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CONCEPT

A concept analysis of transitional care for people with cancer

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Abstract

Aim: Transitional care as the journey between different caregivers in multiple healthcare centres is crucial for the provision of care to people with cancer, but it is often complex and poorly coordinated. This study aimed to analyse the concept of transitional care for people with cancer.

Design: Rodgers' evolutionary concept analysis.

Methods: A systematic literature search was conducted on the databases of PubMed (including MEDLINE), EMBASE, Scopus and Web of Science to retrieve articles published between 2000 and 2022.

Results: Twenty-nine eligible articles were selected and their findings were classified in terms of related concepts and alternative terms, antecedents, attributes and consequences. Attributes included three main categories, namely 'nurse-related attributes', 'organisation-related attributes' and 'patient-related attributes'. Antecedents of transitional care for people with cancer were categorized into two main categories: 'patient-related antecedents' and 'caregiver-related antecedents'. Consequences were categorized into 'psychological consequences' and 'objective consequences'.

KEYWORDS
cancer, care, concept analysis, nurse, transitional care

1 | INTRODUCTION

The global incidence of cancer is expected to increase by 68% and its prevalence will reach 23.6 million per year by 2030 (WHO, 2014). Cancer as a very complicated disease is characterized by various clinical attributes and different stages of treatment. The advent of new therapies has significantly improved the survival rate of people with cancer (Allemani et al., 2018). Therefore, continuity of cancer care has become a priority in healthcare (King et al., 2009). Lack of sufficient hospital beds and staff shortages especially nurses have

changed the model of caring for people with cancer from long-term hospitalization to an early discharge. Therefore, transitional care is an emerging concept in the care of people with chronic diseases including cancer (Thomson et al., 2015).

Transition of care is a critical point in healthcare and any mistake in this period can lead to the discontinuation of care (Schoen et al., 2008). To break the patterns of the frequent use of healthcare services by people with chronic diseases and its negative consequences on the quality of care and healthcare costs, innovative solutions are required that improve the integrity and continuity of care. Overall, these solutions are referred to as 'transitional care' (Naylor et al., 2011).

Transitional care is a wide range of services to ensure the continuity of care and prevent poor consequences among at-risk populations (Naylor & Keating, 2008). It reduces the readmission rate, improves negative consequences after hospitalization, decreases healthcare costs, ensures care continuity and benefits patients, caregivers and the healthcare system (Hendricks et al., 2011). Transitional care is complementary to primary care, care coordination, discharge planning, disease management and case management. However, there are many differences between them in the purpose, target clients, healthcare delivery environment and time of healthcare delivery (Naylor et al., 2011). Prominent attributes of transitional care are focus on chronic or acute illness during important transitions in healthcare, limited nature of services, emphasis on educating patients and family caregivers to address the root causes of poor consequences and prevent rehospitalization (Naylor et al., 2011, 2017; Naylor & Keating, 2008).

Transitional care is initially used as a multidisciplinary model to empower parents with low-birthweight infants who were discharged early and received part of hospital care in their own homes (Meleis, 2010). It was gradually incorporated into the care process for other vulnerable groups such as older adults with multiple chronic conditions, people with deficits in the basic activities of daily living, people with dementia or cognitive impairment and those who were frequently hospitalized (Hirschman et al., 2015). Innovative models of transitional care with the key role of nurses have enhanced the quality and safety of care. They also have improved the experiences and consequences of patient and family caregivers and reduced healthcare costs for chronic diseases (Naylor et al., 2018).

