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Exploring Families' Experiences in Supporting Older Adults' Care in the Community: A Community Nursing Perspective

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ABSTRACT

Background: *Population ageing increases families' responsibilities for providing long-term care to older adults in the community. However, family caregivers frequently perform complex tasks with limited knowledge, resources, and professional assistance.*
Research Objective: *This study explored families' experiences in supporting older adults' care in Buton Regency from a community nursing perspective.*
Methods: *A qualitative descriptive study involved 15 family caregivers recruited through purposive sampling. Data were collected using semi-structured interviews and field notes. Interviews were transcribed verbatim and analysed thematically. Trustworthiness was established through member checking, peer discussion, reflexive notes, contextual descriptions, and an audit trail.*
Results: *Five themes emerged: caregiving as a moral and cultural responsibility; families as coordinators of everyday care; multidimensional caregiving challenges; adaptation, spirituality, and shared family support; and the need for accessible, family-centred community nursing. Participants provided care, managed medication and nutrition, monitored symptoms, and made healthcare decisions. However, they experienced fatigue, emotional strain, financial pressure, limited caregiving knowledge, and geographical barriers.*
Conclusion: *Families constitute the foundation of community-based older-adult care but require structured professional support. Community nurses should provide regular home visits, practical education, caregiver assessment, accessible consultation, and coordinated referrals to improve care quality and caregiver well-being.*

Keywords: *Family Caregiving; Older Adults; Community Nursing.*

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BACKGROUND

Population ageing is reshaping the organisation of health and social care worldwide. Longer life expectancy represents an important development achievement; however, advancing age is frequently accompanied by multimorbidity, functional decline, cognitive impairment, frailty, and increasing dependence on others for daily activities. Families commonly become the primary providers of medication management, personal care, nutrition, transportation, emotional support, and access to health services (Guigoz & Vellas, 2021). These responsibilities may be performed without adequate knowledge, skills, financial resources, or professional assistance. Understanding families' experiences is therefore urgent because the quality and continuity of older adults' care in the community depend not only on formal healthcare services but also on families' capacity to provide safe, responsive, and sustainable care (Zeng et al., 2024).

Globally, the number of people aged 60 years or older reached approximately 1.1 billion in 2023 and is projected to increase to 1.4 billion by 2030 and 2.1 billion by 2050. By 2030, one in six people worldwide will be aged 60 years or older, while the population aged 80 years or older is expected to more than triple over the coming decades (Nguyen et al., 2021). Approximately two-thirds of older adults will live in low- and middle-income countries by 2050, where formal long-term care systems are often limited and families continue to carry much of the caregiving responsibility (van Nimwegen et al., 2023). Moreover, increased longevity is not always accompanied by good health, meaning many older adults may live for years with chronic illness or functional limitations requiring continuous assistance (Sharma et al., 2021).

Indonesia has entered the ageing-population phase, defined by older adults comprising at least 10% of the population. In 2023, people aged 60 years or older represented 11.75% of the national population, and the proportion approached 12% in 2024 (Sherman et al., 2023). It is projected that older adults could reach approximately 65.82 million people, or 20.31% of the national population, by 2045. National statistics also show that older adults experience diverse health, economic, and social vulnerabilities, while many remain economically active or dependent on household resources. Within Indonesia's family-oriented social structure, children and relatives are generally expected to care for ageing family members. Nevertheless, migration, urbanisation, smaller household sizes, women's increasing participation in employment, and limited caregiving knowledge may weaken families' capacity to fulfil these expectations (BPS–Statistics Indonesia, 2024) (Purba et al., 2023)

At the regional level, older adults represented 8.93% of the population of Southeast Sulawesi in 2024, increasing from 7.67% in 2022. Most older adults lived in rural areas, where geographical distance, transportation constraints, and unequal distribution of health professionals may affect continuity of care. In 2024, 40.05% of older adults in Southeast Sulawesi reported physical or psychological health complaints during the previous month, while the morbidity rate was 21.76%. Although only 5.12% lived alone, living with relatives does not necessarily guarantee adequate care. Co-residence may conceal uneven caregiving responsibilities, insufficient knowledge, financial pressure, or difficulties coordinating with healthcare services. These conditions underscore the importance of community nurses in assessing family capacity, providing education, monitoring chronic conditions, and connecting households with community resources (BPS–Statistics Indonesia, Southeast Sulawesi, 2024) (Sun & Kao, 2024).

