Supplementary file 1 – Table 1

Table 1. Characteristics of the studies included

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| --- | --- | --- | --- | --- | --- | --- |
| **Authors (year) country** | **Design** | **Setting** | **Medical condition** | **Study duration**  **(months)** | **Intervention** | **Usual care** |
| **Nurse-led interventions** | | | | | | |
| Barnason et al. (2010)  USA | RCT | Hospital care with follow-up | Heart failure | 3 | **Interventions delivered by:**  - Nurses  **Intervention:**  - Verbal health education/counseling on heart failure with written educational material  - Telephone sessions  **Frequency:**  - Telephone contacts every 2–3 weeks  **Duration:**  - Not mentioned | Routine discharge procedure for patients with heart failure carried out by a nurse |
| Garcia-Aymerich et al. (2007)  Spain | RCT | Hospital and home healthcare setting | Chronic obstructive pulmonary disease | 12 | **Intervention delivered by:**  - Nurses  **Intervention:**  - Comprehensive assessment  - Educational session on self-management with assessment of correctness of administration techniques by the nurse, with written information  - Information on a call center which can solve problems or trigger a home visit  - Individual care plan  - Home visit 72h after discharge  - Phone calls  - Access to a specialized nurse  **Frequency:**  - Weekly phone calls during the first month  - One call in months 3 and 9  **Duration:**  - Educational session of two hours | Standard discharge procedure for COPD patients |
| Kennedy (1990)  USA | RCT | Hospital and home healthcare setting | Geriatric inpatients | 1 | **Interventions delivered by:**  - Nurses  **Interventions:**  - Basic assessment  - Patient education  - Paper reminder  - Telephone reminders  **Frequency:**  - Weekly telephone reminders  **Duration:**  - Not mentioned | Usual discharge care and information sheet |
| Wolfe & Schirm (1992)  USA | CCT | Hospital and home healthcare setting | Geriatric inpatients | 1.5 | **Interventions delivered by:**  - Nurse  **Interventions:**  - Fact sheets  - Patient education/counseling before discharge  **Frequency:**  - 1 time before discharge  - Patient education counseling 3 and 6 weeks after discharge  **Duration:**  - Not mentioned | Usual discharge planning procedure |
| Hornnes et al. (2011)  Denmark | RCT | Hospital and home healthcare setting | Stroke with hypertension | 12 | **Interventions delivered by:**  - Nurses and physicians  **Intervention:**  - Home visits  - Life-style counseling  - If blood pressure elevated, a visit to the GP  **Frequency:**  - Home visits in months 1,4,7, and 10  **Duration:**  - 60 minutes | Stroke unit’s standardized discharge routine care |
| Weller (2015)  USA | CCT | Hospital care with follow up | Geriatric patients | 3 | **Intervention delivered by:**  Nurse  **Interventions:**  Verbal and tactile education program   * Monthly or weekly pill dispenser, ensuring that it was easy to open and manipulate by the patient. * A weekly/monthly calendar was furnished plotting out the times of day all medications were to be taken * Medication information handouts listing how and when to take each medication, as well as general information about each drug.   **Frequency:**  Telephone reminders at 1, 3 and 6 weeks  **Duration:**  Not mentioned, but several verbal reminder during hospitalization | Usual discharge medication education |
| Zhao & Wong (2009)  China | RCT | Hospital transitional care program | Coronary heart disease | 3 | **Interventions delivered by:**  - Nurse, two cardiac physicians, four cardiac nurses, two community nurses  **Interventions:**  - Routine care  - Basic assessment  - Health education  - Education pamphlets  - Home visits  - Phone calls  **Frequency:**  - Home visit on day 2 of discharge  - Home visit in week 3 of discharge  - Phone calls in weeks 2 and 4  **Duration:**  - Not mentioned | Routine usual-care protocol |

