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A TRANSIÇÃO HOSPITALAR-DOMICÍLIO DE FAMÍLIAS EM CONTEXTO NEONATAL: CONTRIBUTOS DA ENFERMAGEM FAMILIAR - SCOPING REVIEW

THE HOSPITAL-HOME TRANSITION OF FAMILIES IN NEONATAL CONTEXT: FAMILY NURSING CONTRIBUTIONS - SCOPING REVIEW

LA TRANSICIÓN HOSPITALAR-HOGAR DE LAS FAMILIAS EN EL CONTEXTO NEONATAL: CONTRIBUCIONES DE LA ENFERMERÍA DE SALUD FAMILIAR - SCOPING REVIEW

Marília Teles[1,2] *https://orcid.org/0009-0003-2814-1358*
Alcinda Reis[1,3] *https://orcid.org/0000-0002-1003-5990*
Catarina Afonso[1,3] *https://orcid.org/0000-0001-7969-8242*

[1] Instituto Politécnico de Santarém, Santarém, Portugal
[2] Unidade Local de Saúde Alentejo Central, Évora, Portugal
[3] RISE-Health, Porto, Portugal

Marília Teles - mariliajsteles@hotmail.com | Alcinda Reis – alcinda.reis@essaude.ipsantarem.pt | Catarina Afonso – catarina.afonso@essaude.ipsantarem.pt

Corresponding Author:
Marília Teles
Rua Francisco Carlos Laranjo
7090-410 – Aguiar - Portugal
mariliajsteles@hotmail.com

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RESUMO

Introdução: A prematuridade representa um desafio face ao bem-estar familiar. Implica complicações médicas e emocionais que afetam o desenvolvimento infantil e parental. Surge, neste contexto, a figura do enfermeiro especialista em enfermagem comunitária de saúde familiar (EEECSF). Com as suas competências, intervém na promoção da saúde e prevenção de doenças, fornecendo suporte contínuo às famílias na transição do hospital para o domicílio.
Objetivo: Mapear evidência científica sobre as intervenções de enfermagem de saúde familiar, dirigidas à família em contexto neonatal, na transição para o domicílio.
Métodos: Esta *Scoping Review* seguiu a metodologia JBI e o relatório PRISMA-ScR. O protocolo foi registado na OSF (DOI: 10.17605/OSF.IO/36BJG). As pesquisas foram realizadas na PubMed e CINAHL (via EBSCO) de 1 a 31 de dezembro de 2024, complementadas pela Scielo, LILACS, RCAAP, B-On e Google Scholar. A elegibilidade foi definida usando o PCC. A seleção de títulos, resumos e textos completos foi feita por dois revisores independentes através da plataforma Rayyan®. Quaisquer divergências foram resolvidas por um terceiro revisor. Os dados foram sintetizados narrativamente e organizados num quadro.
Resultados: Identificaram-se três eixos de intervenção do EEECSF: o empoderamento familiar; a atuação colaborativa entre os contextos hospitalar e comunitário; o enfermeiro como gestor de caso.
Conclusão: Os outcomes desta Scoping Review contribuem para o desenho de projetos de intervenção pelos EEECSF, no momento vulnerável da transição do hospital para casa destas famílias.

Palavras-chave: família; saúde da família; enfermagem familiar; transição do hospital para casa

ABSTRACT

Introduction: Prematurity represents a challenge to family well-being. It involves medical and emotional complications that affect the child and parenting development. In this context emerges the figure of the family health nurse (FHN). With his skill set, he intervenes in health promotion and disease prevention, providing continuous support for the families during the hospital-home transition.
Objective: To map scientific evidence on family health nursing interventions aimed at families in a neonatal context, during the hospital-home transition.
Methods: This Scoping Review followed the JBI methodology and PRISMA-ScR reporting. The protocol was registered on OSF (DOI: 10.17605/OSF.IO/36BJG). Research was conducted in PubMed and CINAHL (via EBSCO) from December 1st to December 31st, 2024, complemented by Scielo, LILACS, RCAAP, B-On, and Google Scholar. Eligibility was defined using PCC. The title, abstract, and full-text selection were done by two independent reviewers through the Rayyan® platform. Any disagreements were resolved by a third reviewer. Data was synthesized narratively and organized in a table.
Results: Three FHN intervention axis here identified: family empowerment, collaborative procedures between the hospital and community contexts, and the nurse as case manager.
Conclusion: The outcomes of this Scoping Review contribute to the design of FHN intervention projects in the vulnerable situation of the hospital-home transition of these families.