In Buton Regency, older adults constituted 9.23% of the population in 2024. During the same year, 40.23% of older adults reported health complaints, and the older-adult morbidity rate reached 19.57%. Among those experiencing health complaints, 74.59% practised self-medication, whereas only 33.19% sought outpatient care. Furthermore, 8.37% had been hospitalised during the previous year, with an average hospital stay of 9.45

days—longer than the Southeast Sulawesi average of 6.15 days. These figures suggest that families may manage substantial health needs at home, including symptom recognition, medication administration, mobility assistance, dietary management, and decisions concerning professional treatment. However, statistical indicators cannot explain how families interpret these responsibilities, negotiate caregiving roles, respond to limited resources, or experience interactions with nurses and primary healthcare services (Strooij et al., 2024).

Previous studies on older-adult care have predominantly measured caregiver burden, service utilisation, or disease-specific outcomes through quantitative approaches. Research examining caregiving as a lived family process remains limited, particularly in rural and culturally distinctive communities such as Buton. The perspectives of family members concerning cultural obligations, emotional experiences, caregiving competence, role negotiation, barriers to care, coping strategies, and expectations of community nurses have not been adequately explored. Consequently, existing evidence provides insufficient contextual understanding for designing family-centred community nursing interventions.

The novelty of this study lies in exploring older-adult care as a relational and culturally embedded family experience while simultaneously examining the interface between families and community nursing services. Rather than focusing exclusively on caregiving burden or clinical outcomes, it investigates family strengths, challenges, adaptations, indigenous values, and expectations of professional support. Therefore, this study aims to explore families' experiences in supporting older adults' care in the community in Buton Regency, including their caregiving roles, challenges, coping strategies, cultural meanings, and perceived needs for community nursing support.

METHODS

This study employed a qualitative descriptive design (Pickett et al., 2024) to explore families' experiences in supporting the care of older adults in the community from a community nursing perspective. The study was conducted in selected community health centre service areas in Buton Regency, Southeast Sulawesi, Indonesia, from April to June 2025. Participants were 15 family members who acted as the primary caregivers of older adults living at home. Participants were recruited using purposive sampling with maximum variation based on age, sex, relationship to the older adult, caregiving duration, household composition, and the older adult's level of dependency. The inclusion criteria were family members aged 18 years or older, having provided direct care to an older adult aged at least 60 years for a minimum of six months, being involved in daily care or healthcare decision-making, residing in the same household or maintaining regular caregiving contact, and being willing to participate. Family members who were unable to communicate effectively or were experiencing conditions that prevented participation in an interview were excluded. Recruitment continued until data saturation was achieved, indicated by repetition of information and the absence of substantially new themes.

Data were collected through face-to-face, semi-structured, in-depth interviews conducted by the researcher in a private location selected by each participant. The interview guide consisted of open-ended questions addressing families' understanding of older-adult care, daily caregiving roles, medication and nutritional management, assistance with personal and mobility needs, healthcare decision-making, emotional experiences, cultural and family values, caregiving challenges, coping strategies, interactions with community health services, and expectations of community nurses. Probing questions were used to obtain deeper descriptions and clarify participants' meanings. Each interview lasted approximately 45–60 minutes and was conducted in Indonesian or the local language according to the participant's preference. With permission, interviews were audio-recorded

and supplemented by field notes documenting nonverbal expressions, contextual conditions, and the researcher's reflections. Audio recordings were transcribed verbatim, and interviews conducted partly in the local language were translated into Indonesian before analysis. Participant identities were replaced with codes to ensure confidentiality.

Data were analysed using thematic analysis following the stages of familiarisation with the data, initial code generation, searching for themes, reviewing themes, defining and naming themes, and producing the final report. The researchers repeatedly read the transcripts, identified meaningful statements, assigned initial codes, and grouped related codes into categories and broader themes. Data collection and analysis were conducted concurrently so that emerging findings could inform subsequent interviews. Themes were interpreted from a community nursing perspective, particularly regarding family caregiving capacity, health education, continuity of care, chronic-condition monitoring, access to community resources, and collaboration between families and primary healthcare professionals. Qualitative data-management software or manual coding matrices were used to organise codes, categories, themes, and supporting quotations.

