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ASSESSING THE ROLE OF FAMILY SUPPORT IN HEART FAILURE CARE: A QUANTITATIVE PERSPECTIVE

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ABSTRACT
Heart failure causes functional impairment and impacts patients' quality of life. A family-centered approach involving families as partners in care is an effective strategy for improving patients' quality of life. Objective: This study aims to identify the role of families in implementing family-centred care for heart failure patients. A quantitative descriptive design involving 317 families of heart failure patients. Purposive sampling based on predetermined criteria was applied in this study. The Family Centered Care Assessment of Family (FCCA-F) instrument was used to identify the role of families in decision-making, providing support, and family-to-family and peer support. Data analysis was performed using computer software. Analysis to present data used descriptive statistics. The results showed that the domain of the role of families in decision-making and the support provided by the immediate family were "relatively strong" in the majority of cases (57.1% and 63.1%). This indicates the active involvement of the immediate family in the care and support process for heart failure patients. However, most (70.3%) of the family-to-family and peer support domain results were "weak." This finding indicates that initiatives to connect patients' families have not been fully realised. These findings show that the family's role in decision-making and supporting heart failure patients is decisive, improving quality of life and therapy compliance. However, the family-to-family and peer support domains are still weak, requiring the development of support group initiatives to optimise patient care and quality of life.

Keywords: family support; FCCA-F; heart failure

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INTRODUCTION

Heart failure is a disease that occurs in the cardiovascular system. Patients with heart failure experience impaired blood-pumping ability, resulting in decreased blood flow throughout the body. Functional impairment in heart failure patients impacts their quality of life.(Hedrick et al., 2020). These functional disorders cause patients to experience shortness of breath, swelling in the ankles, fatigue, and fluid regulation disorders characterised by increased jugular venous pressure, rales, and peripheral oedema (McDonagh et al., 2021). Heart failure is a growing health problem worldwide and requires serious attention. According to the World Health Organisation (WHO) in 2021, the prevalence of heart failure is 6.7 million, and it is the leading cause of death, reaching 17.8 million annually. The prevalence in Indonesia and other countries is estimated to increase over time, predicted to reach 46% of the total number of patients diagnosed with 23 million in 2030(Qadrianti et al., 2021) . Statistical data from the 2018 Basic Health Research (Riskesdas) shows that the prevalence of heart disease is 1.5% based on doctors' diagnosis. The highest number was found in North Kalimantan province at 2.2%, followed by the Special Region of Yogyakarta/DIY at 2%, and Gorontalo at 2%(Sulawesi Selatan, 2018) .

The decline in quality of life experienced by heart failure patients, such as difficulty in daily activities both in the hospital and at home, requires effective care strategies. One considered adequate strategy is family-centred care or care that focuses on patients and families. Patient- and family-centered care is an approach to planning, providing, and evaluating health services involving collaboration between providers, patients, and families(Cruz & Pedreira, 2020). The main principle

in patient-centered care is to respect and follow the wishes and choices of patients as guidelines in every medical decision-making process(Secunda & Kruser, 2022). Patient- and family-centered care aims to provide daily updates on the patient's condition to build trust and understanding(Patel et al., 2022). A patient- and family-centered approach to care can prevent errors in information delivery. Family-centered care promotes patient recovery. Family involvement in patient care is expected to improve the patient's quality of life, physical, mental, and emotional health(Franck & O'Brien, 2019). A patient- and family-centered care approach is crucial because it maximises patient outcomes through support and satisfaction in care. This aims to enhance dignity by valuing the perspectives and listening to the concerns of patients and families. In addition to improving the quality of care, it enhances emotional support and provides information to families (Azoulay et al., 2024).

