Nusantara Medical Science Journal
Volume 11, Issue 1, January – June 2026
P-ISSN: 2460-9757, E-ISSN: 2597-7288
Nationally Accredited Journal, Decree No. 230/E/KPT/2022.

Review Article

Implementation of Discharge Planning Based on Patient Centered Care for Post Stroke Patients in the Stroke Unit: A Systematic Review

Halimatus Sa'diyah[1], Mira Triharini[2], Ilya Krisnana[2], Novia Caecilia Laoli[1], Nurma Lindawati[1]

[1] *Faculty of Nursing, Airlangga University, Surabaya, Indonesia*
[2] *Department of Advance Nursing, Faculty of Nursing, Airlangga University, Surabaya, Indonesia*

Corresponding Author:
Halimatus Sa'diyah
Faculty of Nursing, Airlangga University, Surabaya, Indonesia
Email: imahalima16@gmail.com

ARTICLE INFO

Keywords:
discharge Planning; patient centered care; stroke.

How to cite:

DOI:

ABSTRACT

Introduction: *Stroke is a major mortality factor necessitating coordinated care systems to prevent incidents and enhance patient prognosis. The implementation of discharge planning based on patient centered care in stroke patients aims to increase patient involvement through the provision of personalized information and shared decision making, in order to prepare patients for daily activities after discharge from the hospital. This study aims to Assess the effectiveness and impact of implementing patient-centered care-based discharge planning after stroke on patient satisfaction, quality of life, and reduction in hospital re-visits.*

Method: *The authors conducted a systematic review using PRISMA 2020 Guidelines. The article were derived from four electronic databases (Web of Science, JStor, PubMed, and Scopus) using keywords and terms relevant to the research topic. Consisting of full text original research articles published between 2019 and 2025 using quantitative and qualitative methods.*

Results*: A total of 2,518 records were identified. Nine articles met the selection inclusion criteria were included due to having good methodological quality Patient-*

centered discharge planning interventions were associated with improved quality of life, patient satisfaction, adherence to post-discharge plans, and reduced hospital readmissions.

***Conclusion**: Patient-centered discharge planning models positively influence patient satisfaction, quality of life, and rehospitalization rates among post-stroke patients. Implementing structured, multidisciplinary discharge planning protocols based on patient-centered care principles is crucial to improving stroke recovery outcomes.*

1. INTRODUCTION

Stroke is a significant global health issue, ranking as the primary cause of mortality and disability worldwide [1]. Cardiovascular disease and stroke impose substantial health and economic challenges both in the United States and globally [2]. According to the World Health Organization (WHO), around 15 million people experience stroke each year, and more than 5 million of them die, while another 5 million are permanently disabled (WHO, 2021). Several studies regarding familial preparedness to provide care for individuals who have suffered a stroke indicate that the proportion of those deemed ready is 28.6%, while the segment identified as unprepared constitutes 71.4%. Subsequent to the implementation of a standardized discharge planning intervention from a hospital focusing on family readiness, the results reflect an increase to 33.3% of individuals categorized as ready and a decrease to 66.7% identified as unprepared [3].

Discharge planning constitutes a collaborative endeavor undertaken by a multidisciplinary team to ascertain the most favorable disposition of the patient upon their transition from acute care settings [4]. The rehabilitation requirements may encompass physical therapy, occupational therapy, and speech therapy, along with comprehensive guidance aimed at addressing cognitive and psychological manifestations subsequent to a stroke [4]. The execution of patient-centered care (PCC) within clinical practice faces numerous obstacles, predominantly associated with social, economic, financial, healthcare personnel training, and patient education dimensions [5]. The planning process necessitates contributions from an array of healthcare providers, including nurses, therapists, and case managers [6].

Staff recognized the presence of gaps in discharge information [7]. Patients and their caregivers frequently expressed astonishment at abrupt discharge orders, indicating a deficiency in participatory decision-making processes [7]. PCC possesses the capacity to revolutionize stroke management through the implementation of comprehensive and patient-oriented approaches [8]. Poor inter-team communication, lack of structured systems for referrals, and fragmented discharge planning increased stress and unplanned readmissions [7].

The main obstacles to structured discharge planning are nurses' workload, ineffective communication, and the absence of clear SOP in most hospitals [9]. The discharge planning process has not been optimized due to the unavailability of structured guidelines or SOP [10]. Although the importance of discharge planning is understood, its implementation is hampered by differences in perception, lack of documentation, and the absence of specific PCC-based formats and SOP [11].

