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Review article

# Nurse-Led Family and Community Care for Continuity Across Hospital-to-Home Transitions: An Evidence-Informed Narrative Review

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**Abstract**

Continuity of nursing care is often disrupted during hospital-to-home transitions, when family caregivers assume complex responsibilities with limited professional support. This evidence-informed narrative review examined how nurse-led family involvement and community coordination strengthen care continuity for adults with chronic illness, multimorbidity, frailty, or disability. A purposive search of PubMed, journal and publisher sources, and World Health Organization guidance covered evidence available through 31 July 2026. Randomized trials, systematic reviews, qualitative studies, and implementation research were synthesized across relational, informational, and management continuity. Recent evidence suggests improvements in patient functioning, self-management, caregiver preparedness, and selected readmission outcomes. However, evidence certainty remains limited, findings are heterogeneous, and benefits for caregiver burden and healthcare utilization are inconsistent. The review proposes a nurse-led family–community pathway integrating predischarge assessment, collaborative education, structured information transfer, coordinated community handover, early follow-up, and escalation procedures. Effective continuity requires ongoing assessment of patient and caregiver capabilities, accessible community support, and safety monitoring. Further research should evaluate intervention fidelity, patient independence, caregiver burden, equity, and sustainability.

## INTRODUCTION

A discharge letter or scheduled follow-up appointment does not, by itself, establish continuity of care. It refers to care experienced as connected and coherent over time, across professionals and settings. A widely cited conceptual synthesis distinguishes informational continuity, management continuity, and relational

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continuity; the World Health Organization (WHO) similarly frames continuity and coordination as essential to integrated people-centred care.[1,2]

Hospital discharge is a vulnerable point in this longitudinal process. Patients and relatives may be expected to understand revised medication schedules, perform monitoring, recognize clinical deterioration, navigate referrals, and accommodate new mobility, dietary, or psychosocial needs. Meanwhile, inpatient clinicians and community providers may use different documentation systems, communication channels, and eligibility criteria. These circumstances create discontinuity even where each individual setting provides technically competent care.[1,2]

Nurse-led transitional care models seek to bridge this gap. Early randomized trials showed that advanced practice nurse-directed discharge planning combined with home follow-up could reduce adverse utilization among selected older adults, while transition coaching and reengineered discharge interventions demonstrated the potential of medication reconciliation, patient coaching, structured plans, and early follow-up.[3,4,5,6] Yet treating the hospital discharge itself as the sole endpoint can obscure how care subsequently unfolds in households and communities.

Family caregivers are often the principal continuity agents after discharge: they interpret care plans, monitor symptoms, coordinate transport and services, and support functional recovery. These responsibilities may become unsafe or unsustainable when caregivers are excluded from planning, lack practical skills, or face economic and emotional strain. Thus, a genuinely family-centred nursing model must consider the patient–caregiver dyad, caregiver preference and capacity, and the local network of primary care, home nursing, rehabilitation, and social services.[7,8]

Recent evidence gives grounds for both optimism and caution. A 2025 systematic review found benefits from some nurse-led transition programs, while a large pragmatic heart failure trial failed to improve its composite clinical endpoints. Family-training trials have also generated divergent results. Consequently, this review aims not simply to argue that follow-up is beneficial, but to identify plausible mechanisms, explain conflicting findings, and propose an operational approach to nurse-led family and community care that can be evaluated in nursing practice.[9]

## METHODS

### Review design and purpose

An evidence-informed narrative review was used to examine how clinical, relational, family, and community mechanisms interact across care settings. Evidence includes randomized trials, systematic reviews, qualitative meta-syntheses, implementation-focused studies, and conceptual guidance. The purpose was interpretive synthesis and development of a transparent practice-oriented framework, not pooled effect estimation. The structure was informed by principles in the Scale for the Assessment of Narrative Review Articles (SANRA), especially explicit aims, a visible literature-search description, scientific reasoning, appropriate referencing, and balanced presentation of evidence.[10]

### Review questions and conceptual boundaries

The review addressed five linked questions: (i) how nurse-led care supports relational, informational, and management continuity; (ii) which aspects of family involvement may improve readiness for home care; (iii)

what contributions can community nurses and primary-care networks make after discharge; (iv) how consistent are reported effects on utilization, quality of life, safety, self-management, and caregiver outcomes; and (v) what implementation and equity conditions are necessary for responsible scale-up?

The population of interest comprised adults returning to their homes after inpatient care, particularly people with chronic conditions, multimorbidity, frailty, disability, or complex caregiving needs. Hospital-to-home transfer served as the main organizing transition; palliative, rehabilitation, stroke, and heart failure evidence was included where it clarified transferable nursing mechanisms. The term family caregiver includes unpaid relatives or other trusted supporters selected by the patient. Community caring refers to an ongoing professional and social support network, not to the transfer of responsibility away from nursing services.

