

The family caregiver of the older person with hip fracture: perceptions about the transition to home

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ABSTRACT

Background: Fractures resulting from falls constitute a problem of great magnitude for the older person, as they cause functional decline and difficulty in returning to the state prior to the fracture, and for the family caregiver, as they require care support to face the compromised ability to perform daily life activities that these people experience.

Objective: To characterize the perception of difficulties and needs felt by family caregivers in supporting older person with hip fractures in the transition home.

Methods: A descriptive, exploratory, qualitative study was developed, based on semi-structured interviews with family caregivers of patients with hip fractures undergoing surgical treatment, belonging to a hospital in the central region of Portugal. To analyze the data obtained, Bardin's content analysis was used, with the support of the MAXQDA Analytic pro 2022 software.

Results: From the analysis of the 15 interviews carried out, two categories emerged related to the difficulties perceived by family caregivers in supporting older person with hip fractures in the transition home: Care Support and Responsiveness. In relation to felt needs, the following categories emerged: Continuity of care and Training to provide care.

Conclusions: The family caregiver perceives multiple needs and difficulties experienced in the support provided to older person with hip fractures in the transition home. As this phenomenon is somewhat complex due to the involvement of numerous factors, the analysis of the aspects associated with this care process is essential, contributing to a favorable evolution and a safe transition.

1. Introduction

Fractures resulting from falls constitute a major problem for the elderly, as they lead to functional decline and difficulty returning to the state before the fracture (Contro et al., 2019; Rocha et al., 2024), and for family caregivers, when demanding care support to face the compromised ability to carry out the activities of daily living that these people experience. This condition constitutes a serious public health problem worldwide, requiring greater assistance support (Aftab et al., 2020; Watanabe and Maeda, 2022).

It is estimated that around 50% of older person experience loss of mobility and functional independence after suffering a hip fracture, with difficulty returning to their pre-fracture condition (Contro et al., 2019). This reality and the current context, characterized by the aging of the population, has led to a growing need for support from family caregivers, who have been progressively recognized as a fundamental element in providing care to elderly people (Oliveira et al., 2023).

Considering the aging/elderly/family triad referenced by Sousa et al. (2024) and the complexity of each of these components in this health-disease process, the WHO (2021) reiterates that the safety of

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healthcare depends on the involvement of the patient, family members and caregivers, understood as partners at different levels of care, with emphasis on performance oversight and shared decision making.

Indeed, after discharge from hospital, the older person is compromised in activities of daily living, requiring support from a caregiver (Guilcher et al., 2021). According to the WHO (2021), the family is essential in the context of care, making a unique contribution to the observation and surveillance of the patient, as well as alerting to needs that may arise again, thus making their involvement and training decisive. Considering that there is a positive relationship between the presence of the family and patient safety (Correia, 2017), it is important to value and enhance it.

In fact, family caregivers play an important role in providing physical, emotional and social support to the person with hip fractures, however, in this process they often report poor communication and an unclear understanding of the care plan and subsequent steps (Guilcher et al., 2021).

Ipsen et al. (2024) reports that the vast majority of family members of older person after a hip fracture choose to provide assistance to their family member after hospital discharge, focusing this support on the first two to four weeks after discharge.

In this context, several challenges inherent to the care of older person with hip fractures are identified, in which the person providing care is asked to carry out a series of tasks that include, but are not limited to, helping with meals, personal hygiene, going to the bathroom, generating an internal tension around the need to take care of their family member and overload, with an impact on their personal health and well-being (Guilcher et al., 2021). Equally important is the development of care management strategies within the family, related to division of labor and approaches, that allow family caregivers of these people to maximize safety and prevent adverse events during the recovery period after surgery (Teng et al., 2023).

With regard to improving the self-efficacy and competence of family caregivers, Tseng et al. (2021) refers to the importance of adopting a family-centered care model, ideally integrating an educational component with the inclusion of geriatric assessment, discharge planning, home rehabilitation and training of family caregivers within the scope of interventions aimed at elderly people with hip fractures.

In this context, the continuity and coordination of care, defended by the WHO (2018), assumes vital importance, highlighting the need to reorient services in order to provide a complete response to people's needs.