Varied widely in design, intervention characteristics, outcome measures, and methodological rigor," resulting in a fragmented evidence base with no unified best practices [12]. Patient centered elements are increasingly recognized, evidence for their implementation in discharge planning was inconsistent due to heterogeneous study designs and outcome measures [13]. Healthcare professionals' perspectives and practices of post-stroke coordinated discharge planning [13]. Various approaches in the literature, such as educational programs and interventions for caregivers, show inconsistencies in discharge planning practices [12].

A recent systematic review on post-discharge care for stroke survivors highlights the fragmented and heterogeneous nature of existing evidence, underscoring the necessity to comprehensively identify dan synthesize current models of discharge planning [14]. Lack of standardized programs and good communication among providers are major barriers to discharge planning [15]. Six best practice themes (including patient/family engagement and education) are critical to improving the quality of discharge transitions and continuity of care [16]. The ultimate goal is to "align with the 'triple aim'-improving individual experience of care, improving public health, and reducing healthcare costs" and use 30-day hospitalization as a key indicator of continuity of care [17].

2. METHODS

Study Design

This systematic review was conducted according to the Preferred reporting Items for Systematic Reviews and Meta-Analysis (PRISMA) 2020 guidelines [18].

Eligibility Criteria

The authors included studies that focused on the implementation of patient centered care-based discharge planning in stroke patients. The research design used was qualitative and quantitative methods published between 2019 and 2025. The authors excluded studies whose results did not focus on the implementation of patient centered care-based discharge planning in stroke patients.

Information Sources

We searched the following electronic database: Web of Science, JStor, PubMed, and Scopus. The last search was conducted in 2025.

Search Strategy

The search strategy used combinations of the following keywords and Boolean operators: ("discharge planning" OR "transition planning" OR "care coordination" OR "post-discharge") AND ("stroke" OR "cerebrovascular accident" OR "CVA" OR "brain attack") AND ("patient" OR "individual" OR "client") AND ("model" OR "framework" OR "approach") AND ("rehabilitation" OR "recovery" OR "support" OR "follow-up").

Selection Process

Two reviewers independently screened abstracts and titles. Full-text articles were obtained for investigations that fulfilled the specified inclusion criteria or in instances where eligibility remained ambiguous. Discrepancies were addressed through discussion or by seeking the counsel of a third reviewer.

Data Collection Process

Data extraction was conducted independently by two reviewers utilizing a standardized data extraction instrument. Extracted information included authorship, year of publication, key findings, outcomes, intervention details, population characteristics, and study design.

Data Items

The primary outcomes were patient satisfaction with discharge planning, quality of life after discharge, adherence to post-discharge care, and the number of hospital revisits within 30 days.

Risk of Bias Assessment

The methodological rigor of the studies incorporated in this review was evaluated employing the Joanna Briggs Institute (JBI) critical appraisal instruments specifically designed for prevalence studies, whereas the 9-item JBI Checklist tailored for Quasi-experimental studies was utilized to systematically critique the Quasi-experimental designs [19–21]. Each item of the tools had four possible responses (no, yes, not applicable, or unclear). The summary quality was reported as the percentage of all 'yes' answers divided by all applicable questions, ranging from 0 to 100%, with a higher JBI indicating better methodological quality. Despite no formal guidelines, the authors considered studies with a JBI score ≥ 80% to be methodologically robust. Disagreements between the authors' results were resolved by discussion to reach a consensus, facilitated by the second author.

3. RESULTS

A total of 2,518 records were identified. After removing duplicates, 2,310 records were screened based on titles and abstracts. 98 full-text articles were reviewed, and 9 studies met the inclusion criteria. Nine studies met the inclusion criteria. Patient-centered discharge planning interventions were associated with improved patient satisfaction, quality of life, adherence to post-discharge plans, and reduced hospital readmissions. The whole process of study selection is illustrated in the PRISMA flowchart (Figure 1).

