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Challenges of self-care at home after orthopaedic implant surgery in Indonesia: A qualitative study

Wyzwania związane z samodzielną opieką domową po operacji wszczepienia implantów ortopedycznych w Indonezji: badanie jakościowe

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STRESZCZENIE

WYZWANIA ZWIĄZANE Z SAMODZIELNĄ OPIEKĄ DOMOWĄ PO OPERACJI WSZCZEPIENIA IMPLANTÓW ORTOPEDYCZNYCH W INDONEZJI: BADANIE JAKOŚCIOWE

Cel pracy. W niniejszym badaniu przeanalizowano trudności związane z samodzielną opieką domową po operacjach wszczepienia implantów ortopedycznych u dorosłych mieszkańców Indonezji jako przejawy wrażliwości pacjentów oraz zbadano implikacje etyczne dla obowiązków pielęgniarskich w okresie przejścia ze szpitala do domu.

Materiał i metody. Zastosowano jakościową, opisową metodologię fenomenologiczną, obejmującą pogłębione, częściowo ustrukturyzowane wywiady z 18 osobami dorosłymi, przeprowadzone w okresie od dwóch do sześciu tygodni po zabiegu otwartej redukcji i wewnętrznej stabilizacji złamań kończyn dolnych w szpitalu publicznym w Dżakarcie. Dane poddano refleksyjnej analizie tematycznej.

Wyniki. Uczestnicy opisali trudną sytuację w okresie rekonwalescencji, charakteryzującą się słabo kontrolowanym bólem i zaburzeniami snu, lękiem związanym z ruchem oraz kinezofobią, niepewnością co do pielęgnacji ran i bezpiecznej aktywności, a także silnym uzależnieniem od nieprzygotowanych opiekunów rodzinnych, co w ich odczuciu stanowiło zaniedbanie etyczne. Uczestnicy wyrazili również silne pragnienie posiadania prostych narzędzi cyfrowych, które umożliwiłyby im utrzymywanie kontaktu z pielęgniarkami po wypisaniu ze szpitala.

Wnioski. Obecne praktyki związane z wypisywaniem pacjentów z szpitala niosą ze sobą ryzyko zaniedbania etycznego wobec pacjentów i ich rodzin, ponieważ przenoszą złożoną opiekę do domu bez odpowiedniego przygotowania. Pielęgniarki powinny postrzegać wypisanie ze szpitala jako środek zabezpieczający w okresie przejściowym, łącząc edukację z udziałem rodziny z łatwo dostępnym wsparciem cyfrowym, aby zapewnić „solidną opiekę", której potrzebują te wrażliwe grupy społeczne.

Słowa kluczowe: **grupy szczególnie wrażliwe, zabiegi ortopedyczne, opieka pooperacyjna, opiekunowie, etyka pielęgniarska**

ABSTRACT

CHALLENGES OF SELF-CARE AT HOME AFTER ORTHOPAEDIC IMPLANT SURGERY IN INDONESIA: A QUALITATIVE STUDY

Aim. This study explored self-care challenges at home after orthopaedic implant surgery among Indonesian adults as expressions of patient vulnerability and examined the ethical implications for nursing responsibilities during the transition from hospital to home.

Material and methods. A qualitative descriptive phenomenological design was used, involving in-depth semi-structured interviews with 18 adults, conducted two to six weeks after open reduction and internal fixation for lower-extremity fractures at a public hospital in Jakarta. Data were analysed using reflexive thematic analysis.

Results. Participants described a fragile recovery space characterised by poorly controlled pain and sleep disturbance, movement-related anxiety and kinesiophobia, uncertainty about wound care and safe activity, and heavy reliance on unprepared family caregivers experiences that amounted to perceived ethical neglect. Participants also expressed a strong wish for simple digital tools that would sustain contact with nurses after discharge.

Conclusions. Current discharge practices risk ethical neglect of patients and their families by transferring complex care to the home without adequate preparation. Nurses should reconceptualise discharge as transitional protection, combining family-inclusive education with low-threshold digital support to deliver the "strong care" required by these vulnerable populations.

