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 |