Therefore, the present study aims to characterize the perception of difficulties and needs felt by family caregivers in supporting older person with hip fractures in the transition home.

2. Materials and methods

2.1. Study design

A qualitative, descriptive and exploratory study, was developed, involving family caregivers of patients with hip fractures, undergoing surgical treatment, belonging to a hospital in the central region of Portugal. The qualitative descriptive approach facilitates the understanding of a phenomenon by providing factual answers to questions with rich descriptive content from the perspective of each subject, which is why it is approached for health-related research (Colorafi and Evans, 2016). To structure this article, we followed the guidelines proposed by the Consolidated Criteria for Reporting Qualitative Research (COREQ) (Tong et al., 2007).

2.2. Participants and recruitment

The 15 participants were selected who met the following inclusion criteria: being a family caregiver for patients with hip fractures, undergoing surgical treatment, of both sexes, having accompanied the

patient when returning home, not showing cognitive decline and accepting to participate in the study. These family members were identified while still in the hospital, upon returning home. As an exclusion criterion, people who were not family members and were not involved in the care process were defined. The criterion that determined the number of participants in the study was reaching data saturation.

2.3. Data collection

The data collection technique used was the semi-structured interview (Colorafi and Evans, 2016), consisting of a first part relating to the sociodemographic characterization of the participants and the second relating to the characterization of the perception regarding the difficulties and needs felt in supporting older person with hip fractures, in the transition home. Questions were included such as: What difficulties and needs did you feel in supporting your family member in the transition home?; What strategies did you use to resolve or overcome difficulties?; During hospitalization, what teachings or interventions helped you most prepare you to care for your family member in the transition home? The semi-structured interview guide was validated by two researchers with experience in qualitative research and in the use of semi-structured interviews. They assessed the relevance of the questions to the study's objectives and the clarity of the wording according to the target participants.

Data collection was carried out from April 2024 to November 2024 by a nurse with experience in the field of orthopedics and traumatology, who also worked as a lecturer and was the first author of the study. The interviews were carried out in an external consultation, with family caregivers who met the inclusion criteria and who met to accompany an older person undergoing orthopedic surgery following a hip fracture in the first post-hospital discharge consultation, until data saturation is reached. The participants were informed about the researcher's personal objectives, as well as the motivations and rationale underlying the study. The interviews were audio-recorded and later transcribed, however, they were not returned to the participants for correction, and no repeat interviews were necessary. The average interview time was 30 min. Field notes were taken after the interview.

2.4. Data analysis

Regarding the treatment of the collected data, a content analysis was performed using an inductive approach, which allowed for a deeper understanding of the data and the identification of categories from the collected material. The analysis was carried out in three stages: pre-analysis, with the complete transcription of the interviews and an initial reading; exploration of the material with data coding and grouping into categories by semantic approximation; and, finally, treatment and interpretation, organizing the categories into thematic areas (Bardin, 2020), reflecting the family caregiver's perception of the difficulties and needs felt in supporting the elderly person with a hip fracture upon returning home. This process was supported by MAXQDA Analytic Pro® 2022 software.

2.5. Study rigor

The methodological rigor of this study was maintained throughout all stages, from design to data analysis. All interviews were conducted and transcribed by the same researcher to ensure consistency, and transcripts were carefully reviewed to support trustworthiness. The research team included experienced qualitative researchers. Data analysis was carried out by two researchers and systematically validated by two additional researchers to ensure the comprehensiveness, relevance, homogeneity, representativeness, and exclusivity of the categories.

The criteria of objectivity (confirmability) highlighted by Colorafi and Evans (2016) were addressed to ensure relative neutrality and minimize researcher bias through several procedures: providing explicit

and detailed descriptions of the study's methods and procedures; documenting the sequence of data collection, analysis, and presentation to establish a clear audit trail; reporting personal assumptions and potential biases; and retaining study data while making it available to collaborators for evaluation.

2.6. Ethical considerations

This study was approved by the board of directors and by the Ethics Committee of the health institution in the central region of Portugal (Minutes No. 15/2022). The voluntary and informed participation of participants was always ensured, guaranteeing anonymity. To this end, the interviews were identified with "E" followed by a number (E1, E2, E3, ...). The anonymized findings were stored on a password-protected computer.

