10.1161/JAHA.117.008069>
- Markgren, R., Brännström, M., Lundgren, C., & Boman, K. (2019). Impacts of person-centred integrated chronic heart failure and palliative home care on pharmacological heart failure treatment: A substudy

- of a randomised trial. *BMJ Supportive and Palliative Care*, 9(1), 1–8. <https://doi.org/10.1136/bmjspcare-2015-000894>
- Menéndez-Villalva, C., Gamarra-Mondelo, M. T., Alonso-Fachado, A., Naveira-Castelo, A., & Montes-Martínez, A. (2015). Social network, presence of cardiovascular events and mortality in hypertensive patients. *Journal of Human Hypertension*, 29(7), 417–423. <https://doi.org/10.1038/jhh.2014.116>
- Müller-Tasch, T., Löwe, B., Lossnitzer, N., Frankenstein, L., Täger, T., Haass, M., Katus, H., Schultz, J. H., & Herzog, W. (2018). Anxiety and self-care behaviour in patients with chronic systolic heart failure: A multivariate model. *European Journal of Cardiovascular Nursing*, 17(2), 170–177. <https://doi.org/10.1177/1474515117722255>
- Obieglo, M., Uchmanowicz, I., Wleklík, M., Jankowska-Polanska, B., Kusmierz, M., Obieglo, M., Uchmanowicz, I., Wleklík, M., Jankowska-Polanska, B., Kuśmierz, M., Obieglo, M., Uchmanowicz, I., Wleklík, M., Jankowska-Polanska, B., & Kuśmierz, M. (2016). The effect of acceptance of illness on the quality of life in patients with chronic heart failure. *European Journal of Cardiovascular Nursing*, 15(4), 241–247. <https://doi.org/10.1177/1474515114564929>
- Olano-Lizarraga, M., Martín-Martín, J., Oroviogioechea, C., & Saracibar-Razquin, M. (2021). Unexplored aspects of the meaning of living with chronic heart failure: A phenomenological study within the framework of the model of interpersonal relationship between the nurse and the person/family cared for. *Clinical Nursing Research*, 30(2), 171–182. <https://doi.org/10.1177/1054773819898825>
- Olano-Lizarraga, M., Oroviogioechea, C., Errasti-Ibarrondo, B., & Saracibar-Razquin, M. (2016). The personal experience of living with chronic heart failure: A qualitative meta-synthesis of the literature. *Journal of Clinical Nursing*, 25(17–18), 2413–2429. <https://doi.org/10.1111/jocn.13285>
- Olano-Lizarraga, M., Zaragoza-Salcedo, A., Martín-Martín, J., & Saracibar-Razquin, M. (2020). Redefining a “new normality”: A hermeneutic phenomenological study of the experiences of patients with chronic heart failure. *Journal of Advanced Nursing*, 76(1), 275–286. <https://doi.org/10.1111/jan.14237>
- Pantell, M., Rehkopf, D., Jutte, D., Syme, S. L., Balmes, J., & Adler, N. (2013). Social isolation: A predictor of mortality comparable to traditional clinical risk factors. *American Journal of Public Health*, 103(11), 2056–2062. <https://doi.org/10.2105/AJPH.2013.301261>
- Paturzo, M., Petruzzo, A., Bertò, L., Mottola, A., Cohen, M. Z. Z., Alvaro, R., & Vellone, E. (2016). The lived experience of adults with heart failure: A phenomenological study. *Annali Di Igiene: Medicina Preventiva E Di Comunità*, 28(4), 263–273. <https://doi.org/10.7416/ai.2016.2105>
- Pavlovic, N. V., Gilotra, N. A., Lee, C. S., Nduleme, C., Mamos, D., Dennison, C., & Abshire, M. (2021). Fatigue in persons with heart failure: A systematic literature review and meta-synthesis using the biopsychosocial model of health. *Journal of Cardiac Failure*. <https://doi.org/10.1016/j.cardfail.2021.07.005>
- Pham, M. T., Rajić, A., Greig, J. D., Sargeant, J. M., Papadopoulos, A., & Mcewen, S. A. (2014). A scoping review of scoping reviews: Advancing the approach and enhancing the consistency. *Research Synthesis Methods*, 5(4), 371–385. <https://doi.org/10.1002/jrsm.1123>
- Pihl, E., Fridlund, B., & Mårtensson, J. (2011). Patients' experiences of physical limitations in daily life activities when suffering from chronic heart failure; a phenomenographic analysis. *Scandinavian Journal of Caring Sciences*, 25(1), 3–11. <https://doi.org/10.1111/j.1471-6712.2010.00780.x>
- Polikandrioti, M., Kalafatakis, F., Koutelkos, I., & Kokoularis, D. (2019). Fatigue in heart failure outpatients: Levels, associated factors, and the impact on quality of life. *Archives of Medical Science - Atherosclerotic Diseases*, 4, e103–e112. <https://doi.org/10.5114/amsad.2019.85406>