According to Barbara L.E. McCauley and Susan A.L.M.M. McMurray's family-centered care theory (2011), the family is considered the most important social unit in individuals' and society's lives, and it plays a significant role in patient care and healing(Kuo et al., 2012). This theory identifies four main areas: respecting differences, effective communication, flexible and contextual care, and support for autonomy(Ridgway et al., 2020). Heart failure patients require strong family support. Families not only play a role in providing support and knowledge, but can also increase feelings of safety and comfort during the hospital care process, thereby contributing to a faster recovery(Kitko et al., 2020). Families restore patients' self-esteem, increase confidence in treatment, and provide comfort. Family participation, which includes joint decision-making with medical staff and providing ongoing support, is crucial to ensuring optimal care and influencing patient compliance with treatment. Modern healthcare views families not only as caregivers, but as important partners who are actively involved in the treatment process(de Lima et al., 2023). This approach is particularly important for chronic diseases such as heart failure, most of which are managed at home. By educating families on how to monitor symptoms, manage medication, adhere to dietary restrictions, and adjust lifestyle, the healthcare system ensures that patient care is continuous, even outside the clinical setting(Religioni et al., 2025). Furthermore, when families are involved in decision-making, patients tend to be more compliant with medical recommendations. This occurs because planned interventions are better aligned with the actual capabilities and beliefs of patients and their families. Thus, family-centered care bridges the gap between medical practice and real life, uniting clinical approaches with social aspects(Robinson et al., 2021).

The impact of family involvement in the care of heart failure patients is not without challenges(Shamali et al., 2020). Limitations in daily life and role changes can affect their relationship with the patient. Patients often experience emotional distress and physical and social limitations, which also affect their families. Families may have difficulty understanding and accepting information about heart failure (Checa et al., 2020). Previous research has often focused more on patients' physical condition, so the role of families is often overlooked. Several previous studies have shown that caregiver burden and symptoms of depression significantly affect the role of the family. However, there is still a lack of understanding about the specific factors related to this condition (Kim et al., 2022). The stress experienced by family caregivers has various impacts, both mentally and financially. Caregivers often neglect their own health, careers, and social lives. For example, spouses may reduce their working hours or stop working altogether, which causes economic problems. The emotional stress experienced by caregivers can manifest in the form of anxiety, insomnia, and depression(Rady et al., 2021). These conditions can reduce the quality of care they provide. In addition, cultural norms often require families to continue providing care, even if they do not have adequate capacity, thereby limiting the role of formal assistance. These pressures highlight the importance of structured interventions to support caregivers, such as counselling, support groups, and training programs(Daynes-Kearney & Gallagher, 2023)Therefore, to fully understand the role of caregiving, we must recognise that while it benefits patients, it also

significantly burdens families' well-being. This research's urgency indicates the need for a deeper understanding of how the family's role can be intervened in care.

Therefore, this study aims to identify the role of the family in implementing patient- and family-centered care for heart failure patients. By analyzing three main domains: the role of the family as a decision-making team, a source of support, and family-to-family and peer support, this study is expected to provide more comprehensive insights into the contribution of the family in the care of heart failure patients, as well as identify areas that need to be developed to optimize treatment outcomes and patient quality of life. This study places families as a key element in patient care, beyond their role in decision-making and direct care. The research highlights explicitly the importance of networks between families of fellow patients, which are often overlooked. These networks can transform families who feel isolated into a mutually supportive community, making caregivers feel more resilient and less lonely. By examining family involvement from three perspectives-clinical, emotional, and social- this research provides a new framework. This framework aims to design future interventions that can improve patient conditions while strengthening the resilience of the entire family unit.

METHOD

This study uses a quantitative approach with a descriptive design to clearly understand families' roles in caring for heart failure patients. The population includes all families of heart failure patients being treated at the General Hospital in Surakarta. Out of 1,528 families of heart failure patients, a sample size of 317 families was determined using the Slovin formula. Purposive sampling was utilised, targeting families of patients who met the criteria for inclusion in the study. The research subjects in this study were families of patients who met the following inclusion criteria: (a) families involved in patient care, (b) families living with patients, and (c) families involved in decision-making. Conversely, the exclusion criteria were families who were unwilling to provide informed consent.