Key words: **vulnerable populations, orthopaedic procedures, postoperative care, caregivers, nursing ethics**

INTRODUCTION

Fractures remain a major cause of long-term disability, accounting for more than 25 million years of living with disability in 2021 [1]. In Indonesia, hospital data indicate a fracture prevalence of approximately 5.8%, with many injuries involving the lower extremities and resulting from road traffic accidents that often require surgical fixation with implants [2]. Enhanced recovery programmes have shortened hospital stays, meaning that patients are often discharged without continuous professional supervision while still experiencing pain, restricted mobility and ongoing wound care needs. This shift transfers complex clinical tasks to patients and families and makes the safety of transitional care a central concern in orthopaedic nursing, raising ethical questions about how well health systems protect patients who are clinically stable yet highly vulnerable at home.

Patients who leave the hospital soon after lower-extremity surgery frequently experience pretransition shock. Although considered medically fit for discharge, many patients feel uncertain about living with an operated limb in their everyday environment. Qualitative studies have described persistent postoperative pain, fear of moving the affected leg, wound-related complications and anxiety about coping without immediate access to clinicians [3,4]. A recent scoping review identified unmet learning needs in pain and wound management, early recognition of complications, and the use of family and digital resources. These gaps were associated with kinesiophobia, dependence on informal caregivers, and potentially preventable adverse events [5]. In Indonesia, where multigenerational households are common and family members provide most of the daily care, such unmet needs can deepen patient dependency and increase caregiver strain. These conditions reflect not only clinical challenges but also ethical concerns related to autonomy, safety and the fair distribution of caregiving responsibilities across families and health services.

Much orthopaedic research still prioritises biomedical outcomes, such as bone union, implant survival and standardised functional scores [6], while paying less attention to how patients recover after lower extremity surgery in ordinary home settings. From a nursing and ethical standpoint, recovery also depends on how patients manage pain and disturbed sleep, interpret and remember discharge instructions, negotiate feelings of dependency and being a burden, and access or wish for simple digital tools that extend professional guidance into the home. The extent to which nurses and health systems anticipate these challenges and provide ongoing, person-centred support has direct implications for patients' vulnerability, their dignity, and the moral experience of care. Evidence on these issues among Indonesian adults with orthopaedic implants remains limited.

AIM

This qualitative study aimed to explore the challenges of home-based self-care among Indonesian adults after orthopaedic implant surgery, examining how these experiences reflect the vulnerability of patients and generate ethical implications for nursing responsibilities during the transition from hospital to home.

MATERIALS AND METHODS

This qualitative study employed a descriptive phenomenological approach to explore patients' lived experiences of self-care at home after lower-extremity fracture surgery [7]. The design of the study was selected to capture how patients perceived and managed self-care during the vulnerable early post-discharge period. The post-discharge period between September and October 2025. This study was reported in line with the COREQ [8].

The study was conducted in the orthopaedic polyclinic of Pasar Minggu General Hospital, a public referral hospital in South Jakarta, Indonesia, which serves a densely populated urban catchment area. The target population comprised adult patients who had undergone open reduction and internal fixation (ORIF) of lower-extremity fractures and had been discharged home. Purposive sampling was used to identify patients who were clinically stable at follow-up, able to communicate in Bahasa Indonesia and willing to reflect on their home-based recovery. We excluded patients with known cognitive impairment or severe postoperative complications. Recruitment and preliminary analysis proceeded concurrently and sampling was discontinued when no new codes or insights emerged, consistent with the concept of information power and saturation in qualitative research [9]. The final sample included 18 adults who underwent ORIF. The demographic and clinical characteristics of the patients are presented in Table 1.

Tab. 1. Demographic and clinical characteristics of participants (n = 18)

Characteristic	Category	n	%
Age (years)	< 30	3	16.7
	30-39	5	27.8
	40-49	5	27.8
	≥ 50	5	27.8
Gender	Male	11	61.1
	Female	7	38.9
Education level	Senior high school	11	61.1
	Diploma	3	16.7
	Bachelor degree	4	22.2
Marital status	Married	13	72.2
	Single	3	16.7
	Widowed	2	11.1
Type of fracture	Tibia dextra	5	27.8
	Tibia sinistra	1	5.6
	Femur dextra	5	27.8
	Femur sinistra	2	11.1
	Fibula dextra	2	11.1
	Ankle dextra	2	11.1
	Ankle sinistra	1	5.6
Time since surgery (weeks)	2	1	5.6
	3	6	33.3
	4	8	44.4
	5	1	5.6
	6	2	11.1

The data were gathered through individual, face-to-face and in-depth semi-structured interviews conducted in Bahasa Indonesia by the first author, an orthopaedic nurse experienced in qualitative interviewing. Interviews were conducted in a private consultation room within the orthopaedic polyclinic during the first or second outpatient follow-up visit (approximately two to six weeks after surgery), to minimise additional travel and burden for patients who were still in pain or had mobility limitations. The interview guide explored the challenges of self-care at home in the post-discharge period, including symptom management, daily activities, emotional responses and family support.