3. Results

3.1. Participant characteristics

Of the 15 participants, the majority were female (53.3%), married (93.3%), living in rural areas (73.3%), with an average age of 60.7 years. Of these, 7 were daughters, 4 sons, 1 sister and 3 were husbands.

3.2. Categories

Analyzing the narratives referring to the perception of difficulties and needs felt in supporting a family member with a hip fracture, in the transition home, four categories and respective subcategories emerged, which are systematized in Fig. 1.

Regarding the way in which participants identified the difficulties they experienced, the categories of *care support and responsiveness*.

Participants were also asked about the needs felt in supporting family members with hip fractures in the transition home, with the categories *Continuity of care and Training to provide care* emerging.

3.3. Categorie I: care support

Regarding the *Care Support* category, the participants' narratives revealed their perception of the difficulties experienced, differentiating the following subcategories in the data corpus: Architectural barriers; Support for carrying out ADLs.

The participants' speech was very expressive regarding the difficulties inherent to the architectural barriers existing in the home, especially with regard to the presence of stairs in the home, representing a challenge for these family caregivers, as shown in these quotes:

"There's a house with a huge staircase ...; I think he's afraid of losing his balance, because he already has difficulty, for example climbing stairs ..." (E1)

"On the first and second day it was difficult because there were stairs and I had to use a wheelchair." (E5); "The biggest difficulty was the stairs ..." (E8)

Difficulty in supporting ADL, especially in related activities such as bathing, dressing and transferring, were reported by a large number of family caregivers. Their narratives express initial difficulties, and the consequent effort to overcome them, given the needs of the family member.

"I wasn't used to it ... and at the beginning it was difficult for me ... I was the one who had to do everything ... I had to get her (the wife) out of bed, lay her down, hold her leg for a little while, give her a shower ... and get her dressed ... get her to the bathroom ... She needed help with everything." (E11)

"In the early days it was difficult ... helping my mother ... she had difficulty with everything: taking a shower, getting out of bed, going to bed ..., everything." (E14)

"She needed help with everything: getting out of bed, going to the bathroom, taking a shower, getting dressed, walking ... everything! And at the beginning I had a lot of difficulty with this support, because it was the first time ... and I wasn't used to it." (E15)

Based on the analysis of the participants' statements, one of the main difficulties that the family member of an older person with a hip fracture faces in the support provided, in the transition home, is care support, fundamentally associated with support for carrying out ADL and existence of architectural barriers in the house, which is a reason for some apprehension.

3.4. Categorie II: responsiveness

Regarding the *responsiveness* category, the participants' narratives reveal that when faced with a new situation, in which they deal with the difficulty of meeting the care needs of their family members and readapting to their new condition, they express feelings of difficulty in responding adequately.

"The first 15 days were more complicated ... what was most difficult for me was getting her out of bed, because she complained ... although she helped a little, she complained a lot in the first 15 days ...; The hardest thing for me was putting the bedpan on at night (because it was winter) and getting out of bed ..." (E5)

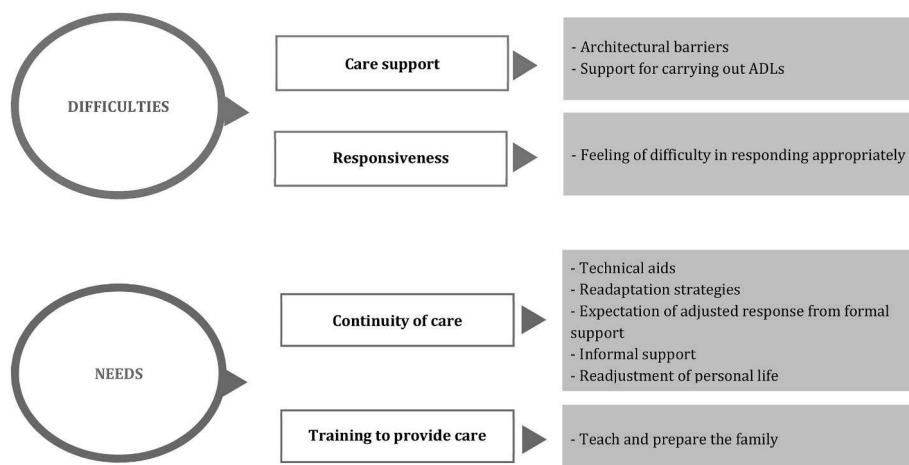


Fig. 1. – Systematization of the categorical analysis regarding Dimensions: Difficulties and Needs.

