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Participation beyond the Front Door: A Conceptual Framework for Community Nursing Responsibilities toward Social Connection and Meaningful Everyday Activity among Homebound Adults with Advanced Illness

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Abstract

To examine how community nursing responsibility should be understood when adults with advanced illness are largely confined to home yet continue to value social connection, ordinary roles, and meaningful everyday activity. Home-based palliative and community care can bring professional services into a person's residence without necessarily improving practical access to valued relationships or activities. Homebound status, symptom burden, mobility restrictions, unequal material resources, changing social networks, and service organization can narrow participation, while reduced activity may also reflect an informed patient preference. A clinically useful account therefore requires separation of service contact, objective isolation, subjective loneliness, and meaningful participation. Discursive, non-empirical conceptual paper developing a participation-oriented account of community nursing responsibility. Peer-reviewed community nursing, palliative-care, gerontology, social-connection, home-based-care, digital-care, and compassionate-community literature published from 2017 to 2024 was critically selected for relevance to patient agency, participation opportunities, homebound status, professional responsibility, feasibility, and implementation boundaries. The analysis treats meaningful participation as patient-defined and dependent on practical access. Community nursing responsibility can include noticing participation concerns, clarifying patient priorities, identifying modifiable access restrictions, facilitating acceptable routes to participation, and coordinating with families, professionals, and community resources. These responsibilities remain conditional on patient preference, safety, professional competence, available services, and the sustainability of nursing work. Extending patient-centred community nursing beyond symptom and functional assessment can include attention to meaningful participation, but the appropriate nursing task is to protect feasible opportunity rather than prescribe social involvement. The resulting framework preserves patient agency while defining limits to professional responsibility.

Keywords: Advanced illness, Community nursing, Homebound adults, Meaningful activity, Palliative care, Social participation

Introduction

Home-based care is often described as patient centred because it brings professional support into the place where many people with advanced illness prefer to remain. Yet the presence of services at home does not reveal whether a person can still reach valued relationships, social roles, familiar routines, or meaningful activities. Social connection has been associated with important experiences and outcomes near the end of life across different national contexts, making it clinically relevant to consider what remains accessible to people whose worlds have become increasingly centred on the home [1]. The conceptual problem for community nursing is therefore broader

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than whether contact occurs. It concerns whether professional care can recognize circumstances in which an individual wants participation but lacks a realistic means of achieving it.

The distinction matters because loneliness and social isolation describe related but non-identical phenomena. People living with terminal illness may experience loneliness as consequential yet difficult to acknowledge, discuss, or seek help for [2]. Longitudinal evidence also shows that objective isolation and subjective loneliness can become prominent during the final years of life [3]. Neither construct, however, establishes what kind of connection a particular person values. A patient may have frequent visitors and remain lonely, live with limited contact without experiencing loneliness, or value participation that is defined less by the number of encounters than by being able to continue a personally important role or ordinary activity. Community nurses therefore require a more discriminating conceptual language than "social need" alone.

Advanced illness also does not erase agency. Qualitative evidence concerning community involvement near the end of life shows considerable variation in how much engagement people and families seek, and reduced involvement can sometimes reflect preference, changed priorities, or a wish to protect limited energy [4]. Longitudinal work with adults living with advanced cancer similarly demonstrates active efforts to preserve, adapt, and renegotiate ordinary life despite progressive illness [5]. Meaningful participation should consequently be understood as something defined by the person and adjusted across an illness trajectory. The nursing question is not how to maximize social activity. It is when a participation opportunity that matters to the patient is being obstructed by a barrier that nursing practice can legitimately identify, reduce, coordinate around, or escalate.

This paper develops that question through a Participation-Oriented Community Nursing Framework. Its purpose is to distinguish practical access to participation from the mere availability of professional contact and to define a defensible boundary around nursing responsibility. The analysis focuses on adults with advanced illness who are substantially homebound and on community nursing relationships that occur within home-based or closely linked palliative-care systems. Participation is treated as a changing interaction among patient preference, physical and social access, family and community relationships, service organization, and professional capability. The framework therefore begins from a bounded premise: nursing may help protect opportunities for a patient-valued life, while the patient retains authority over whether, when, and how those opportunities are used.