According to a concept analysis by Shahsavari et al. (2019), transitional care is not limited to patient care by nurses at discharge. Therefore, its proper implementation requires taking into account many factors including the situation of patients and their families, participation of different healthcare team members and environmental and social conditions and facilities. However, this study examined transitional care for different populations such as older adults; people with myocardial infarction, stroke and mental disorders; and not specifically people with cancer (Shahsavari et al., 2019). Furthermore, another concept analysis of transitional care identified some aspects at the macro-system level of healthcare (Caramanica et al., 2019). Cancer care is complicated, fragmented and poorly coordinated because patients often move between different healthcare centres in several geographical areas. In recent years, transitional care has been highlighted for the improvement of cancer care outcomes and reduction in healthcare costs (Chhatre et al., 2021). However, the concept of transitional care for cancer care has not yet been studied. Moreover, terms and concepts such as 'care coordination', 'continuity of care', 'discharge planning', 'follow-up plan' and 'survivorship care plan' are used interchangeably in the international literature (Agostinelli et al., 2022; Brennan et al., 2014; Jin et al., 2016; Wood, 2018). Therefore, this study aimed to analyse the concept of transitional care for people with cancer to help with the future development of transitional care in the field of cancer nursing by exploring the antecedents, features and consequences of the concept.

2 | METHODS

Concept analysis is the process of examining the main elements of a concept and is a method for clarifying the concept's meaning for various purposes (Walker & Avant, 2005). In nursing science, concept analysis is an essential prerequisite for meaningful research (Tofthagen & Fagerstrøm, 2010). There are various methods for analysing a concept. Rogers's evolutionary approach was used in this study to analyse the concept of transitional care for people with cancer. The process of concept analysis based on Rodgers' evolutionary method includes defining the concept and related terms; determining the appropriate scope for data collection, data collection and selection of texts; analysing data to describe related concepts; determining antecedents and consequences; interpreting the results; and determining assumptions and implications in order to get closer to the concept and reduce semantic ambiguity. The inductive and detailed analysis approach was used with a focus on the collection and analysis of raw data and concepts in a specific social and cultural context (Rodgers, 2000a, 2000b).

2.1 | Database

Four online databases of PubMed (including MEDLINE), EMBASE, Scopus and Web of Science were searched systematically to retrieve relevant articles. In addition, the bibliographic cross-references were searched to improve search coverage. The following predetermined keywords were used:

(('transitional care' OR 'transition of care' OR 'care transition' OR 'healthcare transition' OR 'continuity of patient care' OR 'discharge planning') AND (cancer OR neoplasm OR tumour OR malignanc*)).

Also, analysing the review results after the search led to identification of relevant concepts to transitional care as follows: 'discharge planning', 'survivorship care plan', 'follow-up care', 'follow-up plan', 'continuity of care' and 'care coordination', which were also included in the selection of articles for data analysis.

2.2 | Study selection

Inclusion criteria were studies about transitional care for people with cancer, in the field of nursing, published in English and peer-reviewed journals from 2000 to 2022 as in this period more attention was paid to this concept in the international literature. Exclusion criteria were non-relevant studies about transitional care in people with cancer. The review process such as selecting relevant studies was conducted by two authors independently (AM and MM) and the EndNote software was used for data management. After the search, all retrieved titles were screened and the abstracts of selected studies were scrutinized. The full texts of relevant studies were read carefully and some studies were included in the concept analysis. Discussions were held with a third author (MA or MV) to reach a consensus where there was a disagreement about the studies' inclusion in the concept analysis.

2.3 | Data analysis process

In Rogers' concept analysis method, content analysis is suggested to be used as an analysis method. Therefore, selected studies were analysed using a content analysis approach (Rodgers & Knafl, 1999). This method is helpful for the description and interpretation of textual data through the systematic process of data coding (Vaismoradi & Snelgrove, 2019). The retrieved studies were read to gain an initial understanding of the nature of the concept. Appropriate points and items regarding attributes, antecedents, consequence, contextual basis, related concepts and alternative words were extracted. In each section, data were read several times so that the researcher could extract key points and labels to give clear descriptions of each aspect of the concept. Finally, an inductive analysis of the concept was performed and themes were identified (Vaismoradi et al., 2013; Vaismoradi & Snelgrove, 2019).

