Original Article

# The Facilitators to Care Transition from Hospital to Home After Stroke: A Qualitative Study


## Abstract

**Background:** Ineffective hospital-to-home care transition (HHCT) can lead to the early rehospitalization of patients with stroke (PWS). Therefore, effective HHCT management is essential to maintain patient safety and reduce rehospitalization. This study was undertaken to examine the factors facilitating HHCT after stroke from the perspectives of all stakeholders involved in the process. **Materials and Methods:** This qualitative study was undertaken from 2023 to 2024 in Tehran, Iran, using conventional content analysis. Data were gathered via semistructured interviews with 23 healthcare clients, professionals, and policy-makers. The data were analyzed using Zhang and Wildemuth's 8-step conventional content analysis method. **Results:** A total of 138 codes were generated and classified into eight subcategories and three categories. The categories were improvement of communication and education, maintenance of care continuity, and improvement of infrastructures. **Conclusions:** Different interrelated factors facilitate the process of HHCT. These facilitators include effective communication and education, care continuity, patient-centered care, efficient information systems, quality community-based services, strong support, and clear HHCT guidelines. These findings can be used in designing strategies to improve care quality, reduce rehospitalization, and enhance safe patient management after discharge.


**Keywords:** *Home care services, qualitative research, stroke, transitional care*


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## Introduction

Stroke is among the leading causes of long-term disability and death, is the second leading cause of disease burden, and has considerable socioeconomic effects.[1] In Iran, according to Global Burden of Disease (GBD) 2019 data, 102,778 new stroke cases and 40,912 stroke-related deaths were reported in 2019, highlighting the substantial burden of this disease in the country.[2] Each year, 400,000 patients with stroke are discharged from hospital with some post-stroke physical disorders and disabilities.[3] Around 20% of these patients are rehospitalized within 30 days after hospital discharge.[1]

Readmission of stroke patients represents a multifaceted challenge, intensifying physical morbidity, psychological distress, and economic burdens. Repeated hospitalizations not only adversely affect patients and their families but also impose substantial pressure on healthcare systems. A wide gap in the Hospital-to-Home Care Transition (HHCT) process is one of the primary reasons for such early rehospitalizations in post-stroke patients.[4,5]

Care transition refers to a set of planned actions to ensure the continuity of patient care from the time of patient admission to patient transfer from hospital to home or during patient transfer among the different units of a healthcare setting.[6,7] The main components of care transition include intrahospital comprehensive care planning, postdischarge follow-up, and continuous postdischarge support through telephone contacts or home visits for elderly patients with high-risk and chronic conditions.[8,9]

However, there is no standard HHCT program in Iran, and hospitals implement their own policies, such as predischarge verbal and written education or postdischarge telephone follow-ups. As a result, most patients with stroke (PWS) face various unmet needs and challenges after being discharged to their homes.[10,11] Based on the author's long-standing clinical experience with PWS in Iran, most



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readmissions stem from inadequate care coordination, lack of structured follow-up programs, and insufficient patient and family education before discharge. These observations served as a motivation to address existing gaps through this research.

Evidence shows that almost one third of PWS experience unsuccessful HHCT during the first 30 days after hospital discharge.[12] Unsuccessful HHCT may increase the risks of complications, medication errors, poor health-related outcomes, and rehospitalization, and increase healthcare costs.[13,14] Moreover, the ineffective management of HHCT may endanger patient safety[4,15,16] and reduce patients' quality of life (QOL), self-efficacy, and satisfaction.[17,18] While studies have identified numerous factors influencing HHCT, such as attitudes, communication, interdisciplinary coordination, resources, and policy barriers, most of these researches have focused on patients with other chronic conditions (e.g., heart or pulmonary diseases) or were conducted in developed countries.[19-21] Furthermore, this study is innovative in that it includes multistakeholder perspectives, including patients, healthcare providers, and policymakers, unlike previous studies that focused solely on patients' perspectives.[22-24] Therefore, the present study aimed to examine the factors facilitating HHCT after stroke from the perspectives of all stakeholders involved in the process.