Background

Homebound status alters the conditions under which participation is possible. National longitudinal evidence demonstrates an association between homebound status and social isolation, while also showing that these experiences are socially patterned and cannot be reduced to immobility alone [6]. Direct accounts from homebound older adults during periods of severe social restriction likewise reveal heterogeneous experiences, including loss of contact, dependence on narrower support networks, and adaptation through alternative forms of connection [7]. These findings support treating homebound status as an access condition rather than as evidence that a person is necessarily lonely or wants greater interaction.

Material circumstances further influence what can be done within the home. Lower income is associated with an increased likelihood of becoming homebound among older Medicare beneficiaries, indicating that practical access is partly structured by resources beyond the clinical encounter [8]. Once a person relies heavily on home-based support, communication among patients, families, paid caregivers, and healthcare professionals can also shape what is feasible. Qualitative evidence shows that family members frequently occupy an important coordinating position in communication between paid caregivers and the healthcare team [9]. For participation-oriented nursing, this relational structure is relevant because a desired activity may depend on transport, accompaniment, communication, symptom planning, digital assistance, or coordination with another person. The existence of a social network, however, does not establish that it is available, trusted, appropriate, or authorized to provide such support.

Palliative-care evidence provides a further reason to take participation seriously while retaining conceptual precision. A systematic synthesis of social and spiritual needs in the palliative phase demonstrates that social concerns are substantive components of patients' experiences and can interact with identity, relationships, meaning, and practical support [10]. At the same time, service receipt cannot be used as a proxy for participation. Home-based medical care reaches only a proportion of eligible or homebound older adults, and patterns of receipt reflect healthcare-system access as well as clinical need [11]. Even when home services are frequent, the patient may remain unable to reach a valued relationship or activity. Conversely, a person may achieve meaningful participation largely through family, neighbours, community groups, remote communication, or self-directed routines without extensive professional involvement.

The concept of practical access to participation therefore refers here to a person's realistic ability, under current illness and social conditions, to engage in a relationship, role, routine, or everyday activity that the person identifies as meaningful. It incorporates preference, physical capability, timing, available assistance, communication, material resources, and service constraints. It deliberately excludes the assumption that every reduction in activity is problematic. This distinction creates several recurrent participation-access states relevant to community nursing assessment and is summarized in **Table 1**.

Table 1. Participation-access states relevant to community nursing among homebound adults with advanced illness

Patient-defined participation state	What limits or enables practical access	What a home-care encounter may legitimately clarify	Potential nursing response within scope	Boundary preventing overreach
Valued participation is desired but physically difficult to reach	Mobility limitation, fatigue, symptom fluctuation, inaccessible transport or need for accompaniment	Whether the activity still matters, when it is feasible, and which barrier is potentially modifiable	Coordinate symptom timing, mobility support, referral, transport information, or interprofessional assistance when available	Do not promise access that services cannot provide or encourage activity that conflicts with clinical safety
Social contact exists, yet the patient reports little meaningful connection	Mismatch between available contact and relationships or activities the patient values	Meaning of existing contact and whether additional or different participation is wanted	Explore acceptable alternatives and connect the patient with appropriate resources where feasible	Do not infer loneliness from network size or prescribe more contact as an automatic solution
Participation depends on family, caregivers, neighbours, or other informal relationships	Availability, willingness, trust, communication, caregiver burden and patient permission	Which relationships the patient wants involved and what support can reasonably be requested	Facilitate communication and coordinate agreed roles	Do not transfer professional obligations to unpaid networks or bypass patient consent
Remote or digital participation is potentially useful	Device access, digital literacy, sensory or cognitive capability, connectivity, privacy and personal preference	Whether remote participation is acceptable and meaningful for this patient	Support access, education, referral, or technical assistance when these fall within available services	Do not treat digital contact as equivalent to in-person connection or assume technology is inherently beneficial
Participation priorities fluctuate with illness trajectory	Symptoms, treatment burden, energy, prognosis awareness, mood, environmental demands and changing goals	Current priority and whether a previously valued activity remains meaningful	Reassess rather than carry forward earlier assumptions; coordinate around periods of greater capability where appropriate	Do not establish a static participation target
Reduced participation is intentional	Preference for solitude, conserving energy, privacy, cultural expectations, safety concerns or changed priorities	Whether reduced participation reflects informed preference rather than an unwanted access restriction	Respect the decision while keeping future reassessment available	Do not pathologize chosen solitude or make social engagement a condition of "good" self-care

Note: The table combines evidence-supported distinctions with original conceptual synthesis. It is not a screening instrument, validated assessment tool, or prescriptive intervention protocol. Terms such as "desired," "meaningful," and "acceptable" refer to the patient's current appraisal rather than professional judgement.