**Information sources, time limit, and search approach**

A purposive literature search and update considered publications available through 31 July 2026 using publicly accessible PubMed bibliographic records, journal and publisher article pages, DOI-bearing publication information, and World Health Organization guidance. Foundational controlled trials and systematic reviews were used to identify additional relevant studies. English-language work with clinical relevance on nurse-led or nurse-coordinated hospital-to-home transition, family caregivers, community nursing, patient–caregiver dyads, discharge teaching, home visits, telehealth, and continuity outcomes was prioritized. Search concepts were combined in variations of: (nurse-led OR nursing OR transitional care OR discharge planning) AND (continuity of care OR hospital-to-home OR community care) AND (family caregiver OR family involvement OR dyad OR caregiver training). Searches were also supplemented by condition-specific terms (stroke, heart failure, chronic obstructive pulmonary disease, frailty, and coronary artery bypass grafting). Publications released online on or before 31 July 2026 were eligible; this date refers to the first verified public publication when print issue assignment differed.

This update used publicly available indexing and publisher records; Scopus and CINAHL were not queried directly through authenticated accounts. No complete export of all retrieval results, deduplicated records, or independent two-reviewer screening log was maintained. Accordingly, this narrative review does not claim exhaustive searching, PRISMA screening counts, newly pooled effect estimates, or a formal GRADE assessment. Estimates reported from systematic reviews are attributed to those original reviews, not recomputed here. Overlapping reviews of the same trials were interpreted as corroborating analyses, not independent patient samples.

**Literature relevance and eligibility principles**

Priority was given to peer-reviewed research with transparent designs and verified bibliographic details, particularly randomized controlled trials, methodologically described evidence syntheses, and qualitative studies involving patient, family, or professional experiences. Included reports needed to address at least one of three domains: transitional nursing intervention, family involvement in continued care, or coordination between hospital and community providers. Foundational studies published before 2015 were retained when they informed established transitional-care models. WHO guidance was included for conceptual and service-system context. Reports confined to inpatient care without a post-discharge

implication, unverified bibliographic records, and publications first available after 31 July 2026 were outside the review scope.

## Evidence charting and critical interpretation

A structured narrative chart captured publication year, country or setting, clinical population, study design, nurse or multidisciplinary role, family participation, intervention components and duration, follow-up procedures, patient and caregiver outcomes, key numerical findings where available, and important limitations affecting interpretation. Randomized trials were distinguished from pilot, quasi-experimental, feasibility, and evidence-synthesis designs. Formal duplicate independent data extraction and risk-of-bias adjudication were not undertaken; therefore study quality is discussed narratively, with explicit attention to selection bias, single-center designs, overlapping evidence, short follow-up, and uncertain transferability.

## Thematic synthesis and interpretive safeguards

A concept-driven synthesis mapped evidence onto relational, informational, and management continuity and the interdependent patient, family, hospital, and community care units. New studies from 2026 were integrated with earlier trials and reviews, while discrepancies in outcomes and certainty were retained. Overlapping 2026 stroke systematic reviews were compared without adding their totals as if they represented distinct trials. Pooled statistics and their confidence intervals reflect the original publications. The resulting practice pathway is an unvalidated explanatory framework that requires local testing before use as a clinical standard.

Table 1. Reproducible concepts and boundary conditions for the narrative literature search

| Dimension | Operational specification |
|---|---|
| Core concepts | Nursing-led transitional care; family caregiving; community nursing; continuity across hospital-to-home transition. |
| Search syntax (illustrative) | (nurse-led OR nursing OR transitional care) AND (family caregiver OR family involvement OR community care) AND (hospital discharge OR continuity OR home follow-up). |
| Information sources | PubMed records; article pages hosted by scientific publishers; WHO guidance; iterative citation tracing. |
| Eligible designs | Randomized trials, systematic/scoping reviews, qualitative meta-syntheses, conceptual and policy guidance. |
| Population and context | Adults with health or care needs after hospital discharge; families and professional/community care partners. |
| Publication cutoff | Published on or before 31 July 2026, including articles with online first publication before this date. |
| Not performed | Direct authenticated Scopus export; exhaustive dual screening; pooled meta-analysis; numerical PRISMA flow. |

## RESULTS

### The three dimensions of continuity

Informational continuity requires a usable account of the patient's diagnosis, medication changes, functional status, warning signs, rehabilitation needs, family support, and outstanding tests to accompany the patient to community services. Management continuity entails agreement about who acts, when, and in response to which trigger. Relational continuity refers to a trusted professional relationship that allows changing needs and family concerns to be disclosed. These dimensions are interdependent but can fail separately: a complete discharge summary cannot compensate for absent community follow-up, and supportive telephone calls cannot resolve unsafe medication discrepancies without shared records.[1,11]