## Materials and Methods

This study is the result of a doctoral thesis in nursing. It was conducted from 2023 to 2024 using conventional content analysis. Qualitative designs help provide a comprehensive description of participants' experiences and obtain a more in-depth understanding of the intended phenomena.[25]

The study participants included healthcare clients (including PWS and their family members), healthcare professionals (including home care nurses, physicians, and physiotherapists), and home care policy-makers. They were purposively selected from the Tehran University of Medical Sciences, the University of Rehabilitation and Social Health Sciences, the Deputy Office of Nursing at the Ministry of Health and Medical Education, and two private home care centers in Tehran, Iran. These institutions, all officially licensed by the Ministry of Health, provide nursing services, elderly care, and chronic illness management on a 24-hour basis through multidisciplinary teams consisting of nurses, physiotherapists, and healthcare providers. The selection criteria for patients were age above 18 years, definite diagnosis of stroke, a history of at least 1 hospital-to-home transfer in the past 30 days, healthy cognitive function, and no speech disorder. The criteria for family members included age above 18 years and caregiving to PWS as the main family caregivers, and the criterion for healthcare professionals was a home care work experience of at least 1 year. Moreover, the inclusion criteria for policy-makers were individuals developing home care laws and regulations in the Ministry of Health and Medical Education and university faculty members with research experience in the field of home care and stroke. Sampling was continued until no new data were obtained from participants' experiences and all aspects of the intended phenomenon were adequately explored.[26]

Data were gathered via in-depth, semistructured interviews with a length of 25–50 minutes which were held at participants' houses or workplaces according to their preferences. Interviews were opened using general open-ended questions [Table 1] and managed using probing questions such as "Can you give an example?", "Can you explain further?", "Why?", and "How?".

The data were analyzed using Zhang and Wildemuth's conventional content analysis method. The eight steps of this method are preparing the data, defining the unit of analysis, developing categories and a coding schema, testing the coding schema on a sample of text, coding all the text, assessing coding consistency, drawing conclusions from the coded data, and reporting methods and findings.[27] We typed each interview word-for-word immediately after holding it and read the transcript several times in order to become familiar with the content. The initial coding was carried out by two researchers independently. Then, similar codes were sorted into subcategories based on shared characteristics. These subcategories were further compared and grouped to develop main categories through ongoing discussion and consensus within the research team. Then, the coding schema was tested and used to analyze other interviews.

The four criteria of Lincoln and Guba, namely, credibility, transferability, dependability, and confirmability, were employed for rigor. Credibility was applied through prolonged engagement, member checking, peer checking, and triangulation of the data source (i.e., data collection from PWS, their family members, healthcare professionals, and healthcare policy-makers). Transferability was

**Table 1: Interview questions**

| Healthcare clients | Healthcare professionals | Healthcare policy-makers |
|---|---|---|
| How were you prepared at hospital for transfer to home? | How do you admit a patient with stroke to a home care system? | How are patients with stroke discharged from hospital and transferred to their home? |
| What problems did you face during the first post-discharge days? | What challenges and difficulties do you face in care transition? | What strategies do you recommend for hospital-to-home care transition? |
| How did you manage your problems? | How do you manage these challenges and difficulties? | |
| What factors could improve your transition-related experience? | How can care transition be improved? | |

applied by providing detailed descriptions of participants' characteristics, sampling method, time and place of the study, and all steps of the study. Dependability was applied via careful documentation of the data, peer checking, and provision of direct quotations from participants' experiences. Moreover, confirmability was maintained by asking two external peers experienced in qualitative studies to assess the findings and revising them based on their comments.