Data sources

This discursive analysis draws on deliberately selected scholarship rather than a systematic-review corpus. The evidence problem spans several literatures that use different units of analysis: social-network studies examine relationships, gerontological research examines isolation and homebound status, palliative-care studies address needs and preferences, and community-nursing studies examine the work through which care is delivered. Evidence from these areas was therefore used according to the specific claim it could support, with indirect evidence retained only when its transfer to the present conceptual question was explicit.

Social-network research illustrates why counting contacts is insufficient. Mapping support networks in home palliative contexts shows that people differ substantially in the composition, accessibility, and perceived usefulness of relationships surrounding care [12]. Although such network work includes populations outside the exact adult population addressed here, it provides a methodological warning against treating "having support" as a unitary state. Evidence concerning virtual home-based palliative care makes a related distinction. Patients, caregivers, and professionals have described benefits associated with remote access as well as limitations affecting communication, relationship quality, technology use, and suitability for particular encounters [13]. Remote

contact is consequently relevant as one possible means of participation, not as evidence that participation has occurred.

Studies of care transitions were also included because participation is affected by continuity across settings and services. Patients with advanced illness and family caregivers report that transitions can alter relationships with professionals and create discontinuities that influence how supported they feel [14]. Such evidence informs the conditions under which community nurses may coordinate participation-related needs, although it does not directly measure social participation. Preference research provides a second important boundary. In prospective palliative-care cohorts, older adults' preferences vary and are not always realized because personal, clinical, family, and service conditions intervene [15]. This supports a central premise of the present framework: identifying what a person values is necessary, but the feasibility of achieving that preference must be evaluated separately.

The evidence base was therefore interpreted through three questions. First, what does a source directly establish about patients, social relationships, homebound status, community nursing, or participation? Second, what can reasonably be transferred to homebound adults with advanced illness? Third, where does the present article move from reported evidence to conceptual synthesis? This separation is particularly important because the proposed nursing responsibilities have not been tested as a single intervention. The literature can support relationships among patient preference, practical access, professional practice, community resources, and changing illness conditions; it cannot establish that the integrated framework improves clinical or social outcomes.

Taken together, these sources support a multilevel representation in which patient-defined meaning, practical access conditions, nursing action, and shared social resources remain analytically distinct while interacting over time **(Figure 1)**.