- Ponikowski, P., Voors, A. A., Anker, S. D., Bueno, H., Cleland, J. G. F., Coats, A. J. S., Falk, V., González-Juanatey, J. R., Harjola, V.-P., Jankowska, E. A., Jessup, M., Linde, C., Nihoyannopoulos, P., Parissis, J. T., Pieke, B., Riley, J. P., Rosano, G. M. C., Ruilope, L. M., Ruschitzka, F., ... van der Meer, P. (2016). 2016 ESC Guidelines for the diagnosis and treatment of acute and chronic heart failure. *European Heart Journal*, 37(27), 2129–2200. <https://doi.org/10.1093/eurheartj/ehw128>
- Pronovost, P., Johns, M. M. E., Palmer, S., Bono, R. C., Fridsma, D. B., Gettinger, A., Goldman, Y. C. W., Johnson, W., Karney, M., Samitt, C., Sriram, R. D., & Zenoo, A. (2018). *Procuring interoperability: Achieving high-quality, connected, and person-centered care*. National Academy of Medicine.
- Robins, L. M., Hill, K. D., Finch, C. F., Clemson, L., & Haines, T. (2018). The association between physical activity and social isolation in community-dwelling older adults. *Aging & Mental Health*, 22(2), 175–182. <https://doi.org/10.1080/13607863.2016.1242116>
- Sacco, S. J., Park, C. L., Suresh, D. P., & Bliss, D. (2014). Living with heart failure: Psychosocial resources, meaning, gratitude and well-being. *Heart and Lung: Journal of Acute and Critical Care*, 43(3), 213–218. <https://doi.org/10.1016/j.hrting.2014.01.012>
- Saito, H., Kagiyama, N., Nagano, N., Matsumoto, K., Yoshioka, K., Endo, Y., Hayashida, A., & Matsue, Y. (2019). Social isolation is associated with 90-day rehospitalization due to heart failure. *European Journal of Cardiovascular Nursing*, 18(1), 16–20. <https://doi.org/10.1177/1474515118800113>
- Sedar, N., Lainscak, M., Mårtensson, J., Strömberg, A., Jaarsma, T., & Farkas, J. (2017). Factors related to self-care behaviours in heart failure: A systematic review of European Heart Failure Self-Care Behaviour Scale studies. *European Journal of Cardiovascular Nursing*, 16(4), 272–282. <https://doi.org/10.1177/1474515117691644>
- Siabani, S., Leeder, S. R., & Davidson, P. M. (2013). Barriers and facilitators to self-care in chronic heart failure: A meta-synthesis of qualitative studies. *SpringerPlus*, 2(1), 320–334. <https://doi.org/10.1186/2193-1801-2-320>
- Stephoe, A., Shankar, A., Demakakos, P., & Wardle, J. (2013). Social isolation, loneliness, and all-cause mortality in older men and women. *Proceedings of the National Academy of Sciences of the United States of America*, 110(15), 5797–5801. <https://doi.org/10.1073/pnas.1219686110>
- Strachan, P. H., Currie, K., Harkness, K., Spaling, M., & Clark, A. M. (2014). Context matters in heart failure self-care: A qualitative systematic review. *Journal of Cardiac Failure*, 20(6), 448–455. <https://doi.org/10.1016/j.cardfail.2014.03.010>
- Sundin, K., Bruce, E., & Barremo, A.-S.-A.-S. (2010). Elderly women's experiences of support when living with congestive heart failure. *International Journal of Qualitative Studies on Health and Well-Being*, 5(2), 5064. <https://doi.org/10.3402/qhw.v5i2.5064>
- Takeda, A., Taylor, S. J., Taylor, R. S., Khan, F., Krum, H., & Underwood, M. (2012). Clinical service organisation for heart failure. *Cochrane Database of Systematic Reviews*, 9, 1–158. <https://doi.org/10.1002/14651858.cd002752.pub3>
- Tricco, A. C., Lillie, E., Zarin, W., O'Brien, K. K., Colquhoun, H., Levac, D., Moher, D., Peters, M. D. J., Horsley, T., Weeks, L., Hempel, S., Akl, E. A., Chang, C., McGowan, J., Stewart, L., Hartling, L., Aldcroft, A., Wilson, M. G., Garrity, C., ... Straus, S. E. (2018). PRISMA extension for scoping reviews (PRISMA-ScR): Checklist and explanation. *Annals of Internal Medicine*, 169(7), 467–473. <https://doi.org/10.7326/M18-0850>
- Valtorta, N. K., Kanaan, M., Gilbody, S., Ronzi, S., & Hanratty, B. (2016). Loneliness and social isolation as risk factors for coronary heart disease and stroke: Systematic review and meta-analysis of longitudinal observational studies. *Heart*, 102(13), 1009–1016. <https://doi.org/10.1136/heartjnl-2015-308790>
- Van Der Wal, M. H. L., Van Veldhuisen, D. J., Veeger, N. J. G. M., Rutten, F. H., & Jaarsma, T. (2010). Compliance with non-pharmacological