Keywords: family; family health; family nursing; hospital to home transition

RESUMEN

Introducción: La prematuridad representa un reto para el bienestar familiar. Implica complicaciones médicas y emocionales que afectan al desarrollo infantil y parental. En este contexto, surge la figura del enfermero especialista en enfermería comunitaria de salud familiar (EEECSF). Con sus competencias, interviene en la promoción de la salud y la prevención de enfermedades, proporcionando apoyo continuo a las familias en la transición del hospital al domicilio.
Objetivo: Recopilar la evidencia científica sobre las intervenciones de enfermería de salud
familiar dirigidas a la familia en el contexto neonatal, en la transición al domicilio.
Métodos: Esta revisión exploratoria siguió la metodología JBI y el informe PRISMA-ScR. El protocolo se registró en la OSF (DOI: 10.17605/OSF.IO/36BJG). Las búsquedas se realizaron en PubMed y CINAHL (a través de EBSCO) del 1 al 31 de diciembre de 2024, complementadas por Scielo, LILACS, RCAAP, B-On y Google Scholar. La elegibilidad se definió utilizando el PCC. La selección de títulos, resúmenes y textos completos fue realizada por dos revisores independientes a través de la plataforma Rayyan®. Cualquier discrepancia fue resuelta por un tercer revisor. Los datos se sintetizaron narrativamente y se organizaron en un cuadro.
Resultados: Se identificaron tres ejes de intervención del EEECSF: el empoderamiento familiar; la actuación colaborativa entre los contextos hospitalario y comunitario; el enfermero como gestor de casos.
Conclusión: Los resultados de esta revisión exploratoria contribuyen al diseño de proyectos de intervención por parte de los EEECSF, en el momento vulnerable de la transición del hospital al hogar de estas familias.

Palabras-clave: familia; salud familiar; enfermería familiar; transición del hospital al hogar

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INTRODUCTION

Family is regarded, socially and culturally, as the basic unit of society. It plays an essential role in the physical, emotional, and psychological support of its members (Biroli, 2014; Figueiredo, 2011; Frericks & Gurín, 2023). This is a multidimensional concept that comprehends intrinsic and extrinsic factors, including social and cultural determinants that influence the understanding of the healthcare dynamic and shape the perception of health and sickness. Family is, therefore, a subjective social construct, conditioned by values, practices, and contextual norms, defined by certain places, epochs, and respective realities (Biroli, 2014; Figueiredo, 2011; Frericks & Gurín, 2023).

Among the factors that most impact this social construct, the birth of a premature newborn stands out. This event represents a challenging transition to parenthood and justifies the inclusion of these families in the vulnerability category. Prematurity is a critical event, with significant repercussions in the child's development, and the parents' performance as caretakers. This situation exposes all family members to complex life experiences and to situations of fragility associated with medical and emotional complications. Therefore, it is necessary to have a vigilant and continuous response, based on effective support strategies (Haemmerli et al., 2021; Legge et al., 2023).

The articulation between the different levels of healthcare is one of the key elements to ensure a successful hospital-home transition, with special attention to primary healthcare. These services must maintain a systematic and individualized follow-up, providing families with access to proper community resources. In this process, duly qualified health professionals are responsible for preparing families so they can respond to the specific needs of a premature newborn in the home context (Haemmerli et al., 2021; Hebballi et al., 2021; Neto, 2023).

In this context, the role of the family health nurse, as a skilled professional to facilitate this transition, is particularly relevant. With competencies that include health promotion and disease prevention, the family health nurse finds himself in a strategic position to offer families continuous support. He also assists in the effective communication between family members and between the family and the different levels of the healthcare system. The FHN becomes important to the continuity and quality of healthcare (Haemmerli et al., 2021; Neto, 2023; Ordem dos Enfermeiros (OE), 2018).

Despite the growing appreciation of the role of the family health nurse in the neonatal context, literature remains dispersed regarding the specific interventions implemented in this context. The same happens with their impact on the hospital-home transition (Haemmerli et al., 2021; Johnson, 2024; Neto, 2023; OE, 2018). After a detailed research in PROSPERO, no prior reviews were found. This gap highlights the need to organize previous knowledge in order to guide clinical practice, form organizational decisions, and support the development of family-centred health policies.

Thus, this scoping review proposed to answer the following research question: “What are the family health nursing interventions aimed at a family in the neonatal context, during the hospital-home transition?”

The overall objective is to map the available scientific evidence about family health nursing interventions applied to the hospital-home transition in the neonatal context.

It is expected that the results of this review will contribute to improving the elaboration of intervention proposals on behalf of family health specialist nurses, during a particularly delicate and determinant period for the well-being of the premature newborn and is family.

1. METHODS

For this scoping review, entitled “The hospital-home transition of families in neonatal context: family nursing contributions – Scoping Review”, the Joanna Briggs Institute proposed methodology (JBI,2024) was used, in articulation with the Preferred Reporting Items for Systematic reviews and Meta-Analysis Extension for Scoping Reviews (PRISMA-ScR) guidelines (Page et al, 2021).

The chosen methodology provided a solid structure, allowing for the exploration of the complexity of the subject comprehensively in analysis. The JBI (2024) guidelines ensured a rigorous research, selection, and quality evaluation process of the included studies. The PRISMA-ScR instructions allowed for the elaboration of the research question: “What are the family health nursing interventions aimed at a family in the neonatal context, during the hospital-home transition?” The research criteria were defined according to the PCC method (Population; Concept; Context), in the following way: P: Families with children in the neonatal context; C: Family Health Nurse Interventions; C: Hospital-home/community transition.

The inclusion criteria were defined as primary studies (qualitative, quantitative, and mixed) addressing families with premature newborns. Due to the lack of knowledge in this area, no time limits and no language restrictions were set. Studies referring to families with newborns and adults transitioning from hospital to home were excluded. The article's analysis, and the data extraction and synthesis were conducted by three reviewers.