### Ethical considerations

This study obtained ethical approval from the Ethics Committee of the University of Social Welfare and Rehabilitation Sciences, Tehran, Iran (code: IR.USWR.REC.1398.009). At the beginning of each interview, the interviewer informed the interviewee about the study aim and methods, and their informed consent was obtained.

## Results

Participants were 23 PWS ($n$ = 2), family caregivers ($n$ = 5), nurses ($n$ = 7), physicians ($n$ = 2), physiotherapists ($n$ = 2), and nursing faculty members ($n$ = 5). Most participants were women (52.17%), and their mean (SD) age was 42.6 (6.7) years (in the range of 26–73 years). In the process of data analysis, 138 codes were developed and categorized into eight subcategories and three categories, namely, improvement of communication and education, maintenance of care continuity, and improvement of infrastructures [Table 2].

### Improvement of communication and education

Communication in HHCT refers to the communication of information among all involved individuals in care. Communication and education enable PWS and their families to better understand and manage their self-care activities. The two subcategories of this category are communication between care providers and PWS and patient and family education.

#### *Communication between care providers and patients with stroke*

Most participants highlighted the importance of improving the communication between PWS and care providers. They noted that the multiplicity of care providers, their avoidance of introducing themselves to patients, and their inability to answer patients' questions cause bafflement, disappointment, and distrust among PWS. They also reported care providers' inattention to patients' needs, concerns, and talks and believed that effective and respectful professional communication together with active listening and empathy improve patients' satisfaction and treatment adherence. *"Some nurses happily answered patients' questions, while others either referred us to physicians for our questions or were so indifferent that we preferred not to ask them any questions (P. 9)."*

**Table 2: The facilitators to hospital-to-home care transition after stroke**

| Subcategories | Categories |
|---|---|
| Communication between care providers and PWS | Improvement of communication and education |
| Patient and family education | |
| Care coordination | Maintenance of care continuity |
| Patient-centered care | |
| Improvement of information systems | Improvement of infrastructures |
| Access to community-based services | |
| Access to support services | |
| Development of HHCT guidelines | |

#### *Patient and family education*

Most participating PWS and family caregivers reported the lack of patient and family education about patient care, self-care, medications, and follow-up visits at the time of hospital discharge. They also highlighted that at the time of patient and family education, healthcare providers need to pay close attention to patients' and family caregivers' hearing abilities, language, and memory because these factors can influence the absorption and retention of the provided education. Moreover, they referred to the importance of providing clear and comprehensible written educational materials without the use of technical terms. *"At the time of hospital discharge, they told me that the level of some of my blood parameters was high and I had to undergo laboratory tests 1 week after hospital discharge. However, I forgot it (P. 13)."*

### Maintenance of care continuity

Maintenance of care continuity refers to the maintenance of communication, information flow, and management throughout the process of care, from hospital to home. This category has two subcategories, namely, care coordination and patient-centered care.

#### *Care coordination*

Participants highlighted the importance of effective information transfer between healthcare providers and clients through teamwork and interdisciplinary collaboration. They recommended the development of a new professional role for information exchange between hospital settings and community-based healthcare settings. Healthcare professionals who are assigned with this role need to know all medical information of patients and all community-based healthcare settings and be able to connect patients to hospital and community-based healthcare settings. This role can reduce errors and costs and enhance patient satisfaction. *"We have an office in the hospital for the pre-discharge assessment of patients respecting their treating physicians, diagnoses, necessary equipment and devices, and need for physiotherapy (P. 21)."*

#### *Patient-centered care*

According to the participants, the maintenance of care continuity requires patient-centered care, in which all

services are provided based on the assessment of each patient's physical, mental, socioeconomic, and cultural status, needs, resources, home setting, and family. Patient and family involvement in decision-making and planning for patient-centered care is also important because it facilitates the identification of patients' needs and their preparation for discharge. *"They had to tell us about the time of my father's discharge from hospital so that we could buy a bed and oxygen tank and prepare the home environment (P. 14)."*