- recommendations and outcome in heart failure patients. *European Heart Journal*, 31(12), 1486–1493. <https://doi.org/10.1093/eurheartj/ehq091>
- Virani, S. S., Alonso, A., Benjamin, E. J., Bittencourt, M. S., Callaway, C. W., Carson, A. P., Chamberlain, A. M., Chang, A. R., Cheng, S., Delling, F. N., Djousse, L., Elkind, M. S. V., Ferguson, J. F., Fornage, M., Khan, S. S., Kissela, B. M., Knutson, K. L., Kwan, T. W., Lackland, D. T., ... Tsao, C. W. (2020). Heart disease and stroke statistics-2020 update: A report from the American Heart Association. *Circulation*, 141(9), e139–e596. <https://doi.org/10.1161/CIR.0000000000000757>
- Wagner, E. H., Austin, B. T., Davis, C., Hindmarsh, M., Schaefer, J., & Bonomi, A. (2001). Improving chronic illness care: Translating evidence into action. *Health affairs (Project Hope)*, 20(6), 64–78. <https://doi.org/10.1377/hlthaff.20.6.64>
- Wu, J. R., Frazier, S. K., Rayens, M. K., Lennie, T. A., Chung, M. L., & Moser, D. K. (2013). Medication adherence, social support, and event-free survival in patients with heart failure. *Health Psychology*, 32(6), 637–646. <https://doi.org/10.1037/a0028527>
- Yang, Y. C., McClintock, M. K., Kozloski, M., Li, T., Yang, Y. C., McClintock, M. K., Kozloski, M., & Li, T. (2013). Mortality: The role of chronic. *Journal of Health and Social Behavior*, 54(2), 183–203.
- Zhu, W., Wu, Y., Zhou, Y., Liang, W., Xue, R., Wu, Z., Wu, D., He, J., Dong, Y., & Liu, C. (2021). Living alone and clinical outcomes in patients with heart failure with preserved ejection fraction. *Psychosomatic Medicine*, 83(5), 470–476. <https://doi.org/10.1097/PSY.0000000000000945>

## SUPPORTING INFORMATION

Additional supporting information may be found in the online version of the article at the publisher's website.

**How to cite this article:** Olano-Lizarraga, M., Wallström, S., Martín-Martín, J., & Wolf, A. (2022). Causes, experiences and consequences of the impact of chronic heart failure on the person's social dimension: A scoping review. *Health & Social Care in the Community*, 30, e842–e858. <https://doi.org/10.1111/hsc.13680>