Study Characteristics

Nine studies were published from 2019 to 2025 (Table 1), one study published in 2019 [22], one study published in 2020 [23], one study published in 2021 [24], two studied published in 2022 [25] and [26], two studies published in 2023 [27] and [28], one study published in 2024 [1], one study published in 2025 [29]. One study was Non-randomized controlled feasibility study [30]. One study was Retrospective cohort study [23]. One study was Retrospective case-control cohort study [27]. One study was Randomized controlled trial [29]. One study was Prospective qualitative longitudinal study using semi structure interviews [26]. One study was Cross sectional analytic study [28]. One study was Qualitative study using semi structured interviews [22]. One study was Qualitative action research approach using semi-structured individual interviews [25]. One study was Non-randomized controlled design [24]. Based on research site, two studies originated from China [26,29]. Two

studies were conducted in Sweden [1,24]**.** Two studies were conducted in United States [22,23]**.** One study was conducted in Taiwan [27]. One study was conducted in Indonesia [28]. One study was conducted in Nigeria [25].

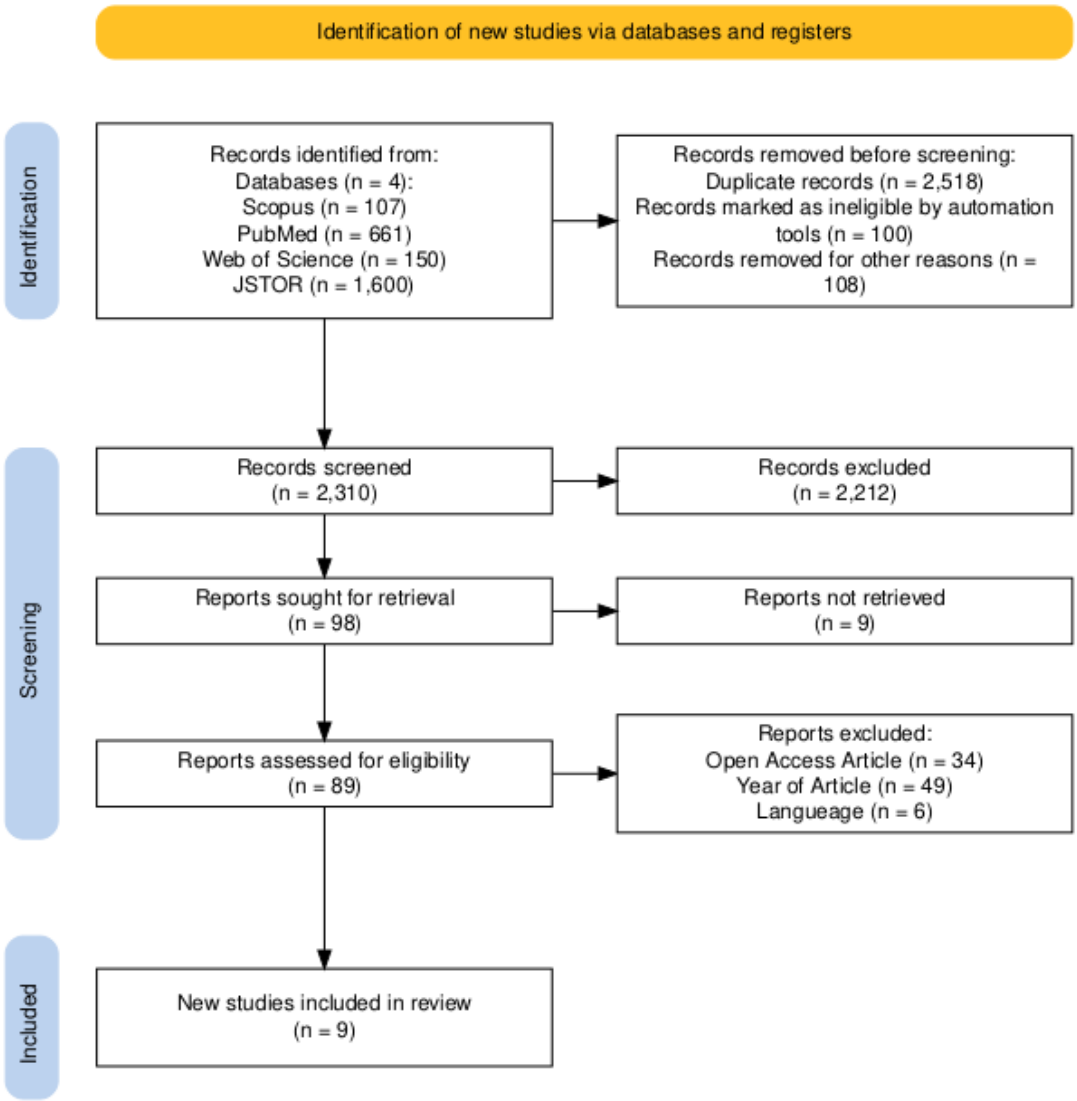

Figure 1. PRISMA flowchart

Table 1. Description of the included studies

Author and Year	Study Design	Country	Participants	Instrument/Data Collection	Key Quantitative/Qualitative Outcomes
Lindblom et al. (2024) [1]	Non-randomized controlled feasibility study.	Sweden	49 stroke survivors: 28 in the intervention group and 21 in the control group	The Normalization Measure Development Questionnaire, participatory observations, focus groups, and semi structured interviews.	The feasibility evaluation showed a 39% patient recruitment rate and a 16% drop-out rate. Data collection was highly feasible with 99% completeness at baseline. The intervention group reported a significantly higher perceived quality of the care transition compared to the control group (mean = 79 vs. 62, p = 0.027). Other outcomes (medication adherence, functioning) showed no significant differences.
Halladay et al. (2020) [23]	Retrospective cohort study	United States (North Carolina)	1300 stroke patient discharged directly to home from a single tertiary hospital	Electronic health records (EHR), compass 2-day follow-up call instrument, conceptual model of patient-influenced factors, multivariable logistic regression model	Overall, 63.2% of patients attended the comprehensive care transitions visit, and 60.2% completed the 2-day follow-up call. The odds of visit attendance were significantly higher if the 2-day follow-up calls were completed and if clinic appointments were scheduled before discharge.
Po et al. (2023) [27]	Retrospective case-control cohort study	Taiwan	7.796 patient	Electronic medical records and databases, activities of daily living (ADL) scale	Multivariate analysis showed an ADL score ≤ 60 significantly increased the risk of >60 days hospitalization (OR = 9.84, p < .001). Patients with an ADL score ≤ 60 and indwelling tubes had significantly higher risks of 14-day and 30-day readmissions. Cox regression indicated an ADL score ≤ 60 was associated with significantly fewer days between discharge and death within 30 days (HR = 3.101).