The availability of competent home care providers is another facilitator to patient-centered care, care continuity maintenance, and HHCT. Most families prefer fixed competent nurses who have adequate knowledge about their patients' medical history and preferences because such nurses improve the trust and safety of patients, reduce the risk of errors, and improve family satisfaction with home care. *"My mother has 3–4 fixed nurses, all of them are skillful and know my mother. My mother feels comfortable with all of them. We have requested that always these nurses provide care to my mother (P. 2)."*

### Improvement of infrastructures

Infrastructure, in this study, refers to facilities and systems which can influence HHCT. The subcategories of this category were improvement of information systems, access to community-based services, access to support services, and development of HHCT guidelines.

#### *Improvement of information systems*

PWS need to receive healthcare services from various healthcare professionals, and, hence, the professionals need to have effective communication with each other. Development of long-term strategies which support interdisciplinary information exchange, such as electronic information documentation and management systems, can facilitate a safe HHCT, maintain care continuity, and reduce errors and costs. However, participants highlighted that current discharge summaries are of low quality, cannot be used by home care centers, and do not contain all necessary patient information. *"Some patients say that hospital staff have not given them their ultrasonography report. As we need the report, we need to re-perform ultrasonography and this imposes added costs on patients (P. 15)."*

#### *Access to community-based services*

Easy access to community-based services facilitates a safe HHCT and alleviates patients' physical, mental, social, and care-related and rehabilitation-related problems during HHCT. However, some participants highlighted that some healthcare professionals do not have adequate information about these services and do not provide patients with adequate information about these services at the time of hospital discharge. Moreover, patients need to travel long distances, experience different transportation-related problems, wait a long time, and spend heavy costs to access these services. *"The nearest public center for physiotherapy is 2 hours away from our home, meaning that I need to take a leave from work for 1 whole day for a physiotherapy session. Home physiotherapy also costs very much and is not covered by insurance (P. 16)."*

#### *Access to support services*

Patients' socioeconomic status greatly influences postdischarge care continuity and treatment adherence. PWS are discharged from hospital, bearing the heavy costs of staying in the intensive care unit on their shoulders. After hospital discharge, they also need to receive home care services which are mostly not covered by insurance. The heavy costs of these services may require their families to cut the costs by resorting to low-quality services, employing lay caregivers, frequently using disposable equipment, and omitting some rehabilitation services such as physiotherapy or swallowing therapy. *"My father lost his job because of the stroke. I have also cancelled many of my work- and family-related affairs to care for my father. We have no strong support; there is no insurance organization or welfare system to help us (P. 7)."*

#### *Development of HHCT guidelines*

Inconsistent HHCT approaches in different hospitals negatively affect interdisciplinary communication, patients' and families' access to homecare equipment and resources, and patient follow-up and monitoring. On the other hand, well-structured approaches for HHCT improve interdisciplinary coordination, maintain care continuity, reduce errors, and enhance patient trust and treatment adherence. *"In my opinion, the current discharge process has problems because rehabilitation and physiotherapy, which are the principal components of stroke management, end after the patient is discharged from hospital and nurses do not provide patients with any advice in this area. We need a protocol for nurses if we want to provide quality services after hospital discharge (P. 11)."*

## Discussion

This study explored the facilitators to post-stroke HHCT from the perspective of all involved individuals. The three main categories of the facilitators in the present study were improvement of communication and education, maintenance of care continuity, and improvement of infrastructures.

Improvement in communication and education was identified in our study as a key facilitator for HHCT as it allows better monitoring, supports self-management, and reduces stress after discharge.[28] This finding is consistent with previous research by Parkes and Shepperd,[29] who reported that structured discharge planning and effective communication are associated with lower hospital readmission rates and better patient outcomes. Similarly, a

recent systematic review and meta-synthesis of qualitative studies (201-2024) found that insufficient communication and education during hospital-to-home transitions often leads to confusion and anxiety among patients and families. The study emphasized that improving the quality of information and providing continued educational support after discharge are crucial for a successful transition.[30] Overall, our results support the evidence that strong communication and educational strategies are essential for a safe and successful HHCT.