A 2025 scoping review identified gaps in the content and transfer of documentation between hospitals and community services. A qualitative meta-synthesis of hospital-to-home experiences emphasized coordination, communication, patient and family participation, and individualized support. These findings suggest that a reliable nursing handoff should capture not only biomedical instructions but also the patient's and caregiver's own needs, comprehension, uncertainty, and available support.[11,12]

### Effectiveness of nurse-led transitional care

Several foundational studies found favorable utilization outcomes. Naylor and colleagues demonstrated that an advanced practice nurse-led program integrating discharge planning and home follow-up improved outcomes in selected hospitalized older adults. Coleman and colleagues observed fewer readmissions with transition coaching, and the reengineered discharge trial found lower 30-day hospital utilization using a nurse discharge advocate and post-discharge pharmacist call. Together, these trials support continuity-focused interventions extending beyond discharge, although they were conducted in particular service systems and cannot establish that every nursing-led approach works similarly.[3,4,5,6]

Evidence syntheses suggest benefits from some transitional-care approaches, with important qualifications. A systematic review focusing on heart failure found that home-visiting and multidisciplinary heart failure clinic programs reduced some readmissions and mortality outcomes, while telephone support had a more selective profile. A network meta-analysis encompassing 126 trials and 97,408 participants reported that low- and medium-complexity transitional interventions reduced readmissions at specific follow-up periods. These categories represent relative program complexity in the original analysis; they should not be equated with minimal staffing or lower clinical risk.[13,14]

The 2025 BMC Nursing synthesis identified 16 randomized trials of nurse-led programs. Its pooled estimates suggested lower readmissions when follow-up exceeded 12 weeks (RR 0.67; 95% CI 0.49–0.92; moderate certainty) and fewer emergency department visits (RR 0.63; 95% CI 0.49–0.81; high certainty). Quality-of-life findings were promising but based on smaller samples and lower-certainty evidence. The broad clinical relevance of these results is tempered by heterogeneity in the populations, program components, institutions, and length of follow-up.[9]

Additional syntheses appeared in 2026. In a synthesis of 17 randomized or cluster-randomized trials involving older stroke survivors, Ankanawin and colleagues reported improved activities of daily living at one month (SMD 0.54; 95% CI 0.12–0.97) and three months (SMD 0.43; 95% CI 0.12–0.74), along with fewer short-term readmissions. However, the investigators

rated the certainty of evidence as low to very low, and substantial between-trial heterogeneity limited definitive conclusions.[15]

Another 2026 stroke meta-analysis, by Ma and colleagues, included 16 trials involving 7,487 participants. Its readmission analysis favored nurse-led transitional care (RR 0.43; 95% CI 0.26–0.73), but included only four trials and 455 participants; improvements in function and quality of life had high statistical heterogeneity, and pooled caregiver burden did not differ significantly. The two stroke reviews may share primary trials and must not be counted as independent sets of evidence.[16]

A 2026 heart failure network meta-analysis of 19 trials (11,452 patients) ranked home visits highest for reducing all-cause readmissions (RR 0.67; 95% CI 0.52–0.86 versus usual care). Network rankings depend on comparability assumptions and do not establish a universal optimal pathway. Separately, a South Korean randomized trial of 465 people hospitalized with COPD reported better self-management and selected functional, psychological, and discharge-preparedness outcomes with nurse-coordinated inpatient education, home visits, and telephone follow-up. These results reinforce the value of assessing patient-centered outcomes beyond hospital use.[17,18]

Not all randomized evaluations show benefits. The pragmatic PACT-HF trial recruited 2,494 adults in 10 hospitals and tested nurse-led education, structured discharge communication, rapid primary-care appointment scheduling, and, for higher-risk patients, home visits and clinic referrals. It found no significant improvement in the primary composite outcome of readmission, emergency department visit, or death at three months. This finding demonstrates that an attractive bundle of activities may be undermined by usual-care quality, implementation uptake, contact intensity, or mechanisms not aligned with clinical endpoints.[19]

**Family engagement: knowledge, capability, and burden**

Family involvement should begin with assessment of willingness, capability, and consent rather than an assumption that relatives are prepared to provide care. Nurses may need to establish who the patient wants involved, what tasks are realistically acceptable, how confident family members feel, whether they can obtain supplies and transportation, and what alternative support exists. Education alone is less informative than observed task performance, comprehension demonstrated through teach-back, and an agreed contingency plan when the family cannot fulfil an assigned task.