Xiao and Xu (2025) [29]	Randomized controlled trial	China	120 patients were initially recruited, final data was available for 115 patients at discharge	Medication adherence rating scale (MARS), national institute of health stroke scale (NIHSS), functional exercise adherence scale, Newcastle nursing service satisfaction scale	Intervention groups showed significantly improved NIHSS scores (F=87.07, P<.01), medication adherence (P=.03), and functional exercise adherence (F=224.71, P<.01) at 6 months. Patient satisfaction was also significantly higher (F=18.25, P=.02).
Lin et al. (2022) [26]	Prospective qualitative longitudinal study	China	23 stroke survivor/caregiver dyads, totalling 46 participants and 92 individual interviews	Semi structure interviews	**Qualitative themes:** The hospital-to-home transition involved three phases. During discharge preparation, both patients and caregivers experienced emotional distress, unpreparedness, and insufficient stroke care knowledge. At home, they faced high stress levels, fragmented post-discharge services, disrupted interpersonal relationships, and significant financial burdens.
Siskaningrum et al. (2023) [28]	Cross sectional analytic study	Indonesia	133 nurses from stroke units participated in the study	Structured Questionnaire	The SECI knowledge management model significantly influenced discharge planning (T = 6.618, p < 0.001). Discharge planning was also significantly affected by family factors (T = 5.715, p < 0.001), nurse factors (p = 0.014), and organizational factors (p = 0.013). The overall model explained 93.6% (R-square = 0.936) of the variance in discharge planning.
Krishnan et al. (2019) [22]	Qualitative study	United States	18 stroke survivors	Semi structured interviews	**Qualitative themes:** The majority of patients were not involved in selecting their PAC setting. Patients reported unmet information needs regarding rehabilitation services, medical interventions,

					insurance, and psychological changes post-stroke. Patients expressed a desire for greater self-advocacy and more comprehensive education prior to discharge.
Lateef and Mhlongo (2022) [25]	Qualitative action research approach	Nigeria	35 nurses participated	Semi structured individual interviews	**Qualitative themes:** Major barriers to PCC included heavy workloads, time constraints, lack of management commitment, and severe resource/infrastructure shortages. Conversely, nurses recognized that PCC enriches practice, improves information sharing, fosters better communication, and ultimately leads to better healthcare outcomes and patient satisfaction.
Flink et al. [24]	Non-randomized controlled design	Sweden	50 stroke patients (25 in the intervention group and 25 in the control group)	NIHSS, barthel index (BI), modified rankin scale (MRS), mini-montreal cognitive assessment, patient health questionnaire-2, stroke impact scale	**Study Protocol:** This paper outlines the protocol for assessing feasibility, fidelity, and acceptability of a co-designed care transition support. Anticipated outcomes include evaluating patient satisfaction (using the Care Transition Measure), health literacy, and 3-month post-discharge clinical and cognitive functions.