Maintenance of care continuity was the second main category of the facilitators to post-stroke HHCT. Despite the known significant role of care coordination in maintaining care continuity,[31,32] some previous studies reported poor coordination between hospital and home care settings.[33,34] The main reasons for this poor collaboration include incoherent organizational structures, shortage of accountable staff, poor communication, ineffective information exchange, and patients' limited participation in care-related decision-making.[35,36] Therefore, strategies such as video conference for information exchange,[37] use of electronic patient medical records for information communication between hospital and home care settings,[38] and use of hospital discharge coordinators[20] are recommended to maintain care continuity. Discharge coordinators can facilitate communication between hospital and home care settings, provide quality education, and, thereby, play a pivotal role in complication prevention, effective HHCT, and patient outcome improvement.[39,40]

Our findings also revealed patient-centered care as a key component of care continuity maintenance and a facilitator to HHCT. This is in agreement with the findings of several previous studies.[19,20,41] Patient-centered care strengthens communication, improves access to resources, facilitates support provision to patients, helps more effectively fulfill patients' needs, and, hence, facilitates safe and healthy HHCT.[42] However, careless patient assessment and routine-based care provision may lead to the disregarding of patients' problems and unsafe HHCT.[41] Involvement of patients and families in the process of discharge helps identify their care-related abilities and needs and improves their responsibility toward care.[23] Therefore, ensuring effective communication using joint decision-making techniques in the process of hospital discharge, improvement of discharge process, and supplying appropriate resources may help facilitate HHCT.[43] In contrast, the lack of patient-centered care during HHCT can cause misconceptions about care plans, reduce patients' autonomy in daily activities, increase patients' unfulfilled care-related needs, and increase the risk of re-hospitalization.[44]

The third main category of the facilitators to HHCT in the present study was improvement of infrastructures. Home care nurses may have challenges and difficulties in accessing patient-related information.[45] Therefore, development of integrated information systems which facilitate information exchange among different healthcare providers is a strategy to facilitate HHCT,[44] reduce information repetition and errors, and improve patient safety.[19,45] Nonetheless, given the challenges of using information systems, further work is still necessary to improve their effectiveness.[46]

Study findings also indicated that access to community-based services can facilitate HHCT. Consistent with this finding, two studies showed the lack of community-based rehabilitation centers, home care centers, financial resources, insurance, and governmental support as the main barriers to post-stroke HHCT.[47,48] However, healthcare authorities in Iran value hospital-based services more than community-based services and consider the hospital setting as the main site for healthcare service delivery. Therefore, patients do not have easy access to home care services and need to refer to hospitals to receive their necessary health-related services.[48] Improving public access to community-based services, providing adequate insurance for these services, and changing the healthcare provision policy from treatment-based to community-based services can facilitate HHCT.[49]

Development of HHCT guidelines was the other infrastructure-related facilitator to HHCT. The lack of HHCT guidelines causes bafflement respecting postdischarge care measures and leads to patients' frequent attendance at healthcare settings,[32] while clear HHCT guidelines help maintain patients' postdischarge autonomy and improve their QOL.[50] Therefore, development of clear HHCT guidelines based on patients' disease type, disease severity, and postdischarge care delivery site can increase HHCT success.[50]

The strength of the present study lies in the exploration of the experiences of all stakeholders involved in the process of HHCT, including healthcare clients, providers, and policymakers. Nonetheless, as this study was conducted in a large city in Iran, its findings may not be widely transferable to other contexts, and replication in smaller cities is recommended. Additionally, some key issues such as the formal structure of home care and the role of telehealth were not explicitly addressed by all participants, including policymakers. Future research should further investigate these structural aspects to provide a more comprehensive understanding.