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1.1 Research Strategy

The research strategy started with the identification of Health Science Descriptors (DeCS) and Medical Subject Headings (MeSH), using a controlled language. For this research, the following descriptors were used: Family; Family Health; Family Nursing, and Hospital to Home Transition. The applied Boolean operators were "AND" and "OR". (Family OR Family health) AND (Family nursing) AND (Transition from hospital to home). Similar terms were used in all consulted databases. The research was conducted in the PUBMED and CINAHL via EBSCO databases, with the analysis of studies containing the keywords identified in the title (TI) or in the abstract (AB), as shown in Tables 1 and 2.

The review protocol was registered in the OSF platform, with the registry number DOI 10.17605/OSF.IO/36BJG

Table 1 - Identification of results, by descriptor and possible conjugations, in the PUBMED database

What are the family health nursing interventions aimed to a family in the neonatal context, during the hospital-home transition?		
Research	(Family OR family health) AND Family nursing AND Hospital to home transition	
#1	(Family OR Family Health)	1935541
#2	Family nursing	88544
#3	Hospital to home transition	3038
#1 AND #2 AND #3	(Family OR Family Health) AND (Family nursing) AND (Hospital to home transition)	380

Table 2 - Identification of results, by descriptor and possible conjugations, in the EBSCO database

What are the family health nursing interventions aimed to a family in the neonatal context, during the hospital-home transition?		
Research	(Family OR family health) AND Family nursing AND Hospital to home transition	
#1	(Family OR Family Health)	2388948
#2	Family nursing	6455
#3	Hospital to home transition	755
#1 AND #2 AND #3	(Family OR Family Health) AND (Family nursing) AND (Hospital to home transition)	1

1.2 Data extraction

The selected articles were stored and, afterwards, transferred to the Rayyan® (Qatar Computing Research Institute, Doha, Qatar), with the duplicates being deleted. The title and abstract selection was carried out by two independent reviewers (MT and CA), based on the inclusion criteria defined previously. The results were compared and discussed between the two reviewers. In case of any discrepancy during the article selection, the final decision was made with the help of a third reviewer (AR). Finally, with the intent of aiding and improving the results discussion, a grey literature research about the studied theme was also done on RCAAP – Repositório Científico de Acesso Aberto de Portugal; Google Scholar; Lilacs; SciELO and B-on.

2. RESULTS

The research identified 381 studies from the previously mentioned databases. After duplicate removal, a total of 380 studies remained. From this number, after title and abstract reading, 349 studies were excluded. From the remaining 31, after full-text reading, it was possible to exclude 16 studies due to non-compliance with the preset inclusion criteria. A total of 11 studies were included in this review. The study selection process was represented in a PRISMA flow diagram to ensure transparency in the article selection and inclusion.

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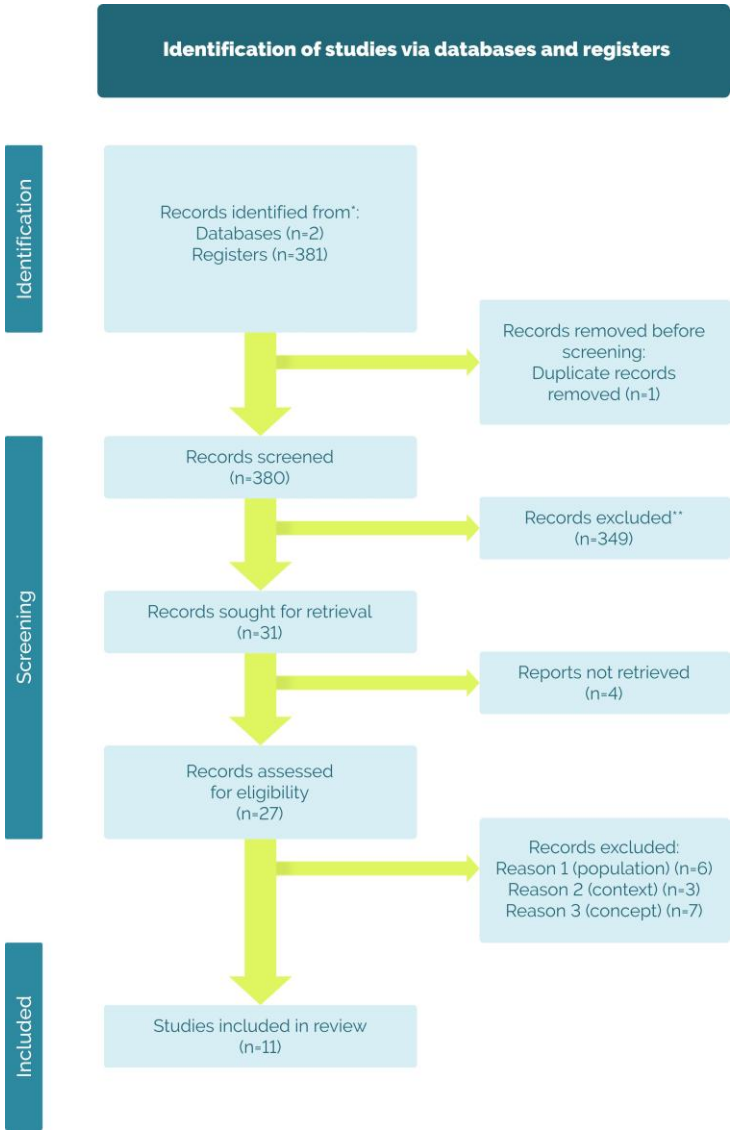

Figure 1 - PRISMA 2020 flow diagram for new systematic reviews, which included searches of databases and registers only

The eligible 11 studies were fully analyzed, and from them, data that answer the research question and this scoping review objective were extracted and synthesized. Table 3 synthesizes the collected data, with regard to authors, year, and country of origin, study objective, method, participants, interventions, results, and conclusions. This approach facilitated the analysis and interpretation, providing a precise view of the participants' characteristics, the study's design, and their main results.