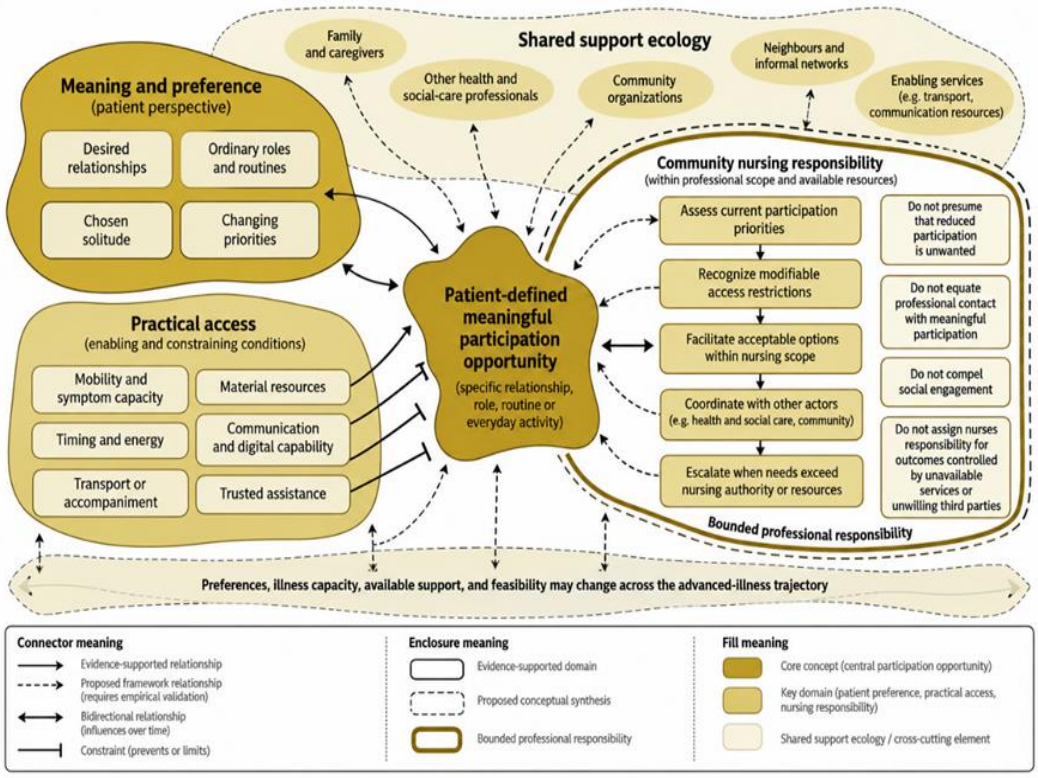


Figure 1. Participation access as a bounded, preference-sensitive field of community nursing responsibility in advanced illness

Overview of the issues

When home visits become task-complete but participation-incomplete

Community nurses operate in environments where immediate clinical tasks can legitimately dominate attention. Symptom assessment, medicines, wound care, monitoring, safety concerns, caregiver support, and coordination may all be time sensitive. Qualitative work with district nurses nevertheless shows that the organization of palliative nursing work affects what nurses can notice and how relational care is enacted [16]. Community nurses providing home-based hospice and palliative care have also described barriers related to knowledge, workforce arrangements, resources, service organization, and interprofessional support [17]. These constraints make it

inappropriate to frame participation primarily as a matter of individual nurse motivation. A nurse may identify that a patient has lost access to a meaningful activity yet have no available transport service, social-care capacity, community resource, or time within the encounter to resolve the restriction.

Task-focused practice becomes conceptually important when completion of necessary care is mistaken for completion of the patient's relevant needs. A clinically successful home visit may stabilize symptoms while leaving a patient unable to speak privately with a distant family member, resume a small domestic role, reach a garden, participate in a faith community, receive a trusted visitor, or continue another personally meaningful routine. Participation-oriented nursing does not require every visit to address these issues. It requires the possibility that they can become legitimate nursing concerns when the patient values them, when an identifiable barrier exists, and when nursing assessment or coordination can alter practical access.

Responsibility is distributed across professional and social systems

Many participation barriers cannot be addressed by a nurse acting alone. Home-based palliative care depends on coordination among nurses, physicians, other professionals, families, caregivers, and community resources. Studies of home-care nurses and general practitioners demonstrate that effective palliative work is shaped by communication and collaboration across professional boundaries [18]. Rural evidence further shows that geography, workforce availability, and local relationships can substantially affect how such collaboration functions [19]. A participation-oriented approach therefore needs to distinguish nursing responsibility to respond from nursing responsibility to personally provide every element required for participation.

This distinction has practical consequences. A nurse who learns that a patient wants to resume contact with a community group may have a role in assessing whether symptoms or treatment timing are relevant, communicating with another service, identifying an available referral route, or helping the patient articulate what support would make participation feasible. The nurse does not thereby acquire responsibility for transportation, companionship, digital infrastructure, family availability, or the conduct of a community organization. Where no feasible support exists, acknowledging and escalating an unmet need may be the appropriate professional response. Defining responsibility this way prevents patient-centredness from becoming an expectation that individual nurses compensate indefinitely for gaps elsewhere in the care system.

Connection technologies extend options but do not settle the participation question

Remote care illustrates the difference between an access mechanism and the outcome the patient values. Longitudinal qualitative evidence from patients using remote home-care technology shows that such systems can improve aspects of accessibility, reassurance, and communication while also introducing limitations linked to usability, preferences, and the nature of the interaction [20]. The relevant question is therefore not whether technology is available, but whether it enables a form of connection or activity that the patient finds meaningful and can practically use.

The temporal dimension is equally important. Longitudinal evidence among older adults shows that deterioration in social support can be associated with the onset of loneliness [21]. Yet support relationships and preferences can change rapidly during advanced illness. A person may seek frequent connection during one period, conserve energy during another, and later value a narrower but more personally significant form of participation. Assessment cannot therefore be a one-time classification. It is a continuing judgement about current preference, capability, opportunity, and the acceptability of available means.