## Conclusion

This exploration concludes that different interrelated factors can facilitate the process of HHCT. Improvement of HHCT infrastructures and development of clear HHCT guidelines are necessary to improve interdisciplinary collaboration, community-based care services, and communication between healthcare clients and providers. Development of strategies to remove the barriers to community-based

care provision is also necessary to improve the quality of HHCT.


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## Conflict of interests

Nothing to declare.

## References


1. Feigin VL, Brainin M, Norrving B, Martins S, Sacco RL, Hacke W, *et al*. World Stroke Organization (WSO): Global stroke fact sheet 2022. Int J Stroke 2022;17:18-29.
2. Fallahzadeh A, Esfahani Z, Sheikhy A, Keykhaei M, Moghaddam SS, Tehrani YS, *et al*. National and subnational burden of stroke in Iran from 1990 to 2019. National and subnational burden of stroke in Iran from 1990 to 2019. Ann Clin Transl Neurol 2022;9:669-83.
3. Tsao CW, Aday AW, Almarzooq ZI, Alonso A, Beaton AZ, Bittencourt MS, *et al*. Heart disease and stroke statistics—2022 update: A report from the American Heart Association. Circulation 2022;145:e153-639.
4. Septianingrum Y, Nurjanah S, Nursalam N. Improved transitional care as a strategy to decrease readmission in stroke patients: A systematic review. Dunia Keperawatan: Jurnal Keperawatan dan Kesehatan 2022;10:241-54.
5. Baldino M, Bonaguro AM, Burgwardt S, Lombardi A, Cristancho C, Mann C, *et al*. Impact of a novel post-discharge transitions of care clinic on hospital readmissions. J Natl Med Assoc 2021;113:133-41.
6. Coleman EA, Mahoney E, Parry C. Assessing the quality of preparation for posthospital care from the patient's perspective: The care transitions measure. Med Care 2005;43:246-55.
7. Coleman EA, Boult C. American Geriatrics Society Health Care Systems Committee. Improving the quality of transitional care for persons with complex care needs. J Am Geriatr Soc 2003;51:556-7.
8. Albert Nancy M, Barnason S, Deswal A, Hernandez A, Kociol R, Lee E, *et al*. Transitions of care in heart failure. Circ Heart Fail 2015;8:384-409.
9. Naylor MD, Sochalski JA. Scaling up: Bringing the transitional care model into the mainstream. Issue Brief (Commonw Fund) 2010;103:1-12.
10. Dalvandi A, Khankeh HR, Ekman SL, Maddah SSB, Heikkilä K. Everyday life condition in stroke survivors and their family caregivers in Iranian context. Int J Community Based Nurs Midwifery 2013;1:3-15.
11. Heydari M, Arsalani N, Dalvandi A, Noroozi M, Daneshvar R. The effectiveness of self-management program based on 5A model on patient care burden for stroke patients. Iran J Rehabil Res 2020;6:1-9.
12. Dong C, Gardener H, Rundek T, Marulanda E, Gutierrez CM, Campo-Bustillo I, *et al*. Factors and behaviors related to successful transition of care after hospitalization for ischemic stroke. Stroke 2023;54:468-75.
13. Zwart DLM, Schnipper JL, Vermond D, Bates DW. How do care transitions work?: Unraveling the working mechanisms of care transition interventions. Med Care 2021;59(Suppl 4):S387-97.