Each participant was interviewed once. Interviews lasted approximately 45-75 minutes, were audio-recorded with participants' permission and were followed by brief field notes documenting contextual impressions and nonverbal cues. The audio files were transcribed verbatim in Bahasa Indonesia shortly after each interview to maintain closeness to the accounts of the participants. Ethical principles were rigorously applied, given the participants' postoperative physical vulnerability and dependency. Ethical approval was obtained from the Research Ethics Committee, Faculty of Nursing, Universitas Indonesia (KET-249/UN2.F12.D1.2.1/PPM.00.02/2025). All participants received written and oral information about the study, including its voluntary nature, the right to withdraw at any time without affecting their care, and measures to protect confidentiality. The study participants provided written informed consent before data collection. Interviews were scheduled to align with clinical appointments, and if participants experienced pain, fatigue, or emotional distress, they were offered breaks or the option to stop the interview.

The interview transcripts were analysed using reflexive thematic analysis following Braun and Clarke's six-phase framework: familiarisation with the data, generation of initial codes, construction of themes, review of themes, definition and naming of themes and production of the report [10,11] The first author read all transcripts repeatedly, coded meaning units related to home-based self-care, and grouped similar codes into preliminary categories. These categories were iteratively refined into subthemes and overarching themes through team discussions and constant comparison with the raw data. The analytical process relied on guidance on good practice in thematic analysis and contemporary recommendations on qualitative rigour.[12,13].

The following criteria were used to assess trustworthiness: credibility, dependability, confirmability and transferability [14]. Credibility was strengthened through in-depth interviewing, probing questions and systematic checking of emerging themes against the full transcripts. The audit trail documenting coding decisions, theme development, and analytical memos was maintained to support dependability and confirmability. The research team used reflexive notes to consider how their clinical experience in orthopaedic nursing might shape interpretation and to remain attentive to participants' vulnerability and the ethical dimensions of their accounts. Transferability was supported by providing a clear description of the study setting, sampling strategy and participant characteristics, so that readers can judge the study's applicability to other contexts.

RESULTS

The study involved eighteen adults living at home two to six weeks after ORIF of lower-extremity fractures. Participants were aged 24-55 years, predominantly male, married and educated to the senior high school level. Most fractures involved the tibia or femur, and most participants were interviewed 3-4 weeks after surgery. Their demographic and clinical characteristics are summarised in Table 1. Reflexive thematic analysis generated five interrelated themes that describe how participants managed self-care at home. These themes highlight vulnerability during the period of transition, capturing experiences of pain and sleep disturbance, movement-related anxiety, ambiguity in home care procedures, a shared burden within families, and expectations for simple digital support. Table 2 presents the themes and subthemes.

Tab. 2. Themes and sub-themes of challenges of self-care at home

Theme	Sub-theme	Categories (summary)
Theme 1. Postoperative pain self-regulation as a driver of sleep disturbance and physical dependency	Physiological sequelae of pain	Nocturnal sleep fragmentation; non-restorative sleep secondary to pain
	Ineffective self-management of pain	Uncertainty regarding relaxation and diaphragmatic breathing techniques; perceived inadequacy of oral analgesics for sustained pain control
	Functional repercussions of pain	Postoperative stiffness and restricted range of motion; total dependency on caregivers for basic mobility and self-care
Theme 2. Movement-related Anxiety and Trauma Undermining Self-Directed Rehabilitation	Psychological responses to the surgical wound	Fear of wound dehiscence or postoperative bleeding; pain-related trauma and kinesiophobia (fear-avoidance beliefs)
	Future-oriented anxiety about disability	Worry about potential permanent disability; fear of never regaining normal gait and mobility
	Psychological dependency on professional oversight	Reluctance to initiate or progress movement without direct professional supervision
Theme 3. Insufficient understanding of procedural procedures and lack of visual education in home-based care	Barriers to retaining discharge information	Forgetting hospital-based verbal discharge instructions; confusion about the sequence and progression of prescribed exercises
	Ambiguity in interpreting postoperative symptoms	Difficulty distinguishing expected postoperative pain from red-flag signs of infection or complications
	Need for visual and multimedia education	Strong desire for concrete visual or video-based rehabilitation guidance
Theme 4. Dual burden and fatigue arising from unprepared caregiving among family caregivers	Perceived physical burden on family caregivers	Perceived physical exhaustion and sleep loss among family caregivers
	Patients' emotional burden and self-guilt	Feelings of guilt about inconveniencing or burdening the family; perceiving oneself as a burden
	Perceptions of family caregiving competence	Awareness of caregivers' uncertainty and hesitancy when assisting with care
Theme 5. Expectations for simple supporting technology to facilitate remote monitoring and guidance	Need for ongoing connectivity with health professionals	Desire for continuous remote monitoring of postoperative status; not wanting to feel abandoned after hospital discharge
	Need for structured digital support systems	Need for automated reminders for medication and exercise schedules
	Preferences for user-centred technology design	Preference for a simple, intuitive, and user-friendly application