4. DISCUSSIONS

This systematic review aimed to synthesize existing evidence on the implementation of PCC-based discharge planning for post-stroke patients. Our findings demonstrate that PCC-oriented interventions yield statistically significant improvements across multiple clinical and patient-reported outcomes. Notably, structured interventions that integrate the Information-Motivation-Behavioral (IMB) skills model and hospital-community-family triad linkages significantly improved neurological recovery (NIHSS scores, $p<0.01$) and medication adherence ($p=0.03$) at 6 months post-discharge [29]. Furthermore, effective PCC transition support has been shown to reduce the risk of 30-day hospital readmissions—a critical indicator where traditional administrative discharges often fail. For instance, the completion of post-discharge follow-up calls and pre-scheduled clinic appointments significantly increased the odds of successful care transitions [23], while poor functional status (ADL ≤ 60) coupled with inadequate discharge support exponentially increased the risk of readmissions and post-discharge mortality [27].

The transition from the acute stroke unit to the home environment is a highly vulnerable period. Traditional discharge processes frequently prioritize administrative

efficiency over patient engagement, leading to unmet information needs and fragmented care. As highlighted by Krishnan et al. (2019)[22], patients often feel excluded from selecting their post-acute care settings and setting rehabilitation goals, leading to dissatisfaction and anxiety. This lack of active involvement directly contributes to emotional distress and places a high burden on family caregivers, who frequently feel underprepared to manage complex home-based healthcare tasks such as mobility assistance and medication management [26].

Addressing these gaps requires structured, individualized, and multidisciplinary discharge planning. When patients are actively engaged through shared decision-making, continuous education, and methods like the "Teach-Back" approach, they exhibit a significantly higher perceived quality of the care transition (mean score 79 vs. 62, $p=0.027$) compared to standard care [1]. Moreover, involving family factors—specifically social support and caregiver role modeling—has been proven to significantly enhance the overall performance of nurses in executing discharge planning ($T = 5.715$, $p<0.001$), reinforcing the necessity of a collaborative care model [28].

Despite the clear benefits, the implementation of PCC remains highly inconsistent. A major finding of this review is the profound impact of systemic and geographical heterogeneity on PCC delivery. In high-resource settings, such as Sweden or the United States, barriers to PCC are often related to fine-tuning inter-organizational communication, utilizing bridged e-meetings, and integrating digital health records [1,23,30]. In these contexts, the infrastructure supports autonomy, and the focus is on optimizing shared decision-making.

Conversely, implementing PCC in low- and middle-resource settings (e.g., Nigeria, Indonesia, or rural China) faces fundamental infrastructural hurdles. Heavy workloads, severe understaffing, and a lack of standardized protocols often force healthcare providers into routine, "uncaring" approaches, despite their theoretical understanding of PCC concepts [25]. In these environments, successful discharge planning relies heavily on family support to compensate for the limited availability of professional community-based follow-up services. Furthermore, financial burdens and inaccessible post-discharge rehabilitation facilities severely limit the continuum of care, making the ideal PCC model difficult to sustain without significant institutional backing [26].

The strength of this review lies in its comprehensive search strategy, adherence to PRISMA 2020 guidelines, and rigorous quality assessment using the JBI checklist, with a specific focus on the stroke population rather than general medical admissions.

However, several limitations must be acknowledged. First, the included studies exhibit considerable heterogeneity in study design (ranging from qualitative interviews to randomized controlled trials), intervention types, and outcome measures, which precluded a meta-analysis. Second, as discussed, the vast differences in healthcare systems, socioeconomic contexts, and cultural family dynamics among the studied countries mean that successful implementation models in one context may not be directly generalizable to another without significant adaptation. Finally, the inclusion of predominantly observational and qualitative studies, along with a restriction to English-language publications, suggests that publication bias cannot be ruled out and the results should be interpreted with caution.