Evidence from stroke care illustrates both potential and heterogeneity. In a randomized trial involving 300 stroke patients and caregivers, structured caregiver training reduced caregiver burden and improved psychosocial outcomes at one year, without improving every patient endpoint. However, the later multicentre TRACS cluster trial did not reproduce the expected benefits in patient or caregiver outcomes. The contrast cautions against treating a single training session or standardized curriculum as a universally effective substitute for tailored assessment and sustained support.[7,20]

A 2022 systematic review of stroke caregiver and dyad interventions reinforced the importance of evaluating caregiver well-being alongside patient outcomes. A 2025 randomized trial among rural caregivers of people with serious illness tested video-based guidance from palliative care nurses; caregiver preparedness improved, whereas communication outcomes did not improve significantly. Preparedness and communication are distinct outcomes; greater confidence alone does not

demonstrate access to clinicians or safe management of complex care at home.[8,21]

In a 2026 randomized trial of 68 family caregivers of people with multiple chronic conditions, a transitional care program delivered from hospitalization through two months after discharge improved caregiver quality of life and reduced reported burden compared with routine care. Although encouraging, the small trial offers limited evidence about long-term sustainability or effectiveness across different health systems.[22]

Another single-center randomized trial published in 2026, 73 patient–caregiver dyads after coronary artery bypass surgery received either usual care or eight weeks of nurse-led messaging-app support. The intervention group had improved cardiac self-efficacy and health-related quality of life, accompanied by lower caregiver burden during short-term follow-up. A 2026 Italian pilot quasi-experiment further reported greater caregiver preparedness after individualized, nurse-led stroke-discharge education (97 intervention caregivers; 216 historical comparators). Because the latter used historical controls, residual confounding remains plausible despite propensity-score matching.[23,24]

## Community connection and longitudinal nursing relationships

After discharge, community nursing extends the inpatient care plan while reassessing needs in the home setting. Structured contacts can determine whether medication changes were implemented, equipment arrived, follow-up appointments occurred, wound or symptom monitoring is feasible, and caregiver strain has emerged. In-person home visits may reveal environmental hazards, hygiene or food insecurity, physical barriers to mobility, or misunderstandings that remote questioning misses. Conversely, telephone and video follow-up can reduce travel burden when a clear escalation route and accessible in-person assessment are available.[4,13,21]

Community continuity cannot be measured by call frequency alone. Its defining feature is accountable coordination: the patient knows whom to contact, community providers know the current plan, and a named nurse or team reviews unresolved risks. A system without closed-loop feedback—confirmation that referrals were received and acted upon—can remain fragmented despite extensive documentation. The WHO integrated-care framework supports designing care around people's longitudinal needs rather than around organizational boundaries.[2,11]

The 2026 TRANSFER-II feasibility study adds an implementation perspective: a nurse navigator intervention for hospitalized frail older adults recruited 127 participants, of whom 106 completed the intervention; 99% of completers could agree to three patient-centred priorities and 93% achieved them. As a non-randomized, single-arm study, it informs feasibility and acceptability but cannot determine effectiveness relative to usual care.[25]

## Patient, caregiver, and service-level outcomes

Readmissions and emergency visits are useful indicators of service use, but their interpretation requires caution. An admission may reflect timely detection of deterioration rather than failed care; conversely, fewer visits do not establish safety when families face access barriers. Measures of treatment understanding, medication discrepancies, symptom recognition, self-care capability, functional status, quality of life, caregiver preparedness, and burden provide a fuller account of continuity. Reviews of transition interventions repeatedly demonstrate variability across these outcomes and follow-up periods.[9,14,26]

Patient experience requires direct assessment: administratively coordinated care may still feel fragmented. Qualitative evidence indicates that people value individualized information, clarity about professional responsibilities, and opportunities to participate in planning. Nursing research should therefore distinguish short-term process measures (for example, documentation completed within 24 hours), intermediate outcomes (follow-up achieved, caregiver confidence), and longer-term clinical and social outcomes (avoidable deterioration, functional recovery, sustainable caregiving).[12,27]