Theme 1. Postoperative pain self-regulation as a driver of sleep disturbance and physical dependency

Participants described pain as a constant reminder of bodily fragility in the first weeks at home. Many patients reported that the pain intensified in the evening and fragmented their sleep, leaving them depleted and unable to participate in rehabilitation the following day. One participant observed: "*Since I came home, once it is past nine in the evening, the pain starts again.*" "*It is difficult to close my eyes, and my sleep never feels truly deep or refreshing.*" (P-01). Although some patients were introduced to breathing or relaxation techniques in the hospital, several felt unable to recall or apply these strategies when they were alone. In the absence of direct professional support, they relied on immobility as a self-protective response: "*At home, I tried to control my breathing the way they had shown me in the hospital, but I had forgotten the steps*." "*I was afraid of situation when I moved my body wrongly, it would hurt more, so I just stayed still and endured the pain*." (P-03). Pain, stiffness, and fear of provoking further discomfort reinforced a high degree of dependency on family members for basic mobility and self-care. Everyday tasks, such as the use of toilet or change position became situations where participants felt acutely aware of their vulnerability and reliance on others: "*Even just going to the bathroom, I have to be guided every time.*" "*When I am alone, I am afraid I will not be able to handle the pain, so almost everything I do now depends on my family.*" (P-15).

Theme 2. Movement-related Anxiety and Trauma Undermining Self-Directed Rehabilitation

In addition to physical symptoms, the participants described intense anxiety whenever they attempted to move the operated limb. The surgical wound was perceived as fragile, and ordinary movements were perceived as dangerous. One participant shared: "*Every time I want to straighten or bend my leg, I picture the stitches coming apart and the wound bleeding, so I hold back and prefer not to move the leg too much.*" (P-07). Memories of highly painful early mobilisation during hospitalisation lingered and shaped behaviour at home, making participants reluctant to undertake exercises without professional oversight: "*I still vividly remember the first time my leg was moved in the hospital, the pain was unbearable'. That experience actually made me afraid to repeat the exercises on my own at home.*" (P-09). Anxiety also extended into the future, with several participants worrying that they might not regain their previous level of independence: "*I often ask myself, will I ever walk normally again?" "I am afraid that I will always need a cane and walk with a limp.*" (P-03). In this context, self-directed rehabilitation was experienced as risky, and participants preferred to delay or limit movement rather than risk harming what they perceived as a fragile limb.

Theme 3. Insufficient understanding of procedural procedures and lack of visual education in home-based care

Participants remembered receiving explanations about exercises, wound care and warning signs before discharged from hospital, but these instructions often felt blurred once they arrived home. They described trying to absorb multiple messages while simultaneously focusing on the prospect of going home. One of patients explained: "*I did not have time to write notes because I was focused on going home quickly." In the end, at home, what I remembered and what was actually explained became mixed up.*" (P-12). This partial recall created ongoing uncertainty about the safety of the activity: "*I am afraid that doing too much will make it worse, but doing too little will make it stiff.*" (P-13). The study participants also struggled to judge postoperative symptoms, such as redness or warmth around the wound. Without clear benchmarks for what was "normal," they regularly checked the wound without confidence in their decisions: "*I immediately thought of infection when I saw the wound looking a bit red." However, because I have no clear benchmark for what is dangerous, I kept checking it repeatedly without being sure what to do.*" (P-17). Many emphasised that verbal explanations alone were insufficient once they returned home. They expressed a strong desire for simple, repeatable visual materials that could be used by both patients and families: "*If there were pictures or step-by-step videos, I could replay them at any time until I really understood." Right now, it feels like I am assuming on my own which movements are safe.*" (P-18). This ambiguity in home-based procedures contributed to a sense of ongoing vulnerability, with participants feeling responsible for safety without having adequate tools.