These issues establish the problem that the framework must solve. Community nursing encounters occur at a clinically useful vantage point from which unwanted participation restrictions may become visible, but visibility does not confer unlimited responsibility. Any defensible model must distinguish the patient's own participation goal, the specific restriction on access, the actions that fall within nursing competence, the contributions expected from other actors, and the circumstances in which facilitation should stop because participation is unwanted, unsafe, infeasible, or dependent on resources beyond nursing control. The resulting distribution of community support responsibilities is organized in **Table 2** before the framework's conceptual relationships are specified.

Table 2. Boundaries of community nursing responsibility when participation is restricted at home

Participation-related situation	Patient-defined question that precedes action	Legitimate community nursing responsibility	Responsibility requiring other actors or resources	Condition that limits or stops nursing action
A valued relationship or activity has become difficult to reach	Does the patient still want this participation, and what currently obstructs it?	Clarify the goal, identify potentially modifiable clinical or practical barriers, and coordinate feasible support	Transport, social-care provision, community access, family availability, environmental modification	Patient declines assistance, the activity is unsafe, or no feasible resource exists

Existing social contact does not feel meaningful	What kind of connection, role, or activity matters to the patient now?	Explore the mismatch between available contact and patient-valued participation; identify acceptable alternatives	Participation by family, friends, peer groups, faith communities, voluntary organizations, or other networks	The patient prefers current contact patterns or does not wish professional involvement
Informal support is necessary for participation	Whom does the patient want involved, and what can those people reasonably provide?	Obtain permission, facilitate communication, clarify practical needs, and avoid unnecessary duplication	Voluntary assistance from family, caregivers, neighbours, or community groups	Informal support is unavailable, unwilling, inappropriate, burdensome, or contrary to patient preference
Another professional or service controls an important access condition	Is the participation barrier related to symptoms, mobility, equipment, social care, communication, or another need outside nursing authority?	Recognize the dependency, make or facilitate an appropriate referral, communicate the patient's priority, and follow up where nursing continuity permits	Medical, rehabilitation, social-care, transport, welfare, psychological, spiritual, or other specialist services	Required service is unavailable, outside eligibility criteria, or unable to provide the requested support
Technology could expand access	Does the patient want remote participation and have the capability and resources to use it?	Assess acceptability and practical barriers; facilitate support or referral where available	Connectivity, equipment, technical assistance, accessible platforms, or assistance from trusted others	Technology creates burden, excludes the patient, compromises privacy, or does not enable the kind of participation valued
Reduced participation is chosen	Is the apparent restriction experienced by the patient as a problem?	Confirm preference, remain attentive to change, and avoid pathologizing solitude or reduced activity	Usually none unless the patient later requests support	Informed patient preference itself limits intervention

Note: Responsibility in this table describes a conceptual scope for recognition, facilitation, coordination, and protection of participation opportunity. It does not assign nurses responsibility for producing a particular social outcome or overcoming structural deficiencies that lie outside available authority and resources.

Conceptual findings

The synthesis indicates that participation-oriented community nursing begins before any attempt to increase social activity. Its first requirement is to establish whether the patient identifies a meaningful relationship, role, routine, or activity that is currently wanted. Older adults living alone have described markedly different priorities when balancing protection, social contact, independence, and other needs, with priorities changing as circumstances change [22]. The relevant nursing object is therefore not low participation itself. It is an unwanted restriction on access to something the patient currently values.

This distinction establishes the first component of the Participation-Oriented Community Nursing Framework: assessing participation in relation to preference. A question about whether someone is socially isolated cannot by itself reveal whether intervention is appropriate. Assessment must connect the observable condition to the patient's own interpretation. A small social network, infrequent outings, or reduced activity can indicate vulnerability, but it can also reflect adaptation, energy conservation, privacy, changing priorities, or chosen solitude. Participation-oriented assessment asks what the person would like to be able to do, whether current circumstances prevent it, and whether the patient wants professional help with that restriction.

The second component is identifying practical access conditions. Once a valued participation opportunity is established, the relevant question becomes what makes it possible or impossible. The barrier may be clinical, such as poorly timed symptom control or limited mobility; material, such as lack of transport or equipment; relational, such as dependence on an unavailable caregiver; environmental, such as inaccessible community space; or technological. Research among older adults in low-income housing illustrates that information and communication technologies can help maintain connection while their usefulness remains dependent on access, skills, confidence, and personal preference [23]. A participation-oriented approach therefore evaluates the means through which a goal might be reached without treating any particular modality as intrinsically desirable.