Healthcare institutions must prioritize patient and caregiver engagement by developing adaptable, context-specific Standard Operating Procedures (SOPs) for PCC-based discharge planning. Continuous training for healthcare providers and the strengthening of community-based support networks are essential to translate PCC principles into sustainable clinical practice globally.

5. CONCLUSION

Patient-centered discharge planning models positively influence patient satisfaction, quality of life, and rehospitalization rates among post-stroke patients. Implementing structured, multidisciplinary discharge planning protocols based on patient-centered care principles is crucial to improving stroke recovery outcomes.

ACKNOWLEDGMENTS

The authors would like to thank the authors of the sources used in this study.

FUNDING

The authors does not receive financial support for the research, authorship, and/or publication of this article.

REFERENCES

1. Lindblom S, Flink M, von Koch L, Laska AC, Ytterberg C. Feasibility, Fidelity and Acceptability of a Person-Centred Care Transition Support Intervention for Stroke Survivors: A Non-Randomised Controlled Study. *Health Expect Int J Public Particip Health Care Health Policy*. 2024;27(5):e70057. doi:10.1111/hex.70057

2. Yousufuddin M, Young N. Aging ang Stroke. *Aging*. 2019;11(9):2542-2544.

3. Kurniati N, Nursalam N, Kartini Y. The Effect Of Discharge Planning Combines Audiovisual With The Family Centered Nursing Preparedness Caring For Acute Post Stroke Patients. *Interest J Ilmu Kesehat*. 2022;10(2):154-165. doi:10.37341/interest.v0i0.345

4. Prick JCM, Engelhardt EG, Lansink Rotgerink FK, et al. Implementation of a patient decision aid for discharge planning of hospitalized patients with stroke: aprocess evaluation using a mixed-methods approach. *Patient Educ Couns*. 2025;136. doi:10.1016/j.pec.2025.108716

5. Diachuk DD, Moroz GZ, Hidzynska IM, Kravchenko AM. IMPLEMENTATION OF PATIENT-CENTERED CARE AND MEDICAL CARE IMPROVEMENT: CURRENT STATE (REVIEW). *Clin Prev Med*. 2023;1(23):67-77. doi:10.31612/2616-4868.1(23).2023.10

6. Gray J, Lyerly M. *Discharge Planning*. 2024. doi:10.1007/978-3-031-66289-8_32

7. Omonaiye O, Ward-Stockham K, Darzins P, et al. Hospital discharge processes: Insights from patients, caregivers, and staff in an Australian healthcare setting. *PLoS ONE*. 2024;19(9 September):1-15. doi:10.1371/journal.pone.0308042

8. Li J, Zhang H, Gao Y, et al. Application of Hospital-Community-Family “Trinity” Remote Rehabilitation Guidance Based on Internet + WeChat Platform in Patients with Stroke After Discharge. *Altern Ther Health Med*. 2024;30(1):358-365.

9. Rahayu CD, Purnamasari I, Alviana F, Wibowo DA, Amir H. Analysis of structured discharge planning implementation for discharged inpatients: a multicenter study. *Healthc Low-Resour Settings*. 2025;13(1):42-46. doi:10.4081/hls.2024.13192

10. Wulandari DF, Hariyati R. 70 PILOT STUDY Wulandari et al. IJNHS. *Int J Nurs Health Serv IJNHS*. 2019;2(1):70-81.

11. Heryyanoor H, Diana H, Melinda Restu P, Asih Dwi M. Nurses' perceptions of discharge planning implementation: A descriptive qualitative study. *J Plb Nurs Stud*. 2024;3(2):68-79. doi:10.55048/jpns126

12. Muhammad Imron Rosadi Mujib, Fitri Arofiati. Development of Discharge Planning for Stroke Patients. *Folia Medica Indones*. 2023;59(4):396-405. doi:10.20473/fmi.v59i4.42819

13. Ingram L, Pitt R, Shrubsole K. Health professionals' practices and perspectives of post-stroke coordinated discharge planning: a national survey. *Brain Impair*. 2024;25(1):1-14. doi:10.1071/IB23092

14. Veronese M, Vellone E, Alvaro R, Pucciarelli G. The transitional care from hospital to home for stroke survivors and their caregivers: A systematic review. *J Vasc Nurs*. 2025;43(2):86-98. doi:10.1016/j.jvn.2025.03.002

15. Wong EL, Yam CH, Cheung AW, et al. Barriers to effective discharge planning: A qualitative study investigating the perspectives of frontline healthcare professionals. *BMC Health Serv Res*. 2011;11. doi:10.1186/1472-6963-11-242

16. Lewis M. Evidence-Based Best Practice for Discharge Planning: A Policy Review. *Univ St Augustine Health Sci*. Published online 2022.