“Regarding the bath ... the fear of the bathroom ... that fear of the bathroom was the worst! I was afraid that she (mother) would fall again ... it was one of my biggest fears that she would fall again and ruin everything ... I had never taken care of anyone with these problems..”. (E8)

“My anxiety, my nervousness and my difficulty was not knowing when she arrives, what will happen, how she will react ... what it will be like ... there are a series of steps that I took to think about ...” (E13)

In the interviews, the experience of family caregivers is reported, expressing feelings of difficulty in responding adequately, largely associated with the loss of mobility and functionality of their family member, with the consequent need for support to carry out ADL, which constituted an important source of concern.

3.5. *Categorie III: continuity of care*

The *Continuity of care* category includes the resources and strategies used by the family member to support the older person, divided into five subcategories: Technical aids; Readaptation strategies; Expectation of adjusted response from Formal Support; Informal support; Readjustment of personal life.

The use of technical aids, by providing support in order to minimize the person's disability, constituted an indispensable resource for the necessary continuity of care, clearly reflected in the participants' speech:

“When she came, she came with the 2 crutches ... and, meanwhile, she only brings one ...”; “The only thing I needed to buy was something to lift the toilet ...” (E1)

“I took the crutches here from home when I went to pick up my mother and there (at the hospital) they adapted them ...” (E4)

“They (nurses) told me that I should buy the toilet lift and then I needed a pedal, and we bought it ... there were chairs and seats suitable for the bathtub ...” (E9)

Participants refer to the need to use readaptation strategies, taking into account the changes in functionality experienced, and their application is described:

“... so I bought a bench to put inside the bathtub; I removed everything; I removed the carpets from the bathroom, the hallway and the bedroom.” (E4)

“I would sit her in the wheelchair and take her to the bathroom, but the wheelchair wouldn't go in ... and I would have to take it out to lift her and put her in the bathroom.” (E5)

“The bathtub is gone. We ripped out the bathtub” ... (E7)

“I have a ground floor that had a kitchen, I put a bed there, the kind that lifts up ... just like the ones in the hospital” (E11)

“... my son already came and got me a bath, he already put in a bench ... and the one next to the toilet ... he already made other safer stairs ...” (E12)

“I've already put support in the shower, in the toilet, I've already removed the rugs ...” (E13)

During the transition home, family members expected an adjusted response from formal support, in order to satisfy their felt needs, which was clearly evident in the participants' narrative:

“There was practically no support from the nurses at the Health Center ... it took them about a month to give me an answer ... I always thought they were going to make moves ... and everything ... they could have given more support!” (E4)

“The nurses from the health center, they came, but they didn't pay much attention ... they didn't pay attention as they should have! (E5)

“We asked for support to do more physiotherapy. They went there one day and never came back. We asked for support, but no one showed up ...; My mother was discharged and then we had no care. We still wait a long time and even think about going private, but ... that part failed ...” (E6)

“Then when she (wife) came home, I liked that she continued doing gymnastics and she too ... I liked it!” (E12)

The participants' narratives revealed the need for informal support in this transition process, to ensure continuity of care:

“I had my husband and my son who always supported me ... if it weren't for the support of my husband and my children ...” (E4)

“We had to have a lady take care of her (mother)” (E6)

“My sister was at home ... one was there or another one was there.” (E8); “We have some neighbors ... they are all friends ... from time to time they would go there to help ...” (E11)

“If they didn't help me, she (wife) would have to go to a nursing home ...” (E12)

“She also has support at home from the village institution (2 hours); “We hired a company to bring him food, they clean the house ...” (E14)