The third component is facilitation within nursing scope. Facilitation may be modest. It can consist of recognizing that symptom timing prevents a valued activity, helping the patient articulate a participation priority during interdisciplinary planning, arranging an appropriate referral, identifying an available community resource, or

adapting the timing of a home-care activity where service arrangements permit. What makes these actions participation-oriented is not their technical form but their connection to a patient-defined goal. Facilitation remains distinct from promising that participation will occur.

The fourth component is shared responsibility. Social participation extends beyond healthcare, and evidence from compassionate-community initiatives shows that end-of-life support can involve social networks, community organizations, volunteers, civic resources, and other actors alongside formal care services [24]. Implementation varies substantially, however, and communities differ in infrastructure, resources, relationships, and readiness. Reviews of compassionate-community practice demonstrate considerable diversity in how such initiatives are organized and evaluated [25]. Community capacity can therefore widen the range of feasible participation options without becoming an assumed resource available to every patient.

Shared responsibility also protects against two opposite errors. The first is professional withdrawal: defining social participation as wholly outside nursing because nurses cannot personally provide friendship, transport, or community life. The second is professional overextension: treating recognition of a participation problem as an obligation for the nurse to solve every condition necessary for its resolution. The framework positions community nurses between these extremes. Where participation matters to the patient and a barrier is visible within care, nurses have a defensible responsibility to consider whether they can assess, facilitate, coordinate, or escalate. Responsibility for the ultimate outcome remains distributed among the patient, informal networks, other services, community resources, and structural conditions.

A fifth component is therefore protecting participation without prescribing it. Protection means avoiding preventable care-related restrictions where possible, making patient priorities visible during coordination, revisiting opportunities as illness changes, and resisting the assumption that task completion is sufficient evidence of patient-centred home care. Protection does not mean maximizing activity. The patient retains the authority to reject assistance, reduce contact, discontinue an activity, conserve energy, or change what counts as meaningful.

The framework is consequently conditional rather than sequential. Assessment, access, facilitation, coordination, and protection are not stages through which every patient progresses. A patient may move repeatedly among them as symptoms, preferences, social relationships, and resources change. Sometimes assessment will establish that no intervention is wanted. Sometimes a small practical adjustment may restore access. In other circumstances, the nurse may identify a legitimate unmet need but have no available mechanism to resolve it. Recognizing that limit is part of the framework rather than evidence that the framework has failed.

Results and Discussion

The central contribution of this analysis is to place meaningful participation within community nursing without converting it into either a compulsory clinical outcome or an unlimited professional duty. Relational community palliative nursing already includes practices through which nurses protect comfort, normality, and patient-defined priorities in the home. Detailed observational work has shown how such nursing is enacted through attentive, flexible, relational practice rather than through technical tasks alone [26]. The framework developed here extends that reasoning specifically to participation: when a patient values a relationship or ordinary activity, practical access to it can become relevant to nursing assessment even when the final means of participation lies outside nursing.

This proposal has important limits. Community nurses work within staffing, time, eligibility, transport, social-care, and organizational constraints. Ethnographic research on planned home deaths shows that nurses can respond to system fragility by repeatedly "going above and beyond," sometimes carrying responsibilities that exceed sustainable professional arrangements [27]. A participation-oriented framework should not normalize that pattern. Identifying a barrier creates a responsibility to respond appropriately, which may involve coordination, referral, documentation, escalation, or acknowledgement that no feasible resource exists. It does not create an obligation to replace absent services with unpaid professional labour.

The same boundary applies to families and informal networks. Family involvement may make participation feasible, but availability must not be mistaken for obligation. A patient may not want relatives involved, relatives may already carry substantial caregiving responsibilities, and relationships can contain conflict or unequal power. Community resources likewise differ across neighbourhoods and health systems. Consequently, the framework cannot assume a uniformly available "community" waiting to receive professional referrals. Equity requires attention to whether the opportunities theoretically offered by the framework can actually be reached by people with low income, limited digital capability, rural residence, language barriers, inaccessible housing, weak informal networks, or restricted local services.

Temporality further challenges static approaches. Long-term longitudinal evidence indicates reciprocal relationships among frailty, social isolation, and loneliness rather than a single simple causal pathway [28]. Advanced illness is likely to intensify this dynamism because functional capacity, symptom burden, social networks, treatment demands, and preferences may change over much shorter periods. A participation goal that was important last month may be exhausting today; an activity previously abandoned may become meaningful

again after symptom improvement. Community nurses therefore need permission conceptually to reassess rather than preserve an earlier plan merely because it was once patient centred.