Table 2. Representative research and synthesis evidence informing family–community continuity (updated through July 2026)

| Study | Design / focus | Key finding | Important caution |
|---|---|---|---|
| Naylor et al. (1999; 2004)[3,4] | Randomized trials; older adults, including heart failure | Nurse-directed discharge planning plus home follow-up improved selected outcomes. | Specialized staff and selected groups limit transportability. |
| Coleman et al. (2006)[5] | Randomized trial; transition coaching | Patient/caregiver activation and follow-up reduced readmissions. | Coaching mechanism differs from comprehensive clinical case management. |
| Jack et al. (2009)[6] | Randomized trial; general medical discharge | Structured nurse education and medication work plus pharmacist follow-up lowered utilization. | Single-site intervention; pharmacist involvement was important. |
| Kalra et al. (2004)[7] | Randomized trial; stroke caregivers | Training reduced burden and improved psychosocial outcomes. | Some patient clinical outcomes did not change. |
| Forster et al. (2013)[20] | Cluster randomized trial; stroke caregiver training | No comparable improvement with structured training in pragmatic setting. | Implementation, population, and program differences matter. |
| Van Spall et al. (2019)[19] | Pragmatic cluster trial; 2,494 heart failure patients | No significant improvement in primary composite clinical outcomes. | Usual-care conditions and implementation can dilute effects. |
| Tyler et al. (2023)[14] | Network meta-analysis; 126 trials | Some low/medium complexity models reduced readmissions. | Complexity categories do not directly identify ideal local components. |
| Sakashita et al. (2025)[9] | Systematic review and meta-analysis; 16 RCTs | Reduced some readmission and emergency visit measures. | Small pooled samples for some endpoints and heterogeneity. |
| Griffin et al. (2025)[21] | Randomized trial; rural family caregivers | Video-delivered nurse support improved preparedness. | No significant effect on measured communication outcomes. |
| Ferreira et al. (2025)[11] | Scoping review; hospital–community records | Documentation and communication gaps undermine transition. | Limited and diverse evidence base. |
| van Grootel et al. (2025)[12] | Qualitative meta-synthesis; stakeholder experiences | Coordination, communication, involvement, tailored support are key. | Experiences do not prove intervention efficacy. |
| Ankanawin et al. (2026)[15] | Systematic review/meta-analysis; 17 stroke transition trials | ADLs improved at 1 and 3 months; fewer short-term readmissions. | Low–very low certainty; heterogeneity; potential study overlap with later reviews. |

| Study | Design / focus | Key finding | Important caution |
|---|---|---|---|
| Ma et al. (2026)[16] | Systematic review/meta-analysis; stroke; 16 trials | Lower pooled readmission risk; function and QoL benefits; no significant caregiver-burden effect. | Readmission estimate from four trials; high heterogeneity for several endpoints. |
| Dai and Wu (2026)[17] | Network meta-analysis; heart failure; 19 trials | Home visits ranked highest for all-cause readmission reduction (RR 0.67). | Indirect comparisons and disease-specific population. |
| Kim et al. (2026)[18] | Randomized trial; COPD; n=465 | Nurse-coordinated inpatient teaching, home visit, and calls improved selected patient-centered outcomes. | Disease- and system-specific trial; outcomes assessed over three months. |
| Karami et al. (2026)[22] | Randomized trial; multimorbidity caregivers; n=68 | Caregiver QoL improved and caregiver burden decreased. | Small sample; short-term follow-up. |
| Maleki et al. (2026)[23] | Randomized trial; post-CABG patient–caregiver dyads; n=73 | Eight-week digital nursing support improved self-efficacy, QoL, and caregiver burden. | Single center; limited long-term generalizability. |
| Veronese et al. (2026)[24] | Pilot quasi-experiment; stroke caregiver education | Greater caregiver preparedness three months after discharge. | Historical rather than randomized comparator. |
| Parker et al. (2026)[25] | Single-arm feasibility study; frail older adults; 127 recruited | High feasibility and goal achievement among intervention completers. | No effectiveness control group; clinical outcomes not established. |

## DISCUSSION

### Why continuity is a nursing process rather than a discharge event

Overall, the evidence suggests that nurse-led continuity is a relational and organizational process spanning multiple encounters. Nurses transform episodic treatment plans into routines that patients and families can use at home, but this conversion requires more than written instructions. A nurse must negotiate goals, assess self-management capability, reconcile biomedical and social priorities, and establish a reliable connection to community professionals. Without this relational work, the transition becomes a transfer of information and responsibility rather than a transfer of care.[1,2,28]

Information transfer is necessary but insufficient. Standardized discharge documents may improve the completeness of data, yet they do not ensure that a patient understands a complex medication regimen, that the caregiver can safely complete a task, or that a primary-care clinician has accepted responsibility for an unresolved problem. Management continuity requires a named owner of each follow-up action and verification that the action occurred; relational continuity makes it more likely that families will disclose concerns early. The proposed integrated model therefore places nursing accountability and two-way communication at the center of transition design.[11,12]