The new condition of the older person who suffered a hip fracture, characterized by some limitations in performing ADL, implied the need to readjust the family member's personal life, emerging as a category in the content analysis of the participants' narratives:

“... I came home more often ... I had to do it like this!” (E4)

“For the first 15 days I didn't go to work and then she (the mother) started doing things and I was able to go shopping and I was able to go to work ...” (E5)

“The difficulty of having your own life too ... and the time ...” Returning home ... wasn't easy ... it meant having someone almost all the time, someone who at least was always watching... .”(E7)

“She (sister), in the first month, practically didn't leave the house ... And I was always here, at home” (E9)

Participants expressed the need for continuity of care, using technical aids to assist in the mobility of their family members, requiring the development of readaptation strategies, which involved some environmental modifications at home, with a view to increasing safety and preventing falls. In this process, family members' expectations stand out in relation to the formal support response they expected, which ended up not being adjusted to the needs felt during this transition. The need for informal support was also mentioned, to help with the continuity of care, as well as the need to readjust their personal life, to respond to the requests of their family members.

3.6. *Categorie IV: training to provide care*

Upon the older person's return home, the family caregiver expresses needs inherent to *training for care*, highlighting the need for teaching and preparing the family, which was evident in the participants' narratives:

“Maybe the nurses could have given us the techniques that were not given to us. We didn't bring as much information that would help her (the mother) recover faster. So it could have improved if these techniques had been more publicized ... they could have given us more techniques for when we got home ...” (E6)

“We weren't called to teach us anything, but I think it was important ... And at home people were always calmer. If I had support from

someone at home I would feel more comfortable and more rested” (E7)

“They gave me a pamphlet, where they also explained what she had and I even went to the hospital one day ... Although for a short time, but they told me how I had to do to get her (sister) up and go to sleep ... But she still knew better than me ... Regarding bathing, no one ever taught me how to do it ... I didn't see her take a bath, I never even saw how they did it ... Between the two armchairs, I placed a chair for her to sit on, support and lift. Nobody told me that either ... it was me ... I tried to do it the best way ... The best thing is to teach family members, so that they can be aware of the situation!” (E9)

“When these patients arrive home it is clear that they need support, that someone should explain to us how we have to proceed regarding the care we have to give them, right? We needed to know how to deal with this, because we don't have experience ... a person who gets into this situation ..., we don't have experience ... someone has to explain to us what to do, obviously! Yes, family members need help and guidance ... no one is prepared for something like this! It takes a little experience and someone has to teach ...” (E14)

The rhetoric of the participants unequivocally reflects the expressed need to train the family member to provide care, with a focus on teaching and preparing the family member, in order to guarantee adequate and safe continuity of care.

Analyzing the participants' speeches and comparing them with the bibliography, we outlined the characterization of the difficulties and needs felt in supporting family members with hip fractures upon returning home. It can be seen that they report the experience of facing difficulties associated with support and responsiveness to care, expressing needs for continuity of care and training to provide care.

4. Discussion

This study revealed the perception of family members about the difficulties and needs felt in supporting their family member with a hip fracture, upon returning home, noting that support for care and responsiveness constitute the greatest difficulties faced, and it is therefore necessary to adopt rehabilitation strategies at home, as well as help (formal and informal) with the necessary care inherent to the situation.

Due to the existence of architectural barriers and the need for support to carry out ADLs, very present in the participants' speech, is amply justified, in the opinion of Santos and Baixinho (2020), the development of interventions aimed at environmental risk assessment, advice on modifications, adaptation of space and equipment as well as assistance in the acquisition of support products and development of cognitive-behavioral strategies, in order to increase the safety of elderly people when using the physical space of the home. Consistently, Silva et al. (2024) also refer to the importance of evaluating and improving practices related to accessibility and social inclusion.

In the context of caring for an older person with a hip fracture, the caregiver is challenged to perform a series of tasks that include, but are not limited to, helping with meals, personal hygiene, going to the bathroom, generating consequent internal tension around the need to take care of your family member, with an impact on your personal health and well-being (Guilcher et al., 2021). In this regard, Ipsen et al. (2024) state that the assistance provided by these people's family members essentially focuses on the first two to four weeks after hospital discharge, a period in which the greatest need for support is identified. In this sense, Martins et al. (2025) warn that the role of caregiver can potentially generate overload, associated with a lack of training or qualification to perform the function.