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Table 3 - Data extraction from included articles

TITLE	AUTHOR, YEAR, COUNTRY	OBJECTIVE	TYPE OF STUDY	PARTICIPANTS	METODOLOGY	RESULTS	CONCLUSIONS
"An Ecological Model for Premature Infant Feeding".	White-Traut et al., 2009, United States of America.	To present a H-Hope Project, based on an ecological model of intervention for feeding and mother-baby interaction.	Theoretical-descriptive study.	Prematures (29–34 weeks) with social risks and their mothers.	Project H-HOPE: sensory based stimulation and home guidance (program)	This project combines baby sensory stimulation and guidance given to the mother. This is provided by a team composed of a NICU nurse and a member of the community. Expected results include: the baby's better behavioural organization; progress in acquiring speech skills; bond increase; reduction of family anxiety, and of unnecessary visits to healthcare services.	The H-HOPE project has potential to reduce health costs, improve family bonding and support child development in vulnerable families. Collaborative action of trained professionals during this transition period from hospital to home allows for this process to be more tranquil.
"A preterm lifeline: Early discharge programme based on family-centred care"	Brødsgaard et al., 2015, Denmark	To present a model for an Early Discharge Program for pre-term babies, based on family-centred healthcare, and describing its impact on these families.	Longitudinal qualitative and quantitative study.	218 prematures and 15 parents.	Longitudinal mixed-method study: babies growth evaluation (quantitative) and focus groups interviews with parents (qualitative).	Parents reported that the program as given them more autonomy, proximity, and a continuous connection with the NICU, facilitating the development of parenting and a healthier family life before the conventional hospital discharge.	With the implement of this early hospital discharge program, families, during this period, felt more supported and empowered for the transition. Highlights that family-centred health-care are absolutely fundamental.
"Developmentally supportive care in the newborn intensive care unit: early intervention in the community".	Bondurant et al., 2003, United States of America.	Discuss the importance of developmental care in the NICU and the transition to community early intervention services.	Theoretical-descriptive study based on review and clinical experiences.	Premature and critically ill newborns and families in the process of transitioning home.	Conceptual approach based on scientific evidence and clinical experiences. Description of the NICAP model and of the early intervention community systems in the USA.	Development-centred care improves long-term results. The transition should be planned since hospital admission. Parental evolvement and collaboration with community services are fundamental.	Nurses have a key role in the connection between hospital and community services. The NIDCAP model strengthens the mother-baby bond, reducing transition barriers.
"Establishment of a Family-centred Care Programme with Follow-up Home Visits: Implications for Clinical Care and Economic Characte-ristics".	Hüning et al., 2012, Germany.	Present the "Elternberatung Frühstart" program, which is an family-centred healthcare program, with house-calls visits for premature and seriously ill newborns.	Retrospective descriptive study with quantitative evaluation of clinical and financial data.	330 families (mainly prematures <32 weeks GA) assisted between 2008 and 2012.	Gradual implementation of the "Elternberatung Frühstart" program; administrative and clinical data analysis; evaluation of the impact on length of hospital stay and re-hospitalizations.	When the program was implemented, the admission period median was reduced by 24 days; the number of patients who stayed longer than average was reduced by 64% in the group of newborn patients with less than 1500 gr. At the same time, the patients transfer rate increased from 243 to 413.	Succinctly, a family-centred health-care program, promoted a continuous follow-up, increasing parents satisfaction, promoting a safe and effective hospital discharge, reducing the number of re-admissions. The program is economically viable.
"Home Care of the High-risk Newborn".	Censullo, 1986, United States of America.	Present Community Health Nurse principles and interventions for high-risk newborns, prematures in particular, during the transition from hospital to home.	Theoretical - reflective study based on evidences and clinical experience.	High-risk newborns (prematures) and families.	Conceptual discussion about nursing strategies: evaluation, diagnosis, goal definition, intervention (emotional support, education, self-esteem promotion, use of community resources),	Emphasizes the crucial role of community health nursing in evaluating the parents needs, in education, emotional support, and promoting the bonding of these families.	The intervention of community nursing is essential to support families transitioning to home, promoting child development and reducing family stress. It involves active listening, parental training, referrals and continuous education.