### Reconciling positive meta-analyses with negative pragmatic trials

The contrast between favorable pooled estimates and the neutral PACT-HF trial requires careful interpretation. A review combines interventions with differing mechanisms and comparators; a pragmatic trial evaluates whether one real-world package improves outcomes in a defined health system. Higher baseline standards of

care, incomplete engagement, insufficient follow-up intensity, staffing constraints, and outcome definitions can each reduce observed effect sizes. PACT-HF also tested a composite outcome that combined clinically different events, while other studies evaluated narrower readmission or emergency-use endpoints. Thus, it would be inappropriate to claim that nurse-led transition care always prevents rehospitalization.[9,14,19]

Conversely, one neutral trial does not nullify benefits observed in selected populations. The question is which patients require which components, at what intensity, by whom, and over what period. High-risk patients with multimorbidity, impaired function, limited health literacy, or weak family support may need face-to-face assessment and rapid escalation mechanisms. Patients with stable conditions and strong caregiver support may benefit from simpler follow-up. Risk-based stratification is a plausible design principle, but comparative studies are needed to test its advantages over standardized approaches.[13,26,29]

The 2026 evidence sharpens this distinction between mechanism and clinical endpoint. The COPD trial suggests that coaching plus follow-up can improve discharge preparedness and self-management, whereas the TRANSFER-II study establishes feasibility rather than effectiveness. The heart failure network comparison emphasizes targeted home visiting, but its indirect comparisons should not be treated as proof that identical programs will perform similarly in all populations. Furthermore, stroke reviews with partly overlapping trials and low certainty should not be described as two independent confirmations of a treatment effect.[15,16,17,18,25]

**From family presence to genuine family partnership**

Family-centred care must avoid equating availability of a relative with safe capacity for caregiving. A clinician who delegates tasks without consent, training, supplies, or respite may decrease professional workload while increasing family burden. Partnership requires shared decisions, assessment of caregiver capacity, attention to competing obligations, and clear boundaries around professional responsibilities. This approach also protects patient autonomy: relatives should participate according to the patient's preferences and applicable consent requirements, not simply because they attend discharge discussions.

The conflicting stroke trials show why the mode of family engagement matters. The favorable Kalra trial delivered practical caregiver training with psychosocial benefit, whereas the pragmatic TRACS trial did not deliver the anticipated gains at scale. Possible explanations include training fidelity, contextual variability, caregiver readiness, and differences between intervention design and routine delivery. These explanations remain hypotheses rather than demonstrated causes of the different trial findings. The caregiver literature also suggests that reducing distress and increasing preparedness are valuable goals even when readmission or disability outcomes do not change.[7,8,20]

The Griffin randomized trial adds a contemporary lesson: nurse-delivered video support can increase caregiver preparedness but does not automatically improve their communication with clinicians. Teams may need specific communication tools—direct contact numbers, shared medication lists, rehearsed escalation scenarios, and explicit roles—to translate preparedness into coordinated action. Evaluations that only ask whether caregivers feel confident risk

overlooking unresolved organizational barriers.[21]

Emerging 2026 caregiver-focused studies make this distinction more tangible. The Karami randomized trial and the Maleki dyadic trial reported reductions in burden, while Ma and colleagues found no significant pooled caregiver-burden benefit in stroke care. These findings are not necessarily contradictory: illness trajectory, intervention content, caregiver baseline burden, support availability, outcome scales, and follow-up length differ substantially. The Veronese pilot adds evidence for improved caregiver preparedness, but its historical comparison cannot fully separate education effects from changes over time. Trials should measure caregiver burden, preparedness, and access to clinical help as separate prespecified outcomes.[22,23,16,24]

## The community as a care partner, not a referral endpoint

Referral alone cannot ensure continuity unless the receiving team has sufficient information, capacity, and authority to respond. Community services must be involved in identifying practical constraints, such as availability of home visits, medicine supply, mobility support, transport, and caregiver respite. Shared care plans should specify clinical triggers that require immediate escalation, routine review dates, and the professional responsible for each decision. This approach distributes work deliberately rather than assuming that care will continue once a hospital chart is closed.[2,11]

Home visiting offers an opportunity to detect barriers that are invisible in electronic records, but resource-intensive visits may not be feasible for every patient in all settings. Tiered contact pathways should combine caregiver and patient risk profiles with early check-ins, selective in-person visits, and accessible telephone or video contact. Importantly, telehealth is an additional channel—not a replacement for physical assessment when there are urgent symptoms, safeguarding concerns, or technological exclusion. Evidence favoring some home-visit programs supports careful targeting rather than an unqualified requirement for universal home visits.[4,13]

Digital messaging may broaden access when nurse-led escalation and privacy protections are embedded, as illustrated by the short-term post-CABG dyadic trial; however, digital access alone does not constitute community continuity. Feasibility studies in frail populations suggest that named nurse navigators and explicit patient priorities can be acceptable, but inequities in device access and staffing must be assessed before scale-up.[23,25]