The data were collected using the Family-Centered Care Assessment of Family (FCCA-F) questionnaire. This instrument comprised 24 questions designed to evaluate the family's role in three key areas: decision-making, providing support, and receiving support from other family members. The measurement uses a 5-point Likert scale, from "1 = not at all" to "5 = always done". Based on the results of (Yuhdiah, 2023). FCCA-F questionnaire research, it shows high validity with a Mean I-CVI value of 0.99, indicating that this instrument can be used with minor revisions in accordance with applicable validity standards. The validity test on the FCCA-F questionnaire used I-CVI for each item. The Item-Level Content Validity Index (I-CVI) was calculated as the number of experts who gave a good rating of 3 or 4 (thus dichotomizing the ordinal scale into relevant = 1 and not relevant = 0), divided by the total number of experts (Yuhdiah, 2023).

The results indicate high validity, and the instrument is considered good. Based on the results of research by (Yuhdiah, 2023) the reliability test in this study tested 24 items, with 8 items in each domain. The reliability test was calculated using Cronbach's alpha. Based on the reliability test results presented, this research instrument shows good consistency in each domain. The Decision-Making Team domain has a Cronbach's Alpha value of 0.682, while the Support Provider domain shows a higher value of 0.791. The Family-to-Family and Peer Support domain has the highest reliability value of 0.831. Overall, all Cronbach's Alpha values are above the commonly used standard limit, indicating that this questionnaire has good internal consistency and is reliable for measuring the variables under study (Yuhdiah, 2023). Data analysis was conducted using computer software. Data analysis was performed using computer software. Analysis to present data used descriptive statistics. This study received ethical approval from the Universitas Sebelas Maret Hospital Ethics Committee, with letter No: 009/UN27.46/TA.04.19/KEP/EC/2025.

RESULT

The study results are shown in Table 1, which outlines the characteristics of the subjects, including age, gender, educational background, occupation, medical history, duration of illness, and functional classification, based on their questionnaire responses.

Table 1.
Respondent characteristics (n=317)

Respondent Characteristic	f	%
Age (year)		
Young adults	30	9.5%
Middle-aged adults	138	43.5%
Seniors	149	47.0%
Gender		
Man	161	50.8%
Woman	156	49.2%
Education		
Elementary school	74	23.3%
Junior High School	77	24.3%
Senior High School	74	23.3%
Diploma	27	8.5%
Bachelor	44	13.9%
Master	21	6.6%
Occupation		
Unemployed	96	30.3 %
Farmer	30	9.5 %
Laborer	71	22.4 %
Civil servants	30	9.5 %
Entrepreneur	47	14.8 %
Retired	23	7.3 %
Others	20	6.3 %
Comorbid		
Diabetes mellitus	50	15.8 %
Hypertension	165	52.1 %
Kidney Failure	26	8.2 %
Others	22	6.9 %
No	54	17.0 %
Long Suffering		
<1 Year	82	25.9 %
1-3 Year	101	31.9 %
>3 Year	134	42.3 %
Functional Class		
NYHA I	35	11.0 %
NYHA II	28	8.8 %
NYHA III	167	52.7 %
NYHA IV	87	27.4 %

According to Table 1, most respondents were elderly, with 149 individuals (58%) falling into this age group. In terms of gender, most respondents were male, totalling 161 individuals (50%). The table also indicates that junior high school graduates comprised the largest segment of the respondents' education level, with 77 individuals (24.3%). Additionally, a significant % of respondents were unemployed, numbering 96 people (30.3%). Furthermore, 165 individuals (52.1%) reported a history of hypertension alongside heart failure. The data reveal that the largest group of respondents, 134 individuals (42.3%), had been living with the illness for more than three years. Lastly, the most prevalent New York Heart Association (NYHA) classification among respondents was Class III, which was observed in 167 individuals (52.7%).

Table 2, the distribution of respondents based on questions regarding the role of the family in the implementation of patient-centered care and families with heart failure shows varying results. Of the total 317 respondents, 441 frequencies (17.4%) assessed the role of the family as a decision-

making team as not at all, while for the option always, there were 1048 (42.8%). For the role of the family in family support, 901 frequencies (35.5%) rated consistently providing support, while 281 frequencies (11.1%) rated not at all. Additionally, regarding family-to-family and peer support, 1,036 frequencies (40.9%) rated it as not at all, while only 403 frequencies (15.9%) rated it as always providing support.