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TITLE	AUTHOR, YEAR, COUNTRY	OBJECTIVE	TYPE OF STUDY	PARTICIPANTS	METODOLOGY	RESULTS	CONCLUSIONS
"Hospital to home transition of children with medical complexities in the Netherlands: current practice".	Haspels et al., 2025, the Netherlands (Holland).	Describe demographic data, clinical characteristics and the development of Children with medical complexity (CMC) transitioning to home; Identify reasons for the postponement of hospital discharge.	Prospective multicenter observational study.	44 CMC children (72,7% less than 1 year old, 25% pre-matures).	Data collected on 4 Dutch children college hospitals during 6 months; weekly interviews and descriptive analysis.	72,7% of CMC presented ages up to 1 year old, 25% being premature. These children remained hospitalized for about 7 weeks. In 65.1% of cases, the postponement of hospital discharge happened for medical reasons, combined with organizational and family factors.	Succinctly, this study claims there are various reasons that contribute for the postponement of CMC discharge, namely: medical fragility, the parents lengthy training process and the challenges of organizing home care.
"How to facilitate parents and their premature infant for the transition home".	Broedsgaard et al., 2005, Denmark.	Present the parents experiences regarding support and coordination after the birth of a premature baby.	Non-descriptive experimental study with qualitative and quantitative methods.	39 families with premature newborns admitted in the NICU of the Hvidovre Hospital, in Copenhagen.	Semi-structured questionnaires (37 families) and focus groups (18 families); thematic analysis and descriptive statistic.	Parents considered that most intervention initiatives contributed to increase support and satisfied their needs, including their trust taking care of their premature baby and their well-being, after hospital discharge.	The main actions of the interventions program are, now, permanent functions in the Neonatal Intensive Care Unit, as well as in the primary healthcare sector. The study also confirmed the benefit of the nurse-coordinator role.
"Perspect-ives of Low Socioeco-nomic Status Mothers of Premature Infants".	Enlow et al., 2017, United States of America.	Understand the experiences of low-income families, during the transition from the NICU to home.	Qualitative study.	27 mothers of prematu-res <35 weeks of gestational age, with low income.	The mothers of babies born with <35 weeks of gestational age, with low-income, were interviewed, by telephone, 30 days after NICU discharge.	Low-income mothers expressed their anxiety during hospital discharge of their premature babies, stressing the importance of clear communication by qualified professionals (preferably nurses), and reported feelings of loneliness, even with available support.	The study concludes that mothers with low-income are confronted with a high-level of anxiety and insecurity during the transition from NICU to home process. Trust in health professionals (particularly nurses), and clear and consistent communication, are essential factors to the success of this transition.
"Scoping review of interventions to support families with preterm infants post-NICU discharge".	Griffith et al., 2022, United States of America.	Map and synthesize existent interventions for support to the families with premature babies, after discharge from the NICU.	Scoping review.	Families with premature newborns, with focus on parents and caretakers.	Systematic research was conducted in databases, PubMed, Web of Science and CINAHL. The articles inclusion criteria were based on data: published in English between 2011 and 2021; focused on families with pre-term babies, and interventions to reduce parental stress and supply support to their families after the NICU discharge.	26 articles were included and synthesized. The interventions were grouped into in-person and remote. In-person. House-calls visits conducted by nurses or skilled professionals, focusing on evaluating the baby's health, guiding parents and emotional support. Remote: telephone calls, video-calls, text messages, e-mails, mobile apps and social media moderated by health professionals.	Succinctly, applying these interventions led to: Reduction of parental stress and anxiety; Increase of parents trust, competence and safety: improvement on family relationship and breastfeeding; Reduction of emergency room visits and re-admissions; increased adherence to routine consultations and vaccination.
"Transition of Premature Infants From Hospital to Home Life".	Lopez et al., 2012, Germany (despite the fact that data collection was carried out in the United States of America).	Conduct an integrative literature review of transition programs for premature babies of the Neonatal Intensive Care Unit (NICU) to the household.	Integrative literature review.	Prematu-res and families during the transition from hospital to home.	Research conducted in CINAHL, PubMed and MEDLINE from 2004 to 2011; seven articles included; analysis of the components and the impact of existent transition programs.	Components identified as effective: house-calls visits by nurses, use of videoconference, support and educational groups, continuity with the same nurse, household evaluations. Programs as COPE. PBIP and Parenting Preemies were reviewed.	It is recommend a structured program with house-call visits, remote support (telephone/video), educational groups, environment assessment and continuity with the primary healthcare nurse. Involving the same nurse who took care in the hospital can increase parents trust.

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TITLE	AUTHOR, YEAR, COUNTRY	OBJECTIVE	TYPE OF STUDY	PARTICIPANTS	METODOLOGY	RESULTS	CONCLUSIONS
"Infants With Technology Depen-dence Facilitating the Road to Home".	Bowles et al., 2016, United States of America.	Explore the challenges and strategies for an effective transition from hospital to home of technology dependent newborns.	Narrative review.	Families with technology dependent prematu-res, during the transition from hospital to home.	Descriptive approach based on the clinical practice of the NICU nurse.	The involvement and training of parents in premature baby care, the use of rooming-in and the action of an ambulatory care coordinator, all help in the transition process of technology dependent babies to their homes in a safer way, strengthening caretakers trust and reducing complications and re-admissions.	The transition of technology dependent premature babies requires a structured hospital discharge planning, continuous support and active family involvement. NICU nurses have a key role in this process, and integration and cooperation with community healthcare services is essential to ensure safety and continuity of home healthcare.

Through the analysis and interpretation of the study's content, it was possible to identify patterns, common points, and emerging areas, which considered the nature of the family health nursing interventions, during the hospital-home transition, of families with premature newborns.

By grouping the extracted data, and through their systematic reading, three nursing intervention axes were identified, containing cross-cutting concerns to this transition process, felt by families with premature newborns during hospital release to the household.