To ensure the credibility of components in the concept analysis, two authors (AM and MA) conducted independent assessments and analyses of relevant studies as part of the concept analysis. The authors discussed online to share results and decide on the next steps of concept analysis. Disagreements were resolved through holding discussions with a third author (MM or MV) and consensus was achieved.

3 | RESULTS

The search process led to the retrieval of 4852 studies. Their titles were screened and 409 studies were selected. Reading their abstracts led to the retrieval of 77 studies. Full-text reading led to the selection of 29 studies, which encompassed multi-types of cancer (Aamodt et al., 2013; Ang et al., 2016; Aubin et al., 2012; Bilodeau et al., 2015; Carrillo et al., 2018; Cox & Wilson, 2003; Franco et al., 2016; Houlihan, 2009; Howell et al., 2012; Jahn et al., 2014; Leach et al., 2017; Lewis et al., 2009; Montero et al., 2016; Shimada et al., 2017; Tuggey & Lewin, 2014), colorectal (Bauer et al., 2015; Cusack & Taylor, 2010; Goldenberg et al., 2020; Lithner et al., 2015; Young et al., 2013), breast (Beaver et al., 2010; Chao et al., 2020; Kvale et al., 2016; Singh-Carlson et al., 2018), lung (Kyte et al., 2019; Moore et al., 2006), breast and lymphoma (Brant et al., 2016), breast and colorectal (Easley et al., 2016) and blood cancer (Thomson et al., 2015). The study flow diagram according to the preferred reporting items for systematic reviews and meta-analyses (PRISMA) is shown in Figure 1. An example of reasons for the exclusion of studies from the concept analysis is presented in Table S1.

The extracted relevant data were presented separately as attributes, antecedents and consequences. Attributes were categorized into three main categories: 'nurse-related attributes', 'patient-related attributes' and 'organisation-related attributes'. Antecedents included two main categories: 'patient-related antecedents' and 'caregiver-related antecedents'. Consequences were categorized into two main categories: 'psychological consequences' and 'objective consequences'. Related and alternative terms were introduced and the antecedents, attributes and consequences of the concept were discussed. A summary of antecedents, attributes and consequences associated with the concept of transitional care for people with cancer is shown in Figure 2.

3.1 | Related concepts and alternative words

Related concepts represented the part of the relationships and dependencies of the main concept, but they did not have all attributes of the concept (Rodgers & Knafl, 1999). The most related words to the concept were 'discharge planning', 'survivorship care plan', 'follow-up care', 'follow-up plan', 'continuity of care' and 'care coordination' in the care of people with cancer.

Alternative words represented the expression of a concept using words and expressions other than the concept chosen for the study (Rodgers & Knafl, 1999). Transitional care for people with cancer could be replaced by the following terms: 'transitional care', 'transition of care', 'care transition' and 'health care transition' (Chao et al., 2020; Howell et al., 2012; Lithner et al., 2015; Shahsavari et al., 2019).

3.2 | Attributes

They were elements that helped identify the study concept (Rodgers & Knafl, 1999). Attributes included three main categories: 'nurse-related attributes', 'patient-related attributes' and 'organisation-related attributes'.

3.2.1 | Nurse-related attributes

This category included general, specialized, educational and practical attributes. General attributes were communication skills, availability and active listening (Beaver et al., 2010; Kvale et al., 2016).