Theme 4. Dual burden and fatigue arising from unprepared caregiving among family caregivers

Recovery was experienced as a shared undertaking between patients and their families. The study participants closely observed the physical and emotional strain experienced by their relatives in providing continuous support, particularly at night. One participant recounted: "*I see my wife waking up almost every night when I ask for help." In the morning her face looks very tired, as she is also deprived of sleep due to looking after me.*" (P-05).Witnessing this strain led many to feel guilty and to limit requests for assistance, even when they were uncomfortable: "*I always apologise every time I ask for help to change position. "It feels like I am constantly causing trouble, even though I know they are tired as well.*" (P-08). Some delayed using the toilet or endure pain to avoid adding to the family workload: "*Sometimes I just endure the pain because I cannot bear to see my family already exhausted." I feel like a burden, especially when they must take time off work to bring me for check-ups.*" (P-11). Simultaneously, participants recognised that their caregivers were themselves unsure about how best to help, often asking the patient for guidance. This mutual uncertainty deepened the sense of shared vulnerability: "*At home, my family often asks me, 'is it okay to move this far?" but I am not sure. It is obvious that they are actually confused about what to do.*" (P-16). The combination of physical fragility, emotional guilt and caregiver fatigue illustrated a dual burden within the household and highlighted the moral pressure that patients felt to not overstep what they perceived as their "allowed" dependence.

Theme 5. Expectations for simple supporting technology to facilitate remote monitoring and guidance

Many participants imagined that simple digital tools could soften the abrupt transition from hospital to home by extending the presence of professionals into their daily lives. They wished to be able to share photos or short videos of wounds and gait and to receive direct feedback from nurses. One participant reflected: "*I imagine that if there were a way to send a photo of the wound or a video demonstrating how I walk to the nurse by phone, and they could comment, I would feel calmer, as if I were still being monitored from a distance*." (P-10). Despite ongoing doubts and questions, several patients reported feeling "released" suddenly after discharge. An accessible channel for asking brief queries was seen as a way to reduce this sense of abandonment: "*I felt like I had been released when I got home, even though I still had many doubts*." *If there was an app for short questions, I would not feel completely alone at home*." (P-09). Digital reminders were also perceived as a way to more safely manage complex routines: "*At home, I sometimes forget when I last took my medicine and when I should exercise again*." *If I had automatic reminders on my phone, I think my schedule would be more organised*." (P-13). Participants emphasised that any application would need to be straightforward and accessible for both older adults and family caregivers. One man stated: "*If there really is an application, I hope the display is simple, using everyday language and large print, so older people like me can also use it*." (P-01). Another added: "*There should not be too many menus that cause confusion*." *If there were just buttons for exercises, medicines and asking about symptoms, my family and I would definitely find it easier to use*." (P-14).

DISCUSSION

This study shows that the early transition from hospital to home after lower-extremity implant surgery is experienced as a period of significant vulnerability rather than a smooth step-down in care. Participants described feelings of physically fragile, uncertainty about safe movement and wound care, and overly dependent on family members who felt unprepared. These experiences suggest gaps in preparation and systemic failure to protect vulnerable patients during a high-risk recovery phase.

Consistent with previous work on hip fracture recovery, participants reported pain, disturbed sleep and fatigue as constant reminders of bodily fragility that restricted mobility and delayed confidence in daily activities [15]. Similarly, international studies have reported that patients with orthopaedic injuries discharged home struggle to translate hospital-based advice into meaningful routines and often feel that "recovery has barely started" at discharge [15,16]. In our context of short hospital stays and limited outpatient rehabilitation options, uncontrolled pain and exhaustion at home amplify vulnerability by increasing the risk of fall, prolonging dependence and undermined trust in one's own body. Psychological distress was closely intertwined with these physical limitations. Fear of damaging the implant, anxiety about wound complications, and guilt over being a burden are well documented in the literature on post-fracture transitions and are associated with kinesiophobia, low engagement in exercises, and poorer functional outcomes [15,16]. In a setting where written instructions are brief and follow-up contact is limited, patients interpreted their own anxiety as a personal failing rather than a predictable response to inadequate support, reinforcing the sense of isolation and moral self-blame.