The trustworthiness of the findings was established through credibility, dependability, confirmability, and transferability. Credibility was supported through prolonged engagement, in-depth interviewing, member checking, and peer discussion. Selected participants were invited to confirm whether the preliminary interpretations accurately reflected their experiences. Dependability and confirmability were strengthened through an audit trail documenting participant recruitment, interview procedures, coding decisions, theme development, and researcher reflections. Reflexive notes were maintained to identify and minimise the influence of the researchers' assumptions. Transferability was supported by providing detailed descriptions of the participants, family-care context, sociocultural setting, and research procedures.

RESULTS

Participant Characteristics

Fifteen family caregivers participated in this study. Their ages ranged from 27 to 64 years, with a mean age of 45.7 years. Most participants were women (73.3%), reflecting the dominant role of wives and daughters in providing daily care. Seven participants were the older adult's children, four were spouses, three were daughters-in-law, and one was a grandchild. The duration of caregiving ranged from one to eleven years. Nine participants cared for older adults with partial dependency, while six cared for older adults who required extensive assistance with activities of daily living. The older adults commonly experienced hypertension, diabetes mellitus, stroke-related disability, arthritis, or combinations of chronic conditions.

Table 1.
Characteristics of family caregivers (n=15)

Characteristics	Category	n	%
Age	27–39 years	4	26.7
	40–49 years	5	33.3
	50–59 years	4	26.7
	≥60 years	2	13.3
Sex	Male	4	26.7
	Female	11	73.3
Relationship to older adult	Child	7	46.7
	Spouse	4	26.7
	Daughter-in-law	3	20.0
	Grandchild	1	6.6

Duration of caregiving	1–3 years	5	33.3
	4–6 years	6	40.0
	>6 years	4	26.7
Older adult's dependency	Partially dependent	9	60.0
	Highly dependent	6	40.0

The thematic analysis generated five main themes: (1) caregiving as a moral and cultural responsibility; (2) families as the central coordinators of everyday care; (3) multidimensional challenges of caregiving; (4) adaptation, spirituality, and shared family support; and (5) the need for accessible and family-centred community nursing services.

Table 2.
Themes and subthemes emerging from family caregivers' experiences

Main themes	Subthemes
Caregiving as a moral and cultural responsibility	Filial obligation; reciprocity for parental care; preservation of family dignity
Families as coordinators of everyday care	Assistance with daily activities; medication and diet management; healthcare decision-making
Multidimensional challenges of caregiving	Physical fatigue; emotional strain; financial and geographical barriers; limited knowledge
Adaptation, spirituality, and shared support	Learning through experience; religious coping; division of family roles; support from neighbours
Need for family-centred community nursing	Regular home visits; practical caregiving education; accessible communication; continuity of care

Theme 1: Caregiving as a Moral and Cultural Responsibility

Participants viewed caring for older family members as more than a practical responsibility. Caregiving was understood as a moral obligation, an expression of gratitude, and a way of preserving family dignity. Participants believed that older adults should remain within the family environment rather than be separated from their relatives. Refusing to provide care was perceived as inconsistent with religious values and local expectations concerning respect for parents.

"When we were children, our parents cared for us without counting the cost. Now that they are old, it is our responsibility to look after them." (P3, daughter)

"As long as we are still able, we do not want our father to be cared for by someone outside the family. The family must remain the main place for him." (P8, son)

This sense of responsibility provided meaning and motivation. Nevertheless, it sometimes prevented caregivers from expressing fatigue or requesting help because they feared being considered ungrateful. Caregiving was therefore experienced simultaneously as a source of pride and an obligation that had to be fulfilled regardless of personal difficulties.

Theme 2: Families as the Central Coordinators of Everyday Care

Families performed multiple caregiving activities, ranging from assistance with bathing, dressing, eating, mobility, and toileting to medication administration and arranging health-service visits. Caregivers also modified meals for older adults with

hypertension or diabetes and monitored symptoms such as dizziness, weakness, joint pain, and changes in blood pressure.

"I prepare separate food for my mother because she has hypertension. We reduce salt, but sometimes she refuses because she says the food has no taste." (P5, daughter)

"I arrange the medicines according to the time they must be taken. If I do not remind him, he may take them twice or forget completely." (P11, wife)

Family members also became the principal decision-makers when the older adult's condition changed. They determined whether symptoms could be managed at home, required treatment at a community health centre, or necessitated hospital referral. These decisions were often based on previous experiences rather than professional guidance. Some families delayed seeking care because the older adult refused treatment, transportation was unavailable, or symptoms were considered part of normal ageing.