These qualifications also define the empirical status of the proposed framework. Its elements are grounded in relevant nursing, palliative-care, gerontological, home-care, and community evidence, but the integrated responsibility structure is a conceptual synthesis. It has not been validated as an assessment instrument or tested as an intervention. Future research should therefore examine whether patients and caregivers recognize the proposed distinctions as meaningful; how nurses identify participation priorities in routine encounters; which barriers are realistically modifiable; how responsibilities are negotiated across professions and community organizations; and whether participation-oriented practices create unintended burden or inequity.

Measurement will require similar caution. Counts of contacts, frequency of visits, network size, or digital engagement should not automatically be treated as participation outcomes. Empirical evaluation should distinguish whether a desired opportunity existed, whether the patient could access it, whether nursing action altered the relevant barrier, whether the patient experienced the resulting participation as meaningful, and whether the action was acceptable and sustainable. Those questions would test the conceptual relationships without assuming in advance that greater activity is inherently beneficial.

Implementation and equity implications arising from these boundaries are summarized in **Table 3**.

Table 3. Implementation and equity conditions for participation-oriented community nursing

Implementation condition	Risk if ignored	Participation-oriented response	Equity or feasibility safeguard	Empirical question remaining
Time and workload capacity	Participation concerns become invisible or nurses compensate through unsustainable extra work	Incorporate concise preference and access questions into existing clinical conversations when relevant	Do not make individual nurses responsible for correcting system-wide resource shortages	Can participation-oriented assessment be integrated without increasing unsafe workload?
Interprofessional role clarity	Needs are duplicated, deferred, or assumed to belong to somebody else	Identify which barrier falls within nursing scope and which requires referral or shared action	Define escalation routes appropriate to local services	Which responsibility arrangements produce acceptable continuity for patients?
Material and geographic access	The framework benefits patients only where transport, services, or community resources are already abundant	Document practical access conditions as part of feasibility	Avoid presenting unavailable services as realistic options	How strongly do geography and service availability alter framework feasibility?
Digital capability and access	Remote options reproduce exclusion or are mistaken for meaningful connection	Offer digital participation only when acceptable, usable, and relevant	Assess device access, connectivity, literacy, sensory needs, privacy, and assistance	For whom do remote options increase patient-defined participation?
Family and informal-network availability	Responsibility is transferred to unpaid or unwilling caregivers	Involve informal networks only with patient agreement and realistic expectations	Consider caregiver willingness, burden, relationship quality, and alternatives	How should shared responsibility be negotiated without creating caregiver burden?
Changing illness trajectory	Earlier participation goals become outdated or burdensome	Reassess preference and feasibility as condition changes	Permit withdrawal, adaptation, or reduced participation without labelling it failure	What reassessment timing is acceptable and useful to patients?
Cultural and personal meanings of participation	Professional assumptions define what "good" participation should look like	Ask what relationships and activities matter to the individual	Avoid standardized social-activity targets	How do cultural and personal meanings change acceptable nursing responses?
Evidence and evaluation	A conceptual proposal is treated as a validated intervention	Use the framework initially for inquiry and research rather than outcome guarantees	Distinguish process feasibility from demonstrated patient benefit	Does participation-oriented practice improve patient-defined outcomes, and under what conditions?

Conclusion

Home-based professional care can cross a patient's front door without restoring access to the relationships, routines, roles, and everyday activities that make life meaningful. Community nursing can appropriately extend beyond symptom and functional assessment when an adult with advanced illness identifies a valued participation opportunity that is being restricted by a potentially addressable barrier.

The appropriate responsibility is bounded. Nurses can notice, clarify, facilitate, coordinate, and help protect feasible participation opportunities, but they should neither prescribe social engagement nor assume ownership of a patient's social life. Patient preference, changing illness capacity, safety, available resources, informal-network willingness, and the responsibilities of other services determine what action is appropriate.

Participation-oriented community nursing therefore reframes patient-centred home care from the simple presence of services toward attention to whether the person can still reach what matters to them. Its value now requires empirical testing that preserves this central principle: meaningful participation is defined by the patient, and professional responsibility concerns feasible access rather than compulsory activity.

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