Table 2.
Implementation of Patient-and Family-Centered Care for Heart Failure

Domain	Not The Same		Seldom		Sometimes		Often		Always	
	f	%	f	%	f	%	f	%	f	%
Team Maker Decision	441	17,4	202	8.0	253	10.0	555	21.9	1085	42.8
Support Family	281	11.1	341	13.4	450	17.7	563	22.2	901	35.5
Family to Family and Peer Support	1036	40.9	443	17.5	287	11.3	367	14.5	403	15.9

Table 3.
Implementation *of* Patient- and *Family-Centred* Care in Heart Failure Based on Domain

Domain	Weak		Relatively Strong		Strong	
	f	%	f	%	f	%
Team Maker Decision	56	25.2	181	57.1	80	25.2
Support Family	95	30.0	200	63.1	22	6.9
Family to Family and Peer Support	223	70.3	77	24.3	17	5.4

The distribution across various domains regarding the role of the family in implementing patient- and family-centred care for heart failure indicates that, among the 317 respondents, the "decision-making team" domain received relatively strong ratings from 181 respondents (57.1%). This was followed by strong ratings from 80 respondents (25.2%) and weak ratings from 56 respondents (17.7%). In the "family support" domain, the highest assessment was relatively strong, with 200 respondents (63.1%) rating it as such. Conversely, weak assessments totalled 96 respondents (30.0%), while only 22 respondents (6.9%) gave strong ratings. Lastly, most assessments were weak in the family-to-family and peer support domain, with 223 respondents (70.3%) rating it. Relatively strong assessments accounted for 77 responses (24.3%), and strong assessments were the least common, with only 17 respondents (5.4%) providing this rating.

DISCUSSION

Most respondents in this study were older adults over the age of 60. This age group is particularly susceptible to heart failure due to structural and functional changes in the heart that occur with ageing, a decline in physical activity, and the prevalence of unhealthy lifestyles (Saheera & Krishnamurthy, 2020). This increased vulnerability in older individuals stems from a combination of factors. In addition to the natural physiological changes that come with aging, recent studies emphasise that older adults often encounter challenges such as limited access to healthcare services, delays in receiving early diagnoses, and lower compliance with routine health check-ups. These factors can increase the risk of complications related to heart failure. Furthermore, degenerative processes like reduced blood vessel elasticity, diminished baroreceptor response, and heightened oxidative stress further worsen cardiovascular function (Izzo et al., 2021). The elderly population is especially vulnerable due to various conditions. Social factors, such as isolation, loneliness, and a lack of family support, further exacerbate the situation for older adults with heart failure. They often face not only biological vulnerabilities but also significant layers of social and psychological challenges (Langmann, 2023). The vulnerability of older adults in various aspects highlights the need for comprehensive support, including social assistance systems, psychosocial interventions, and community-based preventive health programs (Lee et al., 2022). Retirement can diminish financial independence, which subsequently restricts access to nutritious food, regular medical visits, and essential medication.

The majority of respondents in the study were male. Generally, heart failure is more prevalent among men, particularly in young to middle-aged individuals, compared to women. These findings align with the previous research, which indicates that heart failure is often more common in men, especially younger to middle-aged men, due to unhealthy lifestyle habits such as smoking and alcohol consumption (Rahmawati et al., n.d.). Older adults are particularly vulnerable due to health issues and social factors like isolation, loneliness, and lack of family support, especially those with heart failure. They face biological, social, and psychological challenges that require comprehensive support, including social assistance, psychosocial interventions, and community health programs. Furthermore, retirement can decrease financial independence, limiting access to nutritious food, medical visits, and essential medications (Jan et al., 2024). In women, the risk of heart failure is primarily affected by metabolic factors such as obesity, hypertension, and diabetes (Lopaschuk et al., 2021). Furthermore, the response to therapy can vary between men and women. Gender disparities in cardiovascular health are influenced by both cultural and behavioural factors (Sinha et al., 2024). In many societies, men often avoid seeking early medical help, viewing symptoms like fatigue or chest discomfort as “normal” or insignificant. This tendency leads to delays in diagnosis, resulting in more advanced stages of disease by the time they seek treatment. On the other hand, women frequently experience “atypical” symptoms such as nausea, abdominal pain, or unusual fatigue. These symptoms can be misinterpreted by both patients and doctors, further postponing the appropriate treatment. Additionally, women with heart failure may face gender-specific barriers, such as caregiving responsibilities for children or grandchildren, which can make it challenging for them to prioritise their own health needs (Thomas et al., 2025).