The identified axes were:

Family empowerment – involves the interventions aimed to strengthen autonomy, trust, and the parents' ability to take care of their children in the household. These promote parenting skills and reduce stress associated with this stage (Bondurant et al., 2003; Brødsgaard et al., 2015; Enlow et al., 2017; Griffith et al., 2022; Hüning et al., 2012). The hospital-home transition represents a period of high vulnerability to the premature newborns and their families, demanding careful planning with interventions that promote parenting education and the continuity of healthcare. Studies such as those of Enlow et al. (2017) and Griffith et al. (2022) have shown that families that received post-discharge structured support feel more confident, have less stress, and have more ability to deal with the complexity of healthcare at home. Family empowerment emerges as a priority objective of care because it strengthens parenting skills, improves family bonds, and provides for safe child development.

Family-centred care is an enabling intervention for adaptation to the home context. It provides knowledge, emotional support, and values parenting experience, making the parents active agents of care (Bondurant et al., 2003). The inclusion of the parents in clinical decisions and daily care, always respecting the individuality of each family, promotes the development of essential parenting skills. This allows for a healthy family environment and safe child development (Brødsgaard et al.,2015; Hüning et al., 2012). Empowering these families implies recognizing their emotional, social, and educational needs, besides ensuring a structured and accessible support during the hospital-home transition process. It is a strategy that must be initiated during the hospital admission, with continuity in the home/community contexts, being necessary to ensure better health outcomes, strengthening the parents' role and allowing for a safer and functional family environment (Griffith et al., 2022).

Collaborative procedures between the Hospital and Community Contexts – it sums up to the articulation between the neonatal intensive care unit professionals (NICU) and primary health care. The family healthcare nurse stands out to ensure the continuity and the quality of healthcare provided after the hospital discharge (Bondurant et al., 2003; Censullo, 1986; Griffith et al., 2022; Haspels et al., 2025; White-Traut et al., 2009).

In the 1980's, scientific evidence pointed to the central role of the nurse in the continuity of the premature newborn healthcare. The community health nurse is mentioned as the essential link between the hospital and community contexts. The work, evaluating family needs through active listening and individualized interventions, is highlighted. He is a facilitator of family adaptation, developing parental trust and preventing crisis related to hospital discharge. To ensure a safe and effective transition of these families from the hospital to the home context, the collaboration between the professionals of both contexts is needed (Censullo, 1986).

The creation of an integrated care network, in which nurses take the role of facilitators during the transition from the hospital environment to the home context, is necessary. This transition presupposes an anticipated and careful planning, based on clear and effective communication between the different spheres of healthcare. By acting jointly, nurses contribute to the individualization of family interventions. This way, the healthcare initiated in the NICU can be continued and adapted to their

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specific conditions at home. Primary health care teams must be involved in the beginning of the planning of these family-oriented interventions, contributing to a continuous support network (Bondurant et al., 2003).

With the implementation of his H-HOPE project, the collaboration between nurses from hospital healthcare and nurses from community care enhances the therapeutic bond, promotes family autonomy, and enables a more sensible approach to social and environmental risk factors that have an impact on child development. The interconnection between the two care levels (hospital and community) improves healthcare results and allows a more humane and sustainable experience of family-centred healthcare (White-Traut et al., 2009).

The parents' involvement in the care of their premature children is achievable through family-centred healthcare (FCH). Parents are more empowered and enabled to take care of their children in a safe and autonomous way, in the home context. In FCH, each family's individuality is always respected, ensuring that the parents are involved in the decisions, with the support of qualified professionals during the transition process. In this process, where autonomy and trust are developed, elements that build and strengthen healthy parenting and family environment are developed. In reality, this process is not limited to the transfer of responsibility to parents, but also the shared construction of knowledge and trust between the family and health professionals (Brodsgaard et al., 2015; Hüning et al., 2012). As highlighted by Haspels et al. (2025), the fragmentation between assistance levels is one of the main reasons for delays in hospital discharge, especially due to the absence of articulation between professionals and the difficulty in organizing sustainable healthcare at home. The nurse, as case manager, is responsible for the connection between the hospital, family, and healthcare network. They coordinate actions, optimize resources, and promote individualized interventions. This active healthcare management, when sustained by effective communication and relationships of trust with the family, avoids unnecessary readmissions and also ensures a favourable environment for child development and family well-being.

Nurse as the Case Manager - is the reference element in the transition process. They assume planning, monitoring, and individualized family support functions, with the purpose to promote a safe and effective adaptation to the home context (Bowles et al., 2016; Broedsgaard et al., 2005; Censullo, 1986; Lopez et al., 2012). Healthcare articulation, after the hospital discharge of the studied families, is mostly done by the nurse, who becomes the link between contexts and families (Censullo, 1986). The creation of an integrated healthcare network in which nurses take a facilitator role during the hospital-home transition, trough a clear communication and anticipated planning (Bondurant et al. 2003).

The included studies show the importance of creating a specific function of a case manager nurse. He is responsible for managing healthcare between sectors (hospital and community), promoting anticipatory visits by the community healthcare nurse, to structure individualized interventions for this transition. The nurse's performance as case manager fosters greater safety, stress reduction, better enabling, and emotional support to the families (Broedsgaard et al., 2005).