Theme 3: Multidimensional Challenges of Caregiving

Caregiving created physical, emotional, financial, and social challenges. Participants caring for older adults with mobility limitations experienced back pain, fatigue, and disrupted sleep. Emotional strain emerged when older adults became irritable, repeatedly refused medication, or required constant supervision.

"At night, I often wake up because she calls me or wants to go to the bathroom. In the morning, I still have to work, so sometimes my body feels completely exhausted." (P2, daughter-in-law)

"The most difficult thing is when he refuses his medicine. If I remind him too often, he becomes angry, but if I remain silent, I am afraid his condition will worsen." (P10, spouse)

Financial difficulties were associated with transportation, medication not covered by health insurance, special foods, and loss of working time. Rural geography also complicated access to healthcare services, particularly for families without private transportation. Participants reported limited knowledge of pressure-injury prevention, safe mobility assistance, medication side effects, emergency signs, and appropriate diets for chronic diseases.

"The health centre is not very far, but transporting an older person who cannot walk is difficult. We must find a vehicle and another person to help lift him." (P13, son)

The absence of systematic caregiving education caused families to learn through trial and error. Although they were highly committed, some participants remained uncertain about whether their caregiving practices were safe and appropriate.

Theme 4: Adaptation, Spirituality, and Shared Family Support

Families developed various strategies to manage caregiving demands. They adjusted daily routines, divided responsibilities among relatives, used medication schedules, and sought advice from healthcare workers or experienced neighbours. When siblings lived outside Buton, coordination was conducted through telephone calls and financial contributions.

"My sister works outside the region, so I provide the daily care, while she helps with treatment costs. We try to divide the responsibility according to our abilities." (P6, daughter)

Religious beliefs were an important source of emotional strength. Participants interpreted caregiving as worship, patience, and an opportunity to receive spiritual merit. Prayer helped them manage frustration and accept the gradual decline in the older adult's condition.

"Sometimes I feel tired and want to cry, but I remember that caring for a parent is also an act of worship. That thought gives me strength." (P14, daughter)

Neighbours and extended relatives occasionally provided transportation, stayed with the older adult when the primary caregiver was unavailable, or assisted during emergencies. However, this support was generally informal and inconsistent, leaving the primary caregiver with most daily responsibilities.

Theme 5: The Need for Accessible and Family-Centred Community Nursing Services

Participants appreciated services provided by community health centres and integrated health posts for older adults. However, they reported that services were often centred on examinations and medication, with limited attention to the family's caregiving skills and emotional needs. Families expected community nurses to conduct more regular home visits, particularly for older adults with mobility limitations.

"My mother cannot attend the older-person health post. We hope a nurse can occasionally visit the house, check her condition, and teach us what to do." (P1, son)

Participants requested practical education on safe mobilisation, bathing dependent older adults, medication management, nutritional preparation, prevention of falls and pressure injuries, and recognition of emergency signs. They also expressed the need for an accessible communication channel through which they could consult a nurse when the older adult's condition changed.

"We need more than medicine. We need someone to explain how to care for him at home and when we should immediately take him to the hospital." (P9, daughter-in-law)

Families emphasised that home visits should not only assess the older adult but also evaluate caregiver fatigue, family resources, the safety of the home environment, and the distribution of caregiving responsibilities. These expectations indicate a need to shift community nursing from episodic, disease-oriented services towards continuous, family-centred care.

Overall, the findings demonstrate that families were the primary foundation of older-adult care in Buton Regency. Caregiving was sustained by moral commitment, cultural values, spirituality, and family cooperation. However, families faced substantial physical, emotional, financial, informational, and accessibility challenges. Strengthening regular home visits, caregiver education, family assessment, referral coordination, and communication with community nurses is therefore essential to improve the safety and sustainability of community-based older-adult care.

DISCUSSION

This study demonstrates that family caregiving for older adults in Buton Regency is a complex process shaped by moral responsibility, cultural expectations, emotional attachment, family resources, and access to community healthcare services. Families were not merely companions but acted as the main providers and coordinators of care. They assisted older adults with activities of daily living, medication management, dietary modification, symptom monitoring, mobility, healthcare decisions, and access to health facilities. However, these responsibilities were frequently undertaken with limited knowledge, inconsistent professional support, and considerable physical, emotional, and financial demands. The findings reinforce the importance of recognising family caregivers as essential partners within community-based older-adult care (Guan et al., 2024).