The feeling of difficulty in responding appropriately, as well as the expectation of an adjusted response based on formal support, were aspects that generated great apprehension in the family of the person with a hip fracture, upon returning home. In this sense, considering that

dependence affects not only the person, but also the family (Hertz and Santy-Tomlinson, 2018), it would be important to develop interventions that mitigate the difficulties experienced, ensuring rehabilitation, support and post-operative counseling (Rocha et al., 2024). In this context, nurses have a fundamental role in empowering family caregivers so that they can respond positively to the changes induced by the role they assume (Martins et al., 2025).

From the narratives of the participants in this study, the need for continuity of care is extracted, personified by formal support, which demonstrated an expectation of an adequate response to the condition. This is in line with what was defended by Ortiz-Piña et al. (2019), when they highlight the importance of having a rehabilitation program upon returning home as a guarantee of success and effective recovery for people affected by this condition. Ensuring the continuity of the rehabilitation program with a clear focus on the education of the person with a hip fracture and their caregiver is crucial to guaranteeing the improvement of functional indicators in the first year after the fracture (Nicolau et al., 2022).

Another relevant finding are the difficulties related to the ability to respond appropriately to the situation, requiring a readjustment of personal life. This is in line with what is defended by Sousa et al. (2024), when stating that the family, despite representing the main response structure for older person, is incapable of providing the necessary support in an integral way, contributing to this the difficulty in reconciling professional life with care and the difficulty in consider changes, in order to provide the necessary support. According to the same authors, prolonged support for the older person induces changes in the family's daily life, with effects on the sphere of personal and social life, particularly for the member who assumes the role of caregiver. Silva et al. (2025) also highlight the change that occurs in family dynamics, with the need to reorganize routines, as well as the burden on caregivers and resilience strategies. Because of that it is important to make it clear that empowering these individuals for a new reality and transitioning them into the role of informal caregiver requires that healthcare professionals value not only the education but also the training to help the patient with some rehabilitation exercises and promote independence in the performance of the ADLs (Nicolau et al., 2022).

Guilcher et al. (2021) state that, when assisting with caregiving tasks, caregivers express experiencing internal tension, surrounding the need to care for their family member, often to the detriment of their personal health and well-being, causing a considerable impact in the domain of family, work, leisure and finances. In this context, Silva Pereira et al. (2025) emphasize the importance of nursing intervention to strengthen the role of the family as a unit of care, promoting the well-being of the person being cared for and their family members, reinforcing that the absence of adequate support exacerbates their burden.

Carrying out environmental modifications at home as part of readaptation strategies, with a view to increasing safety and preventing falls, clearly highlighted in the narratives, constitutes a fundamental aspect, which is corroborated by several authors, who consider that upon returning to home, the person who has suffered a fracture has an increased risk of falling, so preventing a new fall is a fundamental aspect (Baixinho and Dixe, 2017; Hertz and Santy-Tomlinson, 2018; Contro et al., 2019).

The study participants revealed the need for training in care, especially with regard to teaching and preparing the family in the transition process. Indeed, the training of family caregivers is a central issue, in line with what the WHO (2021) defends and is reflected in the final version of the Global Action Plan for Patient Safety 2021-2030 where, among the guiding principles and as one of the strategic objectives, the involvement of patients and families as partners in safe care emerges.

Sousa et al. (2024) advocate the training of families, in order to provide support in care, with a view to promoting autonomy and independence, and, therefore, preventing complications. This is corroborated by Mendes et al. (2024) when they state that, considering the

enormous challenge that caring for dependent people at home represents for families, it becomes essential that nurses empower them to select and use resources and support products that facilitate self-care (Mendes et al., 2024). Guilcher et al. (2021) also state that improving the management of expectations, improving communication, with regard to content and time spent, the assessment of priorities and objectives, as well as the consistency of information shared with caregivers, could facilitate experiences and make the most positive care interactions.