14. Junge-Maughan L, Moore A, Lipsitz L. Key strategies for improving transitions of care collaboration: Lessons from the ECHO-care transitions program. J Interprof Care 2021;35:633-6.
15. Reeves MJ, Boden-Albala B, Cadilhac DA. Care transition interventions to improve stroke outcomes: Evidence gaps in underserved and minority populations. Stroke 2023;54:386-95.
16. Rennke S, Nguyen OK, Shoeb MH, Magan Y, Wachter RM, Ranji SR. Hospital-initiated transitional care interventions as a patient safety strategy: A systematic review. Ann Intern Med 2013;158(5 Pt 2):433-40.
17. Sabaq AG, Bassam SEA, Said KM. Effect of transition care educational program on transitional readiness, self-efficacy and quality of life among adolescents with type 1 diabetes mellitus. Tanta Sci Nurs J 2022;24:74-103.
18. Van Spall HGC, Lee SF, Xie F, Oz UE, Perez R, Mitoff PR, *et al*. Effect of patient-centered transitional care services on clinical outcomes in patients hospitalized for heart failure: The PACT-HF randomized clinical trial. JAMA 2019;321:753-61.
19. Sun M, Liu L, Wang J, Zhuansun M, Xu T, Qian Y, *et al*. Facilitators and inhibitors in hospital-to-home transitional care for elderly patients with chronic diseases: A meta-synthesis of qualitative studies. Front Public Health 2023;11:1047723.
20. Magagnin AB, Schulter Buss Heidemann IT, de Brum CN. Transition of care for stroke patients: An integrative review. Rev Rene 2022;23:e80560.
21. Bahadoram S, Arsalani N, Fallahi-Khoshknab M, Mohammadi-Shahbolaghi F, Dalvandi A. The principles of home care for patients with stroke: An integrative review. Iran J Nurs Midwifery Res 2024;29:503-14.
22. Ba HM, Son YJ, Lee K, Kim BH. Transitional care interventions for patients with heart failure: An integrative review. Int J Environ Res Public Health 2020;17:2925.
23. Chen L, Xiao LD, Chamberlain D, Newman P. Enablers and barriers in hospital-to-home transitional care for stroke survivors and caregivers: A systematic review. J Clin Nurs 2021;30:2786-807.
24. Lin S, Wang C, Wang Q, Xie S, Tu Q, Zhang H, *et al*. The experience of stroke survivors and caregivers during hospital-to-home transitional care: A qualitative longitudinal study. Int J Nurs Stud 2022;130:104213.
25. Sandelowski M. What's in a name? Qualitative description revisited. Res Nurs Health 2010;33:77-84.
26. Polit DF, Beck CT. Essentials of Nursing Research: Appraising Evidence for Nursing Practice. Lippincott Williams and Wilkins; 2020.
27. Zhang Y, Wildemuth BM. Qualitative analysis of content. In: Wildemuth BM, editors. Applications of Social Research Methods to Questions in Information and Library Science. Libraries Unlimited; 2009. p. 1-12.
28. Ghorbanzadeh K, Ebadi A, Hosseini M, Madah SSB, Khankeh H. Challenges of the patient transition process from the intensive care unit: A qualitative study. Acute Crit Care 2021;36:133-42.
29. Parkes J, Shepperd S. Discharge planning from hospital to home. Cochrane Database Syst Rev 2000;(4):CD000313.
30. van Grootel JWM, Collet RJ, van Dongen JM, van der Leeden M, Geleijn E, Ostelo R, *et al*. Experiences with hospital-to-home transitions: Perspectives from patients, family members and healthcare professionals. A systematic review and meta-synthesis of qualitative studies. Disabil Rehabil 2025;47:1644-58.