The most effective hospital discharge programs for premature newborns during the hospital-home transition of these families highlight the nurse with an important leadership and active monitoring role. In this context, the nurse acts as a case manager by conducting house calls, remote monitoring, training, and connecting the different health sectors, ensuring the continuity of healthcare to these families (Lopez et al., 2012). The ideal professional to coordinate the entire hospital discharge process for newborns with complex needs, according to the literature, it is the nurse who provides neonatal healthcare. This nurse should plan the hospital discharge, promoting parenting skills, taking in consideration their emotional fragility during this transitioning period. They must also articulate the hospital discharge process with the primary healthcare, with the purpose of reducing hospital readmissions and promoting a safe and humane transition (Bowles et al., 2016).

There is a growing appreciation of the nurse as a case manager, by being integrated in clinical care, interdisciplinary communication, and family support. For the hospital-home transition of these families to be conducted in a safe and tranquil way, there must be a collaboration between the NICU nurses, the hospital staff, and the community healthcare nurses. The same applies to the family health nurse, as a strategy to ensure the healthcare continuity after hospital discharge (Bondurant et al., 2003; Censullo, 1986).

3. DISCUSSION

Evidence analysis allowed the identification of three interconnecting major axes of intervention: family empowerment, collaborative procedures between the hospital and primary healthcare, and the nurse as case manager during the transition process. All of them are fundamental to a safe, effective, and humane process.

In regard to the hospital-home transition period of families with premature babies, authors are unanimous, claiming it to be a critical period that carries anxiety and uncertainty about the future (Bondurant et al., 2003; Bowles et al., 2016; Broedsgaard et al., 2005, 2015; Censullo, 1986; Enlow et al., 2017; Griffith et al., 2022; Haspels et al., 2025; Hüning et al., 2012; Lopez et al., 2012; White-Traut et al., 2009).

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Family empowerment is a main intervention to enable parents in the healthcare of their premature children, promoting the parents' trust, autonomy, and safety, especially in the first weeks after the hospital discharge. Studies show that the active and progressive involvement of parents in healthcare, even during the internment period, facilitates their preparation to assume the role of main caretakers at home (Osório et al., 2018; Shillington et al., 2021). Acquiring skills, such as parental autonomy, is directly connected with the efficiency in the management of healthcare in the home environment (Van de Riet et al., 2023).

Active inclusion of the family in the hospital discharge planning isn't only to technically prepare the caretakers, but also to reinforce family bonds and increase trust during healthcare (Smith et al., 2022). Family empowerment is seen as an essential tool in transition healthcare. It includes components such as the promotion of development, nutrition, environmental safety, and affective bonding. It also shows the need to strengthen parenting skills before hospital discharge (Kim & Kim, 2024).

Supporting this evidence, the *Standards Europeus de Cuidados de Saúde Neonatal* recommend the implementation of individualized and family-centred case management plans. They should be carried out in close cooperation with the parents, to ensure the interventions' proper coordination, the hospital discharge planning, and healthcare continuity upon returning home (Damhuis et al., 2018). This way, the family empowerment and involvement are ensured, at the same time it sustains practices based on evidence for the organization of neonatal healthcare.

In conjunction with empowerment, literature also highlights the importance of healthcare continuity between the hospital and community contexts. It acknowledges this connection as a necessary condition for a safe and effective transition process. Continuous and coordinated communication between multi-professional teams is mentioned as one of the main reasons that contribute to the healthcare quality at home. Besides ensuring that the family understands and correctly follows the given guidance, this collaboration promotes the correct usage of available resources in the community (Kim & Kim, 2024; Smith et al., 2022). The connection between these two contexts must be aware of the specific cultural and social needs of each family, allowing for a more humane approach, centred on their real needs (Osório et al., 2018).

Several studies also point to the importance of specific resources, such as home monitoring programs, as well as an effective coordination between the primary and the specialized healthcare services. These elements reveal themselves particularly helpful in the healthcare of children with special needs after hospital discharge, enabling a more fluid transition, and re-enforcing a feeling of support and safety for the family (Granero-Molina et al., 2018). The "Transition to Home" (TtH), implemented in Switzerland, appears as an example of good practices in this field. In this model, the presence of an advanced practice nurse, acting as a case manager, is appreciated by families. This professional ensures the healthcare continuity through house-calls visits and telephone contact. This way, they promote therapeutic trust connections that translates in a significant reinforcement of family empowerment, and in the reduction of parenting stress (Haemmerli et al., 2022). Regular meetings between the professionals of the different healthcare sectors and families, have shown to be effective in promoting collaborative and integrated action.

Despite the identified breakthroughs, there are still gaps in interinstitutional coordination that may compromise the healthcare quality and contribute to the increase of family's stress, as shown by Curaan et al. (2020) and Van de Riet et al. (2023. In this situation, educational interventions and the use of digital tools are gaining ground. These interventions have significantly reinforced family resilience, the cornerstone of family empowerment (Khoshnood et al., 2023). Early intervention programs with eHealth support, namely through teleconsultations and mobile apps, reveal themselves to be effective in reducing parental anxiety and increasing healthcare competence. This hybrid approach, which combines technology with in-person contact, shows itself to be particularly advantageous in contexts of geographical and socioeconomic inequalities (Ferraz et al., 2024).