Educational level influences the condition of heart failure patients, with lower education often linked to lower socioeconomic status (Mangendara, 2024). Most respondents reported that their highest level of education was junior high school. This may influence their ability to understand lifestyle changes. Low health literacy due to low education levels often results in families of heart failure patients failing to understand the warning signs of worsening conditions (Jarrah et al., 2023). The literature consistently shows that low levels of education have an impact on poor understanding of healthy diet concepts, medication use, and early detection of signs of deterioration (Coman et al., 2024). Low levels of education also limit access to valid health information. In the digital age, much health information circulates freely without scientific verification. Families with low literacy are more prone to believing myths or misinformation, such as the use of certain herbal medicines that are claimed to cure heart failure, when in fact they risk worsening the patient's condition. Conversely, families with high literacy tend to be able to sort out reliable sources of information, utilize health technology (telemedicine), and actively participate in medical decision-making (Burrell, 2024).

Patients with heart failure and low health literacy often do not understand the significance of sodium restriction in their diet, leading them to consume high-salt instant foods that worsen their condition (Watso et al., 2023). Families with low health literacy often struggle to fully understand medical instructions. This can result in high rates of rehospitalisation due to delays in treating symptoms. For instance, these families may not promptly recognise signs of pulmonary edema or severe shortness of breath, which can lead to delays in bringing patients to healthcare facilities (Akinso, 2025). Low health literacy also has implications for families' ability to manage low-salt diets, monitor fluid intake, and understand the importance of medication adherence (Mohd Isa et al., 2021). Individuals with lower education levels are often more likely to work in physically demanding jobs or face higher health risks (Wahidah & Harahap, 2021).
Most respondents are unemployed, which is expected since most are retired. This situation will naturally lead to a higher number of unemployed individuals with heart failure within this population. It is important to note that many respondents are also labourers, a job type that may increase the risk of heart failure. Labour-intensive work often involves heavy physical activity,

exposure to unhealthy working conditions, and long hours(Basuki et al., 2025). This is in line with the findings of Hardiyana & Kristinawati (2023) that low socioeconomic status can increase the risk of heart failure. Socioeconomic conditions play an important role in the development of heart failure. Patients with low socioeconomic backgrounds tend to have difficulty accessing health services, purchasing routine medications, and undergoing follow-up examinations. Occupational factors such as heavy physical labour or long working hours can increase the risk of hypertension, coronary heart disease, and ultimately heart failure. In addition, heavy physical labour without adequate nutrition and rest accelerates heart muscle fatigue. In terms of comorbidities, hypertension was found to be the most common. Hypertension is the most common cause of heart failure due to the close relationship and complex mechanisms between the two(Kelly et al., 2019). The main reasons include excessive cardiac workload, left ventricular hypertrophy, vascular damage, and the risk of coronary artery disease. Among these factors, hypertension is the most dominant contributor to the development of heart failure, making it the most commonly found condition in patients with heart failure (Schwinger, 2021). Patients with chronic hypertension are more likely to develop heart failure with a worse prognosis (Anker et al., 2023). In addition to hypertension, other comorbidities such as diabetes mellitus, chronic kidney disease, and obesity are also commonly found in patients with heart failure(Triposkiadis et al., 2022). The interaction between these comorbidities creates a vicious cycle that worsens the patient's condition.