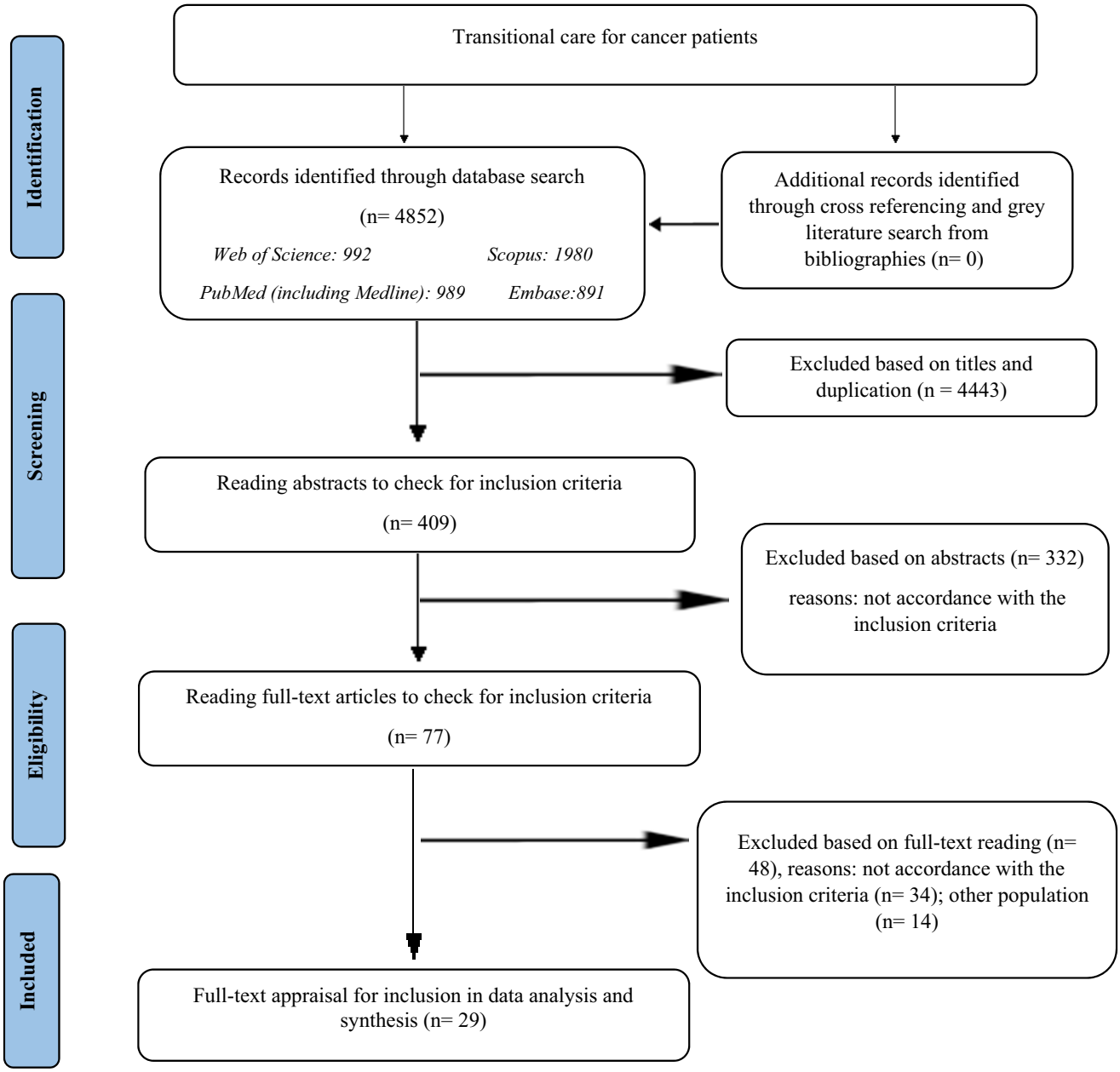

FIGURE 1 The preferred reporting items for systematic reviews and meta-analyses (PRISMA) for the present study.

Specialized attributes were specialized visits by the oncology nurse at home and the time of hospitalization (Ang et al., 2016; Aubin et al., 2012), communication between the oncologist nurse and hospital nurse (Carrillo et al., 2018), dedicated nurses leading to transitional care and scheduling visits. Developing an individual care plan and reviewing it by the team, provision of treatment summary in terms of test schedule visits and reporting important signs to the healthcare team, identification of complications and symptoms, treatment and management of them and also the visit after surgery were other aspects of specialized attributes (Brant et al., 2016; Franco et al., 2016; Houlihan, 2009; Jahn et al., 2014; Montero et al., 2016; Moore et al., 2006; Shimada et al., 2017).