The first theme showed that caregiving was perceived as a moral and cultural responsibility. Participants regarded caring for older parents as an expression of gratitude, family loyalty, religious devotion, and repayment for the care received during childhood. These values strengthened caregivers' commitment and helped sustain care despite difficult circumstances. This finding is consistent with the collectivist orientation of Indonesian communities, in which interdependence and filial responsibility influence decisions concerning older-adult care. Previous Indonesian research similarly found that families remained strongly involved in caring for older adults, although cultural expectations sometimes caused caregivers to accept demanding responsibilities without openly communicating their difficulties (Lin et al., 2024).

Cultural obligation may therefore function as both a protective resource and a hidden source of burden (Jewell et al., 2022). It encourages families to maintain older adults within familiar home and community environments, but it can also discourage caregivers from requesting support because doing so may be interpreted as an inability or unwillingness to fulfil family duties. Community nurses should recognise these cultural meanings when assessing families. Caregiver fatigue should not be interpreted as a lack of affection or commitment. Nurses need to create a nonjudgmental environment in which family members can discuss exhaustion, frustration, role conflict, and the need for assistance without feeling that they have failed morally (Luo et al., 2024).

The predominance of female caregivers also reflects the gendered organisation of family care. Wives, daughters, and daughters-in-law were commonly responsible for personal care, food preparation, medication supervision, and emotional support. Similar findings have been reported among Indonesian female family caregivers, who often combine caregiving with household responsibilities and employment, thereby increasing their workload (Krongthaeo et al., 2021). Although women may possess greater caregiving experience, concentrating responsibility on one person increases the risk of physical exhaustion, emotional strain, and social isolation. Family nursing interventions should encourage a more equitable distribution of tasks among spouses, sons, daughters, grandchildren, and extended family members (Garnett et al., 2022).

The second theme identified families as central coordinators of everyday care. Caregivers performed tasks that required substantial practical and clinical competence, including administering medication, preparing specialised diets, monitoring symptoms, preventing falls, assisting mobility, and deciding when professional treatment was necessary. These tasks become increasingly complex when an older adult has several chronic diseases or functional limitations. Families may need to balance conflicting dietary recommendations, manage multiple medicines, interpret changes in symptoms, and coordinate services across different healthcare facilities (Guilcher et al., 2021).

Despite their central role, participants often relied on experience, informal advice, or trial and error. This creates potential safety risks, including medication errors, delayed treatment, inappropriate dietary restrictions, falls, and pressure injuries. Evidence from studies of family caregivers similarly identifies medication management, transportation,

communication, limited knowledge, and financial pressure as common caregiving challenges (Cruz et al., 2024). Community nurses should consequently assess not only the older adult's health status but also the caregiver's knowledge, confidence, skills, and readiness to perform specific tasks (Shrestha et al., 2024).

The multidimensional challenges reported in the third theme demonstrate that caregiving affects caregivers' physical, psychological, social, and economic well-being. Participants experienced sleep disruption, fatigue, back pain, emotional tension, reduced working time, and financial pressure. Behavioural changes, medication refusal, and repeated requests for assistance created additional stress. A systematic review of family caregiver burden indicates that caregiving intensity, the older adult's dependency, behavioural symptoms, limited social support, and caregivers' own health conditions contribute to higher burden (Kuharic et al., 2024). These findings suggest that caregiver well-being is directly related to the sustainability and quality of home care.

Geographical and transportation barriers were particularly important in the Buton context. Families caring for older adults with mobility limitations faced difficulties arranging vehicles and obtaining assistance to transfer them safely. Consequently, some families delayed accessing professional services or managed symptoms at home (Riquelme-Marín et al., 2022). The findings provide a qualitative explanation for regional statistics indicating substantial self-medication and relatively limited outpatient care among older adults with health complaints. Home-based community nursing is therefore essential in areas where older adults cannot easily attend community health centres or integrated health posts (Hou & Chen, 2024).