## Nursing competencies and interprofessional responsibilities

For implementation, nurses need competencies in comprehensive risk assessment, motivational interviewing, teach-back, medication reconciliation within authorized scope, functional screening, caregiver assessment, interprofessional negotiation, and escalation. Community nurses should be enabled to verify the care plan, update goals as circumstances change, and communicate back to hospital specialists. Collaboration with pharmacists, rehabilitation professionals, physicians, social workers, and community health workers is often essential; describing the program as nurse-led should identify leadership and accountability rather than implying that nurses perform every task independently.[6,28]

Explicitly assigned nursing responsibilities may reduce handoff failures. The hospital nurse is responsible for making the plan comprehensible and actionable before discharge; the receiving community or primary-care nurse is responsible for verifying uptake and identifying new risks; the family is an informed partner with

clearly agreed roles; and the wider network provides clinical and social services that exceed any single professional's remit. A feedback loop closes the transition when unresolved problems have been acknowledged and addressed, not merely documented.

## Ethical and equity considerations

Family and community continuity programs may reproduce inequality if they rely on unpaid caregiver labor, smartphone access, personal transport, or stable housing. Nurses should ask who cannot participate and why: patients living alone, people with sensory or cognitive limitations, families with multiple jobs, and individuals in rural or underserved communities may require additional resources. Ethical implementation requires meaningful informed consent, privacy-preserving information sharing, culturally appropriate education, accessibility accommodations, and alternatives to digital contact. Evaluation should examine how benefits and burdens differ across groups rather than reporting only average effects.[2,12]

Caregiver burden is also an ethical safety endpoint. A decline in hospitalization may be misleading if achieved by shifting an unsustainable workload to families. Routine measures should ask whether caregivers are willing and able to continue, whether emotional strain is increasing, and whether formal support or respite can be activated. Patient and caregiver preferences may diverge; nursing practice must preserve the patient's rights while recognizing legitimate family support needs.

## Implications for community nursing in Indonesia

In Indonesia, hospital-to-home continuity may involve hospital discharge teams, Puskesmas nurses, community nursing services, local clinicians, village health cadres, and family networks. The proposed framework could be adapted to these service interfaces by using a standardized but concise nursing handoff, documented caregiver readiness, contact details of a responsible receiving clinician, and risk-based follow-up. Cadres can assist with outreach and navigation within their authorized functions, but clinical judgment, medication decisions, and escalation should remain with qualified health professionals. These statements are implementation suggestions derived from broader evidence, not claims that this specific model has already been evaluated in Indonesian health facilities.

Feasibility work should compare urban and rural delivery models; identify integration points with existing health information and referral systems; and estimate workforce time, transportation demands, family costs, and training needs. A preliminary pilot could assess discharge-to-community handoff completion, documented family competency, timely nursing contact, and follow-up resolution before proceeding to a sufficiently powered pragmatic effectiveness trial.

## Proposed nurse-led family–community continuity pathway

Figure 1 outlines a five-stage pathway that translates the synthesis into adaptable operational steps. The pathway should begin before discharge, use a patient-approved caregiver and a named nursing coordinator, and continue until clinical stability and community responsibility are confirmed. It is not a validated intervention protocol; its components and timing should be refined through stakeholder consultation, feasibility testing, and prospective evaluation.

| | | |
|---|---|---|
| **01 Assess and partner** | Hospital nurse + patient + nominated caregiver | Risks, family capacity, priorities and consent |
| **02 Co-plan and teach** | Dyad + hospital discharge team | Teach-back; task demonstration; medicines, equipment, red flags |
| **03 Hand over and confirm** | Hospital → receiving community/primary care nurse | Named recipient; structured summary; closed-loop receipt |
| **04 Follow up and adapt** | Community nurse + family + multidisciplinary team | Risk-based calls/visits; escalation; needs and caregiver burden |
| **05 Sustain and re-evaluate** | Patient/family + community services | Monitor outcomes, resources, and ongoing accountability |

Figure 1. Proposed nurse-led family–community continuity pathway (conceptual framework; not yet validated)

Feedback and escalation loop: any unresolved risk returns to the responsible nurse and, when indicated, the prescribing or emergency care team.