Educational attributes included provision of simple verbal and written information at the appropriate time, encouragement and education about active self-care, adherence to the therapeutic regimen, physical–psychological–sexual advice and communication compatible with the patient's culture and needs. Other aspects of educational attributes were training about the identification of symptoms and how to manage them, conducting educational–psychological interventions, holding support sessions, training about lifestyle modifications and training health caregivers (Aamodt et al., 2013; Ang et al., 2016; Carrillo et al., 2018; Chao et al., 2020; Easley et al., 2016; Franco et al., 2016; Goldenberg et al., 2020; Montero et al., 2016; Thomson et al., 2015).

For practical attributes, completing the case file, finding clues to health objectives and interventions to implement them, phone follow-up after discharge, written planning and coordination of care plan due to the patient's specific needs were mentioned. Other

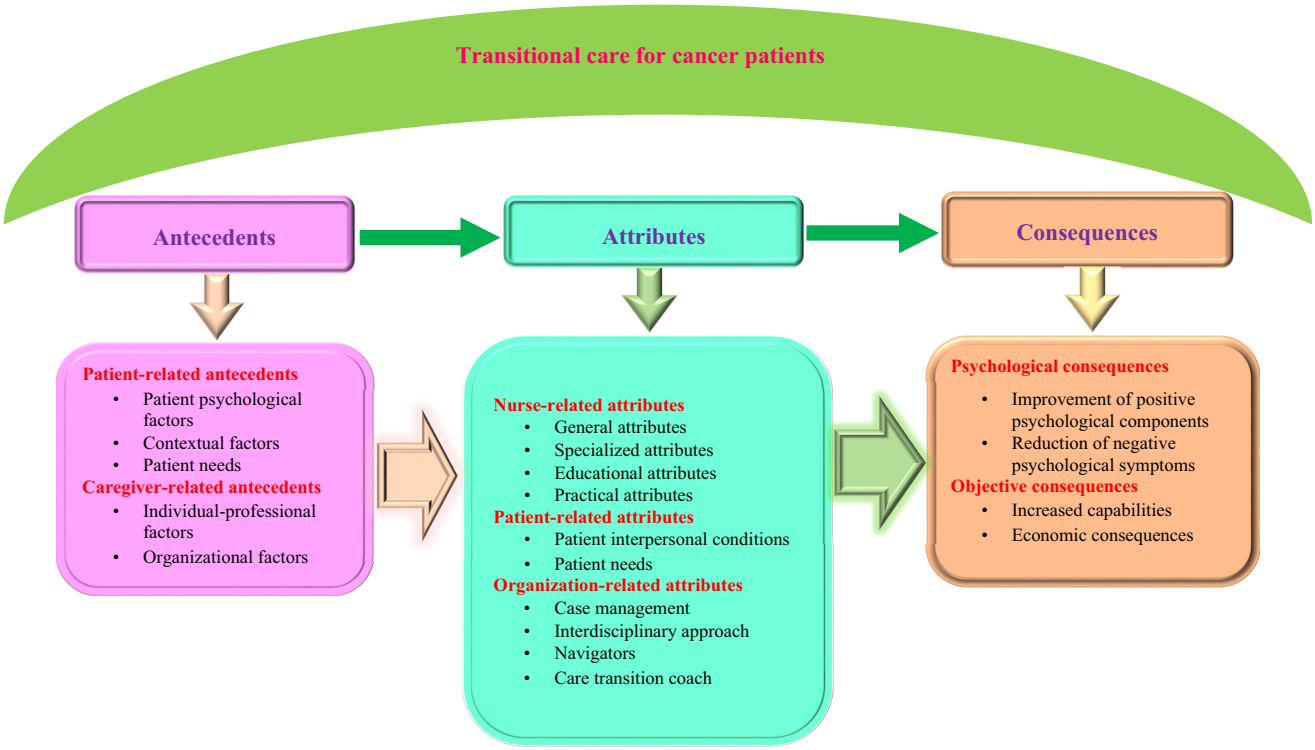

FIGURE 2 Summary of antecedents, attributes and consequences of the concept analysis of transitional care for people with cancer.