31. Webb S, Tucker JA. Care coordination and transition management: A new course to prepare prelicensure students. J Nurs Educ 2023;62:471-4.
32. Zimmerman WD, Grenier RE, Palka SV, Monacci KJ, Lantzy AK, Leutbecker JA, *et al*. Transitions of care coordination intervention identifies barriers to discharge in hospitalized stroke patients. Front Neurol 2021;12:573294.
33. Dolu I, Naharcı Mİ, Logan PA, Paal P, Vaismoradi M. Transitional 'hospital to home' care of older patients: Healthcare professionals' perspectives. Scand J Caring Sci 2021;35:871-80.
34. Liebzeit D, Jaboob S, Bjornson S, Geiger O, Buck H, Arbaje AI, *et al*. A scoping review of unpaid caregivers' experiences during older adults' hospital-to-home transitions. Geriatric Nurs 2023;53:218-26.
35. Callister C, Jones J, Schroeder S, Breathett K, Dollar B, Sanghvi UJ, *et al*. Caregiver experiences of care coordination for recently discharged patients: A qualitative metasynthesis. West J Nurs Res 2020;42:649-59.
36. Topham EW, Bristol A, Luther B, Elmore CE, Johnson E, Wallace AS. Caregiver inclusion in IDEAL discharge teaching: Implications for transitions from hospital to home. Prof Case Manag 2022;27:181-93.
37. Knight SW, Trinkle J, Tschannen D. Hospital-to-homecare videoconference handoff: improved communication, coordination of care, and patient/family engagement. Home Healthcare Now 2019;37:198-207.
38. Fjellså HMH, Husebø AML, Storm M. eHealth in care coordination for older adults living at home: Scoping review. J Med Internet Res 2022;24:e39584.
39. Buchinsky K, Pope L, Noah P, Hackett C, Cerejo R. Abstract TP35: Stroke nurse navigation-evolving care delivery to effectively meet the needs of stroke patients and families. Stroke 2022;53(Suppl_1):ATP35.
40. Organes L, Schoefeld N. Improving Patient Outcomes through Use of a Stroke Navigator Program. 2021.
41. Nikbakht-Nasrabadi A, Mardanian-Dehkordi L, Taleghani F. Abandonment at the transition from hospital to home: Family caregivers' experiences. Ethiop J Health Sci 2021;31:525-32.
42. Provencher V, Clemson L, Wales K, Cameron ID, Gitlin LN, Grenier A, *et al*. Supporting at-risk older adults transitioning from hospital to home: Who benefits from an evidence-based patient-centered discharge planning intervention? Post-hoc analysis from a randomized trial. BMC Geriatr 2020;20:84.
43. Sun M, Qian Y, Liu L, Wang J, Zhuansun M, Xu T, *et al*. Transition of care from hospital to home for older people with chronic diseases: A qualitative study of older patients' and health care providers' perspectives. Front Public Health 2023;11:1128885.
44. Arbaje AI, Hsu YJ, Keita M, Greyson S, Wang J, Werner NE, *et al*. Development and validation of the hospital-to-home-health transition quality (H3TQ) index: A novel measure to engage patients and home health providers in evaluating hospital-to-home care transition quality. Qual Manag Health Care 2024:33:140-8.
45. Alarslan G, Mennes R, Kieft R, Heinen M. Patients involvement in the discharge process from hospital to home: A patient's journey. J Adv Nurs 2024;80:2462-74.
46. Norlyk A, Deleuran CL, Martinsen B. Struggles with infrastructures of information concerning hospital-to-home transitions. Br J Community Nurs 2020;25:10-5.
47. Shannon B, Shannon H, Bowles KA, Williams C, Andrew N, Morphet J. Health professionals' experience of implementing and delivering a 'Community Care' programme in metropolitan Melbourne: A qualitative reflexive thematic analysis. BMJ Open 2022;12:e062437.
48. Sadeghi H, Arsalani N, Fallahi-khoshknab M. Barriers of home nursing care plane in Iran: A systematic review. Iran J Syst Rev Med Sci 2023;3:12-24.
49. Hesamzadeh A, Dalvandi A, Maddah SB, Khoshknab MF, Ahmadi F. Family caregivers' experiences of stroke recovery among older adults living in Iran: A qualitative study. Iran Red Crescent Med J 2018;20(S1):1-9.
50. Alizadeh-Khoei M, Fadayevatan R, Sharifi F, Chehrehgosha M, Aminalroaya R. Effects of hospital-to-home transitional care on health outcomes of elderly patients in Islamic Republic of Iran. East Mediterr Health J 2023;29:451-61.