In this sense, Correia (2017) states that structured family involvement initiatives generate positive results, meaning that the family should be considered a partner in the safety of care (WHO, 2021). Also Oliveira et al. (2023) reiterate the preponderance of family participation in the rehabilitation and discharge planning process, in order to provide a safer transition between hospital and home.

Although there is a growing increase in scientific attention related to the older person, the response to the needs that emerge from this segment of the population continues to be scarce, therefore, the approach that places the person and their needs at the center of the care of each person/family must be privileged (Sousa et al., 2024).

These findings can also contribute to an increase in the quality of care with direct involvement of the family of the person with a hip fracture, who is experiencing a transition situation after hospital admission, and eventually influence policies, whose investment, in Sousa's et al. (2024) opinion, is clearly insufficient, as far as these people and their families are concerned, which constitute a fundamental pillar of support for the elderly.

4.1. - implications for clinical practice and research

This study may allow nurses to make decisions aimed at ensuring a safe transition of these older patients with hip fractures from hospital to home, based on discharge planning based and an adequate assessment of the needs of the patient and family, and consequent training structured for them.

Taking into account the need for formal support and training programs for family caregivers, it is important to develop interventions that optimize the collaboration of the professional/caregiver/political decision-makers triad, in order to better respond to the needs of elderly people in the recovery process after a hip fracture. In addition to direct care, nurses can also participate in the implementation of psychosocial support programs, helping families cope with the emotional burden and daily challenges of caregiving.

Nursing training should also include components that address the topic of patients' safe transition to their home, as well as the individual and family needs inherent in this process.

These aspects may serve as guidance and influence for the implementation of appropriate policies, aiming to find adapted responses to the difficulties of patients and families facing this situation, meeting their needs.

Regarding the implications for research, it is suggested that new studies be carried out that compare the perceptions of patients, nurses and family caregivers about the needs and difficulties experienced after the occurrence of a hip fracture, in the transition home, to make the results more robust.

4.2. - study limitations

The limitations of this study are related to the type and number of participants, belonging to just a single institution, whose data may have been influenced by the context of the organization and may not reflect the perspectives of a more diverse group.

5. Conclusion

The results of this study reveal that the family member who takes

care of the older person with a hip fracture upon returning home, faces several difficulties: support for care, which is associated with architectural barriers and support for carrying out ADLs; and also responsiveness, related to the feeling of difficulty in responding appropriately.

With regard to verbalized needs, there is continuity of care, which includes technical support, readaptation strategies, the expectation of an adjusted response based on formal support, informal support and readjustment of personal life; and training for providing care, namely teaching and preparing the family.

As this phenomenon is somewhat complex due to the involvement of numerous factors, the analysis of the aspects associated with this care process is essential, contributing to a favorable evolution and a safe transition.

These findings may guide the nurse's action, aiming to adapt the planning and preparation of the family member for the transition of the patient with a hip fracture to home, where their training and support appear as essential for a successful process of continuity of care. They can also help to design and implement a new approach and support for these people and their families, anchored in formal and informal support networks.

CRedit authorship contribution statement

Paula Rocha: Writing – review & editing, Writing – original draft, Software, Methodology, Investigation, Formal analysis, Data curation, Conceptualization. **Carlos Albuquerque:** Software, Methodology, Investigation, Conceptualization. **Susana Batista:** Software, Methodology, Investigation, Conceptualization. **Maria Adriana Henriques:** Validation, Supervision, Software, Resources, Project administration, Methodology, Investigation, Funding acquisition, Data curation, Conceptualization. **Cristina Lavareda Baixinho:** Writing – review & editing, Visualization, Validation, Supervision, Software, Resources, Project administration, Methodology, Investigation, Funding acquisition, Formal analysis, Conceptualization.

Ethical statement

All family caregivers received oral and written information that identified the objective of the study, the confidential nature of the interviews and the voluntary nature of participation, which they could interrupt at any time if they wished.

All participants authorized the use of anonymous quotes.

Declaration of competing interest

The authors declare the following financial interests/personal relationships which may be considered as potential competing interests: Paula Rocha reports financial support was provided by Nursing Research, Innovation and Development Centre of Lisbon (CIDNUR) - Nursing School of Lisbon.

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