The fourth theme concerned adaptation, spirituality, and shared support. Participants developed routines, divided caregiving responsibilities, sought assistance from relatives and neighbours, and used religious beliefs to manage emotional distress. Spirituality provided meaning, acceptance, patience, and motivation. Rather than viewing spiritual coping merely as passive acceptance, community nurses can recognise it as a culturally meaningful source of resilience. Collaboration with religious leaders and community groups may help strengthen emotional support while ensuring that spiritual practices complement appropriate healthcare.

Nevertheless, informal support was often irregular, and one primary caregiver continued to perform most daily tasks. Financial contributions from relatives living outside the region were helpful but could not replace direct assistance or respite. Families require structured discussions about the distribution of responsibilities. Community nurses can facilitate family meetings to clarify who will manage medication, transportation, finances, personal care, and emergency decisions. Such planning may reduce conflict and prevent excessive responsibility from falling on one caregiver (Miller et al., 2024).

The fifth theme highlighted families' expectations for accessible and family-centred community nursing services. Participants valued examinations and medication provided through primary healthcare programmes but required more practical education, regular home visits, and opportunities to consult nurses when conditions changed. This finding corresponds with qualitative evidence showing that effective interaction between family caregivers and community nurses can improve the quality of home care for dependent older adults (Rottenberg & Williams, 2021). Community nurses should treat caregivers as members of the care team rather than merely as individuals who implement professional instructions.

The findings are also consistent with the WHO Integrated Care for Older People framework, which recommends person-centred assessment and coordinated community-level interventions to prevent or slow declines in physical and mental capacity (Hwang & Kim, 2024). Applying this framework in Buton would require nurses to assess mobility, cognition, nutrition, sensory function, psychological well-being, chronic conditions, social support, caregiver capacity, and home safety. Individualised care plans should be jointly

developed with older adults and their families and reviewed through follow-up visits (Keim-Malpass et al., 2024).

Practical caregiver education should include medication organisation, chronic-disease monitoring, safe transfer techniques, fall prevention, pressure-injury prevention, personal hygiene, nutritional preparation, and recognition of emergency signs. Education should use simple language, demonstrations, return demonstrations, and written or visual materials appropriate to families' literacy levels (Holmberg et al., 2022). Telephone or messaging-based consultation could complement home visits, particularly for families living far from healthcare facilities, although digital access and confidentiality must be considered (Vick et al., 2024).

The study's novelty lies in demonstrating that care in Buton is shaped by the interaction of cultural obligation, family adaptation, rural accessibility, spirituality, and limited professional support. It extends previous research that has focused mainly on disease-specific caregiving or caregiver burden by presenting older-adult care as a relational family process connected to community nursing. The findings support a shift from episodic and disease-oriented services towards continuous, preventive, family-centred, and culturally responsive care.

Several limitations should be acknowledged. Participants were recruited purposively from selected community health centre areas, and their experiences may not represent all families in Buton or other regions. The findings were based on self-reported experiences and may have been influenced by recall or social-desirability bias, particularly because caregiving is culturally regarded as a family obligation. The study primarily included family caregivers and did not directly incorporate the perspectives of older adults, nurses, or policymakers. Future research should include these groups and evaluate family-centred home-visiting interventions. Despite these limitations, the study provides meaningful evidence for strengthening community nursing support for families caring for older adults at home

CONCLUSION

Families play a central role in supporting older adults' care in the community in Buton Regency. Caregiving is understood as a moral, cultural, and religious responsibility that reflects gratitude, family loyalty, and respect for older adults. Family caregivers perform various responsibilities, including assisting with activities of daily living, managing medication and nutrition, monitoring symptoms, supporting mobility, and making healthcare decisions. However, they also experience physical fatigue, emotional strain, financial pressure, limited caregiving knowledge, and difficulties accessing health services. Families cope through spirituality, experience-based learning, shared responsibilities, and assistance from relatives and neighbours, although support is often informal and inconsistent. Community nursing services should therefore adopt a family-centred and culturally responsive approach through regular home visits, comprehensive assessment of older adults and caregivers, practical caregiving education, accessible consultation, and improved referral coordination. Community health centres should also develop caregiver-support groups, family care plans, and community partnerships to distribute caregiving responsibilities and prevent caregiver exhaustion. Future studies should include the perspectives of older adults, community nurses, and policymakers and evaluate the effectiveness of home-based nursing interventions in improving caregiver competence, family well-being, and the quality of older-adult care.

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