related aspects were provision of social support to patients and their families, arrangement of hospitalization, follow-up and telephone call, provision of a summary of the treatment plan, transitional care sessions with the participation of medical team, family and other caregivers and supportive face-to-face sessions (Bauer et al., 2015; Brant et al., 2016; Jahn et al., 2014; Montero et al., 2016; Shimada et al., 2017; Young et al., 2013). Nurses had a central role in follow-up programmes during transitional care. Follow-up programmes should identify and manage complications associated with cancer and its treatments and provide recommendations to improve health condition. These programmes should be patient-centred and compatible with their needs (Houlihan, 2009; Howell et al., 2012; Jahn et al., 2014).

3.2.2 | Patient-related attributes

Patient-related attributes were patient interpersonal conditions and patient needs. People with cancer needed continuous help and support during transitional care. Training should meet their information needs in achieving self-care objectives (Ang et al., 2016; Bilodeau et al., 2015; Easley et al., 2016; Franco et al., 2016; Kvale et al., 2016). They needed to actively engage and maintain relationships with health caregivers (Carrillo et al., 2018). During the critical period of transitional care, they should try to create social networks with family and friends and emphasize collaboration, distribution of responsibilities, delegation and shared participation in order to facilitate their presence in the patient's own home (Carrillo et al., 2018).

People with cancer face many problems in managing symptoms related to treatment and cancer, which interfere with their daily and social activities and require support and counselling (Carrillo et al., 2018). Fear of cancer recurrence was a major cause of anxiety for patients during transitional care, which should reassure patients that the situation was under control (Lewis et al., 2009). Patients also needed precise scheduling for laboratory tests and visits, and contact information to health caregivers to resolve their concerns during transitional care (Franco et al., 2016; Houlihan, 2009; Kyte et al., 2019; Lewis et al., 2009; Lithner et al., 2015). Successful transition of care depends on the active involvement of the patient in self-management initiatives (Kvale et al., 2016; Lithner et al., 2015). The coaching model as patient-owned survivorship transitional care for activated and empowered survivors helped people with cancer to identify health objectives and drive self-management to achieve care objectives (Kvale et al., 2016).

3.2.3 | Organization-related attributes

Organization-related attributes included case management, interdisciplinary approach, navigators and care transition coach. Case managers who were often nurses played a valuable role in the provision of transitional care and continuous care through the development of transitional care plans. They were responsible for discharge planning; primary care coordination; and carrying out transitional care meetings with the healthcare team, nurses, family caregivers and clinical social workers. They provided individualized information and

emotional support and conducted telephone follow-ups within 72 h after discharge (Aubin et al., 2012; Shimada et al., 2017; Thomson et al., 2015).

Although nurses played an essential and dominant role in transitional care, the cooperation of various specialists in the form of an interdisciplinary team was required (Aubin et al., 2012; Bilodeau et al., 2015; Houlihan, 2009; Lewis et al., 2009; Moore et al., 2006; Thomson et al., 2015; Tuggey & Lewin, 2014). Palliative care physicians and advanced practice nurses (APNs) had specialized training in advanced communication skills and complex symptom management. APNs work primarily in the community and enhance cancer patient's quality of life by building a trusting supportive relationship with the patient, family and other members of healthcare team (Tuggey & Lewin, 2014).