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| **Authors (year) country** | | **Design** | | **Setting** | | **Medical condition** | | **Study duration**  **(months)** | | **Intervention** | | **Usual care** | |
| **Nurse-collaborative care** | | | | | | | | | | | | | |
| Eggink et al. (2010)  Netherlands | | RCT | | Hospital patients at discharge | | Heart failure | | 1.5 | | **Intervention delivered by:**  - Pharmacist, nurse, cardiologist  **Intervention:**  - Follow up consultation with a cardiologist  - Counseling by a pharmacist for discharge medication  - Patient education with verbal and written information about (side)effects by a pharmacist  - Healthcare professional’s feedback: written information to the patient with instructions to forward the information to the GP  - Patient reminder systems:  **Frequency:**  - Visit within 6 weeks  - If necessary, additional visit by a heart failure nurse  **Duration:**  - Not mentioned | | Routine discharge planning, including information about drug therapy delivered by a nurse | |
| Bisharat et al.  (2012)  Israel | | CCT | | Hospital with transition care program | | Chronic heart failure | | 9 | | **Interventions delivered by:**  - Pharmacist and nurses  **Intervention:**  - Pharmacist counseling  - Verbal instructions/patient education by pharmacist (e-learning)  **Frequency:**  - Monthly  **Duration:**  - Not mentioned | | Discharge counseling by a nurse | |
| Rich et al. (1996)  USA | | RCT | | Hospital and home healthcare setting | | Congestive heart failure | | 1 | | **Interventions delivered by:**  - Nurse, dietician, social assistant, geriatric cardiologist, primary care physician  **Interventions:**  - Comprehensive teaching about CHF with 15-page patient leaflet  - Home visit  - Patient education about medication compliance  **Frequency:**  - Daily visits  **Duration:**  - Not mentioned | | Conventional medical care and hospital’s standardized discharge protocol and pre-discharge medication instructions | |
| Rinfret et al. (2013)  Canada | | RCT | | Hospital inpatient follow-up at home | | Drug-eluding stent with anti-platelets | | 12 | | **Interventions delivered by:**  - Nurse, physician, pharmacist  **Interventions:**  - Counseling before discharge by physician and pharmacist  - Phone calls  **Frequency:**  - Four telephone follow-ups at day 7 and months 1, 6 and 9  **Duration:**  - 5- to 10- minute calls | | Usual counseling before discharge | |
| Tsuyuki et al.  (2004)  Canada | | RCT | | Hospital discharge follow-up program | | Heart failure | | 6 | | **Intervention delivered by:**  - Nurse, physician  **Interventions:**  - Written educational materials  - Verbal instructions  - Medication organizer  - Medication schedule administration  - Telephone contacts  - Monthly newsletter  **Frequency:**  - Daily weighing  - Telephone contacts at weeks 2 and 4 and monthly thereafter  **Duration:**  - Not mentioned | | Usual discharge planning | |
| Rytter et al. (2010)  Denmark | | RCT | | Hospital and municipality care centers | | Geriatric inpatients | | 3 | | **Interventions delivered by:**  - Physician and nurse  **Interventions:**  - Home visit or clinic visit  - Adjustment of medication  - Social and personal support  **Frequency:**  - One week after discharge  - At weeks 3 and 8  **Duration:**  - Week 1: 50 minutes (range: 15–100)  - Week 3: 30 minutes (range: 5 –80)  - Week 8: 25 minutes (range: 5–80) | | Usual care made up of a short patient education session by a nurse prior to hospital discharge | |
| Antonicelli et al.  (2010)  Italy | | RCT | | Outpatient clinic | | Congestive heart failure | | 12 | | **Interventions delivered by:**  - Nurses, cardiologist and e-health unit  **Intervention:**  - Routinely visits in the CHF outpatient clinic  - Patient education on weight and heart rate  - Tele-monitoring ECG  **Frequency:**  - Telephone contact reminders twice a week  - Weight and heart rate transmitted three times a week  - Weekly ECG  - Clinic visits: frequency not mentioned  **Duration:**  - Not mentioned | | Routinely planed care visits in the outpatient clinic with a nurse | |