Based on the duration of the disease, most patients have suffered from heart failure for more than three years. The impact of heart failure lasting more than three years significantly limits patients' ability to perform activities. Patients often experience fatigue and shortness of breath even when performing light activities. Long-term heart failure correlates with the patient's level of disability. Patients with a disease duration of more than three years tend to adapt poorly to physical limitations, resulting in a drastic decline in quality of life(St-Laurent et al., 2025). These long-term effects also include psychological aspects. Many patients feel helpless, lose their social roles, and experience depression. This condition not only worsens their quality of life but also has a direct impact on their medical prognosis, as depression reduces adherence to therapy (Religioni et al., 2025). In addition, families also experience significant caregiver burden, ranging from financial pressure to emotional stress. This makes a family psychoeducation approach very important so that families are able to face the challenges of caring for long-term patients (Ong et al., 2021). Most heart failure patients face significant challenges due to the severity of their symptoms and functional limitations. The course of a chronic illness like this reshapes nearly every dimension of a patient's life. Over time, individuals often develop a sense of “illness identity,” where their daily schedule, dietary choices, and even social interactions revolve around managing symptoms (Morley, 2022). For example, a patient who once enjoyed community gatherings may withdraw due to embarrassment about frequent shortness of breath or the need to limit fluid intake. The prolonged duration of this disease thus transforms heart failure from a purely medical condition into a deeply social one, where isolation, loss of independence, and emotional stress become as burdensome as the physical symptoms themselves (Jan et al., 2024). In terms of NYHA classification, the majority of patients are in NYHA class III, which indicates a significantly higher incidence of cardiovascular events(Rohde et al., 2023). In fact, one-third of patients are in NYHA class IV, indicating that these patients have severe disease. The distribution of patients in NYHA classes III and IV confirms that the majority of the study population has a high level of severity. Class III patients experience significant limitations in daily activities, while class IV patients are unable to perform even light activities without severe symptoms. This condition requires intensive management, including optimal pharmacological therapy and close monitoring. Family involvement in supporting patients with NYHA III-IV is crucial to the success of treatment, both medically and emotionally. Functional limitations, making even light physical activity not recommended(Merkaš et al., 2021).

NYHA III and IV conditions not only limit patient activity but also often require further intervention, such as the use of advanced medical devices. Therefore, the role of the family in providing emotional and practical support becomes increasingly vital. Families must be trained to recognise signs of acute deterioration, such as increased shortness of breath, extremity oedema, and sudden weight gain due to fluid retention. Patients classified as NYHA Class III and IV generally require more intensive care, as they often struggle to perform everyday activities such as eating, bathing, and moving around. Research has shown that caregiver burden is strongly associated with increased levels of depression and a decline in the quality of life for families (Arslan et al., 2019). Patients with NYHA Class III and IV conditions typically need more intensive care because they often lose their ability to perform daily activities like eating, bathing, and moving around. Previous studies have indicated that caregiver burden is closely linked to levels of depression and a decline in the quality of life for families (Lahoz et al., 2021). Family-based interventions should prioritise the well-being of families as primary caregivers, in addition to addressing patient needs.

This study's results indicate that the family's role in implementing patient- and family-centred care in cases of heart failure shows varying perceptions regarding family involvement in several important aspects of care. This study specifically examined three main domains in family-centred care. Regarding family involvement in the decision-making team domain, most respondents said they always or often indicated that families were actively involved in the decision-making process related to heart failure patient care. These results show that the Family Centred Care model has been well implemented, where patients, families, and health workers form partnerships in every stage of care (Kaslow et al., 2020). Although most families are involved, the quality of this involvement needs evaluation. In some instances, family engagement is only a formality and does not fully meet the patient's aspirations (Richards, 2025). Healthcare professionals must adopt participatory communication strategies that position patients and their families as equal partners in care. This approach highlights the importance of transparent discussions about all medical decisions—ranging from selecting medications to choosing invasive procedures and planning long-term care—with patients and their families (Tarantini et al., 2025). Recent research indicates that patient satisfaction levels significantly improve when families are encouraged to ask questions and express their opinions during medical team meetings. Therefore, enhancing communication between the medical team and families is a crucial component of implementing Family-Centred Care (Asuncion et al., 2022).