Finally, the role of the nurse as a case manager proves to be transversal to all previously discussed dimensions, being essential to highlight the Family Healthcare Specialist Nurse (FHSN) as the most qualified professional to assume this function in an integrated and continuous way. With specific training and privileged insertion in the communities context, the FHSN finds himself in a strategic position to coordinate the assistance, to lead the preparation process for the hospital discharge, to formalize individualized healthcare plans and promote parents training, simultaneously ensuring the articulation between the nursing team and the other professionals of the healthcare network, attending to cultural, social, and emotional specificities of each family (OE, 2018).

The nurse acts as a facilitator in the building of trust bonds, promoting the active participation of the caretakers and reinforcing their autonomy, giving continuous emotional support throughout the hospital-home transition at the same time. Active listening, empathy and communication focused on the family are intrinsic skills to the FHSN practice, and fundamental to ensure a humane and safe transition (Miller et al., 2022; OE, 2018; Osório et al., 2018).

In addition to fostering parental empowerment, the FHSN plays a decisive role in the holistic evaluation of the family needs, in the guidance about proper use of technology and home support resources, and in the mediation between the different healthcare levels (OE, 2018). This integrated action decreases family anxiety and provides a more suitable environment for the needs of the premature newborn. As Granero-Molina et al. (2018) point out, nurses who work in the community are the continuity link between the hospital and home contexts, promoting a more personalised and family-centred assistance, which are the fundamental skills of the FHSN (OE, 2018).

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As a clinical and educational mediator, facilitating the understanding of the therapeutic plan, ensuring adherence, and fostering the family's role in healthcare, the FHSN promotes family empowerment. This action is even more relevant in the current scenario, marked by a growing clinical complexity and organizational challenges in the provision of integrated healthcare (OE, 2018; Smith et al., 2022).

Thus, the articulation between empowerment, healthcare continuity, and case management converges in the figure of the Family Health Specialist Nurse, as the pivot of the neonatal hospital-home transition process. Although the literature approaches these dimensions in a dispersed way, there is a growing trend of valuing the FHSN as a strategic agent to implement family-centred healthcare models, to implement individualized therapeutic plans, and ensure the effective follow-up of families after hospital discharge.

This growing recognition of the FHSN role highlights the need for investment in advanced clinical practices, specialized training, and policies that allow for their full integration in the neonatal and intersectoral healthcare teams, contributing to the consolidation of more effective, humane, and family-centred care responses.

STUDY LIMITATIONS

Although this scoping review provides an overview of the available evidence regarding family health nursing interventions during the hospital-to-home transition in neonatal contexts, some limitations should be acknowledged. First, the number of eligible studies identified was relatively limited, despite the absence of time and language restrictions in the search strategy. This may reflect the still fragmented and underdeveloped body of literature addressing this specific topic. In addition, as this review followed the scoping review methodology, no critical appraisal of the methodological quality of the included studies was conducted, which may limit the depth of interpretation of the findings. Finally, although several electronic databases and grey literature sources were consulted, the search was restricted to online sources, which may have led to the exclusion of potentially relevant studies available only in printed formats or non-indexed sources. Nevertheless, the evidence mapped in this review contributes to a better understanding of existing family health nursing interventions in neonatal hospital-to-home transitions and highlights the need for further research in this field.

CONCLUSION

This scoping review allowed us to map the available scientific evidence regarding family health nursing interventions aimed at the family in the neonatal context, during the hospital-household transition. Three major intervention areas resulted: family empowerment, the collaboration between the hospital and the community context, and the role of the nurse as case manager.

The hospital-home transition process is a vulnerable period for families with premature newborns, being necessary the development of interventions that promote parental training, healthcare continuity, and the building of a relationship of trust between health professionals and families. Strategies based on family-centred healthcare proved to facilitate a safer and more humane transition process, which should be initiated in the hospitalization context and continued after hospital discharge by community healthcare professionals.

It is concluded that a successful hospital-household transition requires a multifaceted approach, where family empowerment, collaborative action between hospital and primary healthcare environments, and the nurse as case manager are dynamically interconnected. Valuing relational proximity, active listening, and adaptation to family realities should be the guiding axis of family healthcare in a neonatal context and nursing interventions.

Practice implications

This subject reveals implications for future practice, to the extent that the Family Health Nursing interventions are preponderant for the promotion of the continuity and quality of healthcare in neonatal health. The articulation between the different health sectors (hospital and community) is vital for the well-being of these families, namely during the NICU-home transition process. The FHSN assumes a crucial role in reducing inequalities in healthcare access, increasing literacy and parental training, and establishing itself as a fundamental link in the support network for these families.

Future investigation on FHSN interventions is suggested, exploring and documenting them, in order to support evidence-based practices and promote their full integration into family healthcare networks, in this delicate context of transition.

AUTHORS´ CONTRIBUTION

Conceptualization, M.T., A.R. and C.A.; data curation, M.T., A.R. and C.A.; formal analysis, M.T., A.R. and C.A.; investigation, M.T., A.R. and C.A.; methodology, M.T., A.R. and C.A.; supervision, M.T., A.R. and C.A.; validation, M.T., A.R. and C.A.; writing – original draft, M.T., A.R. and C.A.; writing – review & editing, M.T., A.R. and C.A.

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CONFLICT OF INTERESTS

The authors declare no conflict of interests.

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