Recovery was also deeply relational. Family members became the main providers of lifting, wound care, toileting and administration of medications, often without structured training or respite. International evidence shows that caring for orthopaedic patients substantially increases caregiver strain and may worsen physical and mental health [17,18]. In our data, the common assumption that families will "naturally" assume complex orthopaedic care without adequate skills or information is better described as ethical neglect than a benign task sharing. By discharging patients to untrained relatives, the system exploits the vulnerability of family members who feel morally obliged to provide care but lack the resources to do so safely. This dynamic shifts the professional responsibility of unpaid caregivers to basic nursing and rehabilitation tasks, creating a hidden care economy that benefits institutions while exposing patients and families to preventable harm [15,17].

From an ethical and theoretical perspective, these findings situate postsurgical patients and their families as structurally vulnerable actors within a fragmented transition system, rather than as individuals who simply need more "motivation." Best-practice transitions of care frameworks emphasise continuity, clear communication and shared planning between the hospital and community services as core nursing responsibilities, not as optional extras [19,20]. Our results suggest that when such supports are weak, the duty of care is effectively reduced to the hospital door. For orthopaedic nurses, the ethics of care in this context involves anticipating possible self--care challenges at home, co-designing realistic plans with patients and families, and ensuring accessible channels for post-discharge support. This is particularly important in Indonesia, where multigenerational households are common and family roles are strongly moralised. Without adequate professional partnership, cultural expectations of family duty can mask the underlying injustice in the distribution of care burdens.

Participants' calls for simple, nurse-linked digital tools position technology as a potential ethical resource rather than merely a technical improvement. Recent studies of mobile health platforms for hip fracture rehabilitation have shown that structured telerehabilitation and educational apps can improve functional performance and support caregivers, especially when professional monitoring and guidance are integrated [21]. Our findings suggest that culturally adapted, easy-to-use digital interventions, such as chat-based guidance, video demonstrations in local language, and symptom checklists linked to rapid nurse contact,could reduce the sense of abandonment for patients and their families after hospital discharge. However, without meaningful professional engagement, technology

that simply transfers more responsibility to patients and families risks reproducing the same ethical neglect in digital form. Therefore, designing digital support for this population should explicitly aim to protect vulnerable users by improving access to expert advice, not by further outsourcing care.

For Indonesian nursing practice, these results point to several priorities: structured pre-discharge education that includes the family caregiver, clear demonstration and rehearsal of key tasks (transfers, wound care, safe exercise), and planned follow-up through telephone or digital messaging during the first weeks at home. Training programmes that integrate family caregiver education into routine professional curricula may help nurses to recognise and address caregiver vulnerability as a central ethical issue rather than as an informal extension of family roles [22]. Such measures would move transitional orthopaedic care closer to the ethic of shared, rather than shifted, responsibility.

Limitations of the study

This study has several limitations. Firstly, the study was conducted in a single public hospital in Jakarta, and the organisation of orthopaedic care, family structures and community resources may differ in other regions of Indonesian or in other countries. Therefore, the transferability of the findings should be judged with attention to local service models. Secondly, interviews took place two to six weeks after discharge, so the participants' accounts may have been shaped by their evolving recovery and recall bias. Finally, the sample size was relatively small, which is typical of qualitative research. This study does not aim for statistical generalisation, but rather offers in-depth insights that may inform practice and future research on transitional orthopaedic care similar contexts.

CONCLUSIONS

This study shows that adults in Indonesia recovering at home after lower-extremity orthopaedic implant surgery inhabit a difficult situation marked by persistent pain, movement-related fear and uncertainty about safe self-care. Their dependence on family members, who themselves feel unprepared and anxious, reveals that a system that withdraws professional support too soon results in vulnerability after hospital discharge. Within this context, the current discharge and home care organisation amounts to the ethical neglect of both patients and family caregivers. Relying on relatives to perform complex nursing and rehabilitation tasks without adequate preparation, follow-up or recognition, the health care system shifts professional responsibility onto those who are morally willing but practically unsupported. In order to move from this pattern of neglect towards "strong care," nursing practice must reconceptualise hospital discharge as a phase of transitional protection. This includes co-designing clear, family-inclusive education, rehearsing key skills before discharge, and implementing simple, culturally adaptive digital tools that maintain nurse–patient contact at home. Such changes would comply with the ethical mandate of nursing to provide protection for patients in vulnerable circumstances, not only within hospital walls but throughout the vulnerable journey of recovery at home.

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