According to research by Siebinga(2022)Patient-centred communication generally focuses on behaviours that build good communication and connections, and the role of the family as a decision-making team greatly supports this (Siebinga et al., 2022). This involvement ensures that the patient's goals and preferences are integrated into the care plan, which ultimately improves the patient's quality of life. In practice, family involvement in decision-making can minimise conflict, increase patient satisfaction, and strengthen trust in healthcare professionals (Park, 2021) Conversely, ineffective communication can lead to misunderstandings, especially in families with low educational backgrounds. Therefore, healthcare professionals must develop an empathetic, clear, and continuous communication approach. For the family support domain, it shows that family support has a dominant effect in the "relatively strong" category. This indicates that the family is the primary source of support for heart failure patients. This support includes emotional, instrumental, and informational support in care management. Emotional support includes empathy, attention, and moral encouragement, which have been shown to improve patient compliance with therapy (Atta et al., 2024). Instrumental support, such as helping with daily activities, arranging follow-up appointments, or reminding patients to take their medication, also has a significant impact on clinical outcomes. Meanwhile, informational support involves providing patients with accurate and precise medical information, helping them understand their condition and the steps they need to take. Families who are able to provide all three types of support consistently will have

a positive impact in reducing readmission rates and slowing the progression of heart failure (Browder & Rosamond, 2023). According to Alharrasi's research (2025)The family is considered an important source of social support, contributing directly to self-care. A strong family role can increase patient motivation and adherence to therapy(Alharrasi et al., 2025). Heart failure patients who self-care with family support tend to have better outcomes and quality of life (Kitko et al., 2020). Therefore, according to research Amilatusholiha & Kristinawati (2023) The role of the family has a positive influence on heart failure treatment, and patients with a strong family role tend to have a high quality of life (Amilatusholiha & Kristinawati, 2023). The role of the family is vital in the care of heart failure patients, helping patients maintain their condition. Family involvement in the care of heart failure patients can significantly reduce the frequency of recurrence, slow the progression of the disease, improve their overall quality of life, and reduce hospitalisation rates(Kyriakou et al., 2020).

Family-to-family and peer support pose challenges in this study because they are still underdeveloped. Most respondents answered "not at all" or "rarely," indicating that this type of support is not yet optimal. Although a small number responded with "often" or "always," the proportion of those answering "not at all" is significant. The absence of peer support highlights cultural and social barriers to creating a community for heart failure patients (Osokpo & Riegel, 2021). Many families consider this disease to be personal and taboo to discuss outside the immediate family. As a result, opportunities for patients' families to share experiences are minimal. In fact, peer support has enormous benefits, such as sharing care strategies, providing psychological motivation, and building solidarity among patients and families (McCauley et al., 2021). This suggests that initiatives aimed at connecting families of heart failure patients with other families experiencing the same condition may not be widely implemented or may not be seen as wholly beneficial. In the view of the community and the respondents, heart failure is regarded as a sensitive and deeply personal issue. Families can effectively fulfil their caregiving roles by providing mutual support, highlighting peer support as a crucial element that complements the direct assistance from immediate family members (Bergenholtz et al., 2020). The absence of peer support makes it challenging for patients and families to find a place to share their experiences (Joo et al., 2022). This type of support has the potential to be utilised in further interventions focused on the family's role in caring for heart failure patients and families by building support among families(Yunus, 2021). This study emphasises the importance of family involvement in implementing family-centered care assessments for families dealing with heart failure. While there have been advancements in engaging families in decision-making and providing direct support, gaps still exist in fostering support among families. Therefore, education focused on enhancing communication is essential for creating a supportive community for families of heart failure patients(Kitko et al., 2020). This is a strategic step toward optimising family-centred care and improving the quality of life for patients and their families.

CONCLUSION

This study highlights two main findings about family involvement in heart failure care: families are crucial for decision-making and daily support, aligning with family-centred care principles, yet family-to-family and peer support remain underdeveloped. To improve care, reduce caregiver burden, and enhance the quality of life for patients and their families.

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