17. Parry C, Johnston-Fleece M, Johnson MC, Shifreen A, Clauser SB. Patient-Centered Approaches to Transitional Care Research and Implementation: Overview and Insights from Patient-Centered Outcomes Research Institute's Transitional Care Portfolio. *Med Care*. 2021;59(3 S):S330-S335. doi:10.1097/MLR.0000000000001593

18. Page MJ, McKenzie JE, Bossuyt P, et al. The prisma 2020 statement: An updated guideline for reporting systematic reviews. *Med Flum*. 2021;57(4):444-465. doi:10.21860/medflum2021_264903

19. Barker TH, Habibi N, Aromataris E, et al. The revised JBI critical appraisal tool for the assessment of risk of bias for quasi-experimental studies. *JBI Evid Synth*. 2024;22(3):378-388. doi:10.11124/JBIES-23-00268

20. Oley MH, Oley MC, Kepel BJ, et al. Hyperbaric Oxygen Therapy for Diabetic Foot Ulcers Based on Wagner Grading: A Systematic Review and Meta-analysis. *Plast Reconstr Surg - Glob Open*. 2024;12(3):e5692. doi:10.1097/GOX.0000000000005692

21. Oley MH, Oley MC, Sukarno V, Faruk M. Advances in Three-Dimensional Printing for Craniomaxillofacial Trauma Reconstruction: A Systematic Review. *J Craniofac Surg*. 2024;35(7):1926-1933. doi:10.1097/SCS.0000000000010451

22. Krishnan S, Hay CC, Pappadis MR, Deutsch A, Reistetter TA. Stroke Survivors' Perspectives on Post-Acute Rehabilitation Options, Goals, Satisfaction, and Transition to Home. *J Neurol Phys Ther*. 2019;43(3):160-167. doi:10.1097/NPT.0000000000000281

23. Halladay J, Bushnell C, Psioda M, et al. Patient Factors Associated With Attendance at a Comprehensive Postacute Stroke Visit: Insight From the Vanguard Site. *Arch Rehabil Res Clin Transl*. 2020;2(1). doi:10.1016/j.arrct.2019.100037

24. Flink M, Lindblom S, Tistad M, et al. Person-centred care transitions for people with stroke: Study protocol for a feasibility evaluation of codesigned care transition support. *BMJ Open*. 2021;11(12). doi:10.1136/bmjopen-2020-047329

25. Lateef MA, Mhlongo EM. A qualitative study on patient-centered care and perceptions of nurses regarding primary healthcare facilities in Nigeria. *Cost Eff Resour Alloc*. 2022;20(1). doi:10.1186/s12962-022-00375-y

26. Lin S, Wang C, Wang Q, 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. doi:10.1016/j.ijnurstu.2022.104213

27. Po HW, Lin FJ, Cheng HJ, et al. Factors Affecting the Effectiveness of Discharge Planning Implementation: A Case-Control Cohort Study. *J Nurs Res*. 2023;31(3):E274. doi:10.1097/jnr.0000000000000555

28. Siskaningrum A, Yusuf A, Mahmudah, Machin A. Nurse Performance and Influence Factors in Discharge Planning Based on Knowledge Management SECI Model in Stroke Patients. *J Med Chem Sci*. 2023;6(10):2558-2568. doi:10.26655/JMCHEMSCI.2023.10.30

29. Xiao Y, Xu X. Enhanced stroke rehabilitation outcomes through Information-Motivation-Behavioral skills model and Hospital-Community-Family ternary linkage integration: A randomized controlled trial. *Med U S*. 2025;104(9):e41547. doi:10.1097/MD.0000000000041547

30. Lindblom S, Flink M, von Koch L, et al. A person-centred care transition support for people with stroke/TIA: A study protocol for effect and process evaluation using a non-randomised controlled design. *PLoS ONE*. 2024;19(3 March). doi:10.1371/journal.pone.0299800

Conflict of Interest Statement:

The author declares that the research was conducted in the absence of any commercial or financial relationships that could be construed as a potential conflict of interest.