## Measurement, research priorities, and implementation evaluation

A future study should separate intervention fidelity (was the documented handoff actually received?), intermediate mechanisms (whether the family understands and can perform agreed care tasks), patient outcomes (safety, functioning, quality of life, service use), and caregiver outcomes (burden, preparedness, wellbeing). Observations at discharge, within the first week, at 30 days, and at 90 days would capture changes over different risk periods. Long-term follow-up may be important for chronic conditions and disability, but timing must reflect the intervention mechanism rather than an arbitrary uniform schedule.[9,12,14]

For evaluations conducted after the 2026 evidence update, an additional priority is the dual-endpoint structure: (a) patient functioning, safety, symptom control, and potentially avoidable healthcare use, and (b) caregiver preparedness, autonomy, quality of life, burden, and access to respite. Apparent effectiveness should be interpreted alongside study design and certainty. A short-term gain in confidence or goal achievement is not equivalent to demonstrably fewer readmissions or sustainable reduction in caregiver workload.[15,16,22,24,25]

Rigorous evaluation should record intervention dose, professional competencies, baseline community service capacity, caregiver availability, and reasons for missed contacts. Hybrid effectiveness–implementation designs could assess both outcomes and fidelity. Cluster or stepped-wedge designs may suit complex service implementation but need attention to contamination, secular trends, and intracluster correlation. Patient–caregiver dyad outcomes should be prespecified to avoid interpreting a neutral patient result as proof that the program provided no meaningful family benefit, or vice versa.

Table 3. Suggested nursing continuity components, responsibilities, and closed-loop evidence

| Stage | Nursing / family action | Verification or escalation |
|---|---|---|
| Before discharge | Assess symptoms, functional capacity, caregiver willingness/skills, medicines, social needs, and access. Co-design a realistic family–patient plan. | Caregiver demonstrates key tasks; patient approves involvement; clinical risks recorded. |
| At handoff | Transmit concise standardized nursing summary to named community recipient; reconcile medicines and appointments. | Receipt confirmed; unresolved tasks allocated to named professional with due date. |
| First post-discharge contact | Use nurse phone/video contact or in-person visit according to risk; reassess symptoms, supplies, comprehension, and caregiver strain. | Unexpected deterioration escalated; plan revised and documented. |
| Community follow-up | Coordinate Puskesmas/home care, rehabilitation, pharmacist and social supports, using referral feedback loops. | Referral completed or actively tracked; goals and responsibilities reviewed. |
| Transition closure / continuation | Agree longer-term monitoring intensity and self-care support; provide accessible re-entry route. | Patient/family know whom to call; ongoing team owns future follow-up. |

Table 4. Proposed core outcome set for future nurse-led family/community continuity evaluations

| Domain | Suggested indicator | Timing / interpretation |
|---|---|---|
| Process fidelity | Confirmed handoff; follow-up scheduled/completed; medication reconciliation; referral closure. | Discharge, days 2–7; process measures do not themselves prove improved outcomes. |
| Patient safety | Medication discrepancies, unplanned deterioration, preventable adverse events, timely escalation. | Days 7–30; include harm detection and appropriate admission. |
| Patient-centred outcomes | Care-transition experience, self-management confidence, functional status, health-related quality of life. | Discharge, 30 and 90 days; use validated instruments where available. |
| Family outcomes | Caregiving preparedness, burden, willingness, competence, emotional well-being. | Discharge, 30 and 90 days; include proxy and caregiver data separately. |
| Service utilization | ED visits, readmissions, outpatient follow-up, days alive at home. | 30 and 90 days; adjust for baseline risk and access barriers. |
| Equity and resources | Coverage by geography, income, disability and digital access; nursing time and costs. | Throughout; disaggregate data and document unintended workload transfer. |

## STRENGTHS AND LIMITATIONS

This review combines clinical trials, systematic and qualitative evidence syntheses, caregiver research, and practice-oriented implementation insights, incorporating publications through 31 July 2026. It compares patient and family outcomes instead of treating readmissions as the sole measure of success. Important limitations remain: literature discovery was purposive rather than exhaustive, no direct authenticated Scopus or CINAHL search was conducted, search counts and duplicate screening were not recorded, formal risk-of-bias scores were not assigned, and no new quantitative synthesis was performed. Several newly published interventions are small, single-center, short-term, or feasibility studies; two stroke reviews

overlap in included primary trials and should not be considered independent replications. The proposed five-stage pathway and outcome indicators require expert consensus, implementation testing, and contextual adaptation before use as practice standards.

## CONCLUSION

Nurse-led family and community care may strengthen continuity when hospital and community services share responsibility for patient-centred assessment, caregiver readiness, reliable information transfer, accessible follow-up, and prompt escalation. Studies published in 2026 add encouraging results for stroke rehabilitation, COPD self-management, caregiver education, and post-CABG family support, but the certainty and generalizability of benefits vary; caregiver burden and long-term clinical events do not improve consistently across studies. Rather than treating discharge as the endpoint of care, nursing services should develop risk-responsive, equitable pathways with clear accountability between patients, caregivers, and community teams. Multisite effectiveness–implementation research with prespecified patient and caregiver outcomes is needed to establish which combinations of interventions are sustainable and beneficial.

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