Nurses were considered 'navigators' and took measures such as planning patient visits and educating patients. They followed the patient primary care programme, answered patients' questions about their concerns, developed an individualized care plan and reviewed the care plan with the healthcare team members (Brant et al., 2016; Easley et al., 2016).

Furthermore, nurses as the care transition coach provided transitional care services to people with cancer. The role of coaches was to focus on patients' statements, talk about changes and find clues about health goals and examples of self-management in patients' statements. They were responsible for directing interventions towards identifying health goals, identifying potential obstacles and removing them, providing telephone follow-up and using family, friends and acquaintances to meet patients' daily living needs (Kvale et al., 2016).

Nurses should be easily accessible to patients 24 h a day to ensure care continuity so that patients can share their questions and concerns (Cusack & Taylor, 2010; Easley et al., 2016; Shimada et al., 2017). Nurses have an undeniable role in the transition journey of a patient from the hospital to the primary care setting (Franco et al., 2016; Goldenberg et al., 2020).

3.3 | Antecedents

Antecedents as the prerequisites of the concept affected the occurrence of the concept (Rodgers & Knafl, 1999). Antecedents in this study were identified in two main categories: 'patient-related antecedents' and 'caregiver-related antecedents'.

3.3.1 | Patient-related antecedents

In the category of patient-related antecedents, patient psychological factors, contextual factors and patient needs were identified. The patient's psychological factors included the codes of patient's psychological status, patient and caregiver stress, desire for life, level of awareness, patient resilience, patient trust, importance and respect. Stress experienced by people with cancer during treatment and the economic problems of patients impeded their readiness for transitional care. The desire of people with cancer to gain support in the active post-treatment period and recognition of the importance of learning to deal with post-transition conditions were the basis for the active participation of these patients in the transitional care process (Bilodeau et al., 2015; Carrillo et al., 2018). Also, the level of patients' awareness; receiving support from their partner, family, friends and religious groups; and resilience were main facilitators in transitional care (Chao et al., 2020). The desire of patients to return to normal life, which caused them to make great efforts to improve the situation during transition, influenced successful transitional care (Kyte et al., 2019).

The contextual factors included patient's age, socio-cultural conditions, religion, economic situation, insurance support and degree of interference with the normal life. In addition, attention to the social, cultural, religious, psychological and economic status of patients was essential to gain optimal transitional care (Chao et al., 2020; Leach et al., 2017; Singh-Carlson et al., 2018).

The patient needs included information needs, socio-supportive needs, need to learn about coping skills, spiritual needs, specific needs of each patient before transition, physical and psychosocial needs, need for supportive care and rehabilitation/follow-up. Identifying various needs such as information, physical, psychosocial, rehabilitation and support needs of people with cancer was considered an important factor in the provision of optimal transitional care, patient participation and appropriate interventions during the transition period (Aamodt et al., 2013; Bauer et al., 2015; Cox & Wilson, 2003; Houlihan, 2009; Jahn et al., 2014; Lithner et al., 2015; Young et al., 2013).

3.3.2 | Caregiver-related antecedents

Caregiver-related antecedents included individual–professional factors and organizational factors. Comprehensive knowledge and communication skills were observed in professional–individual factors. The provision of transitional care services such as follow-up care required the development of knowledge in various dimensions such as care and social services, information delivery and patient support skills. It also required communication skills in health caregivers including those nurses who played a pivotal role in transitional care (Beaver et al., 2010; Cox & Wilson, 2003; Cusack & Taylor, 2010; Moore et al., 2006). Furthermore, making a trusting relationship between the nurse as the transitional caregiver and the people with cancer, building a sense of trust in patients, showing respect for them and reassurance to patients that their needs would be adequately addressed were the facilitators of transitional care (Beaver et al., 2010; Easley et al., 2016; Franco et al., 2016; Lithner et al., 2015; Tuggey & Lewin, 2014). Therefore, the need for proper training of nurses and other health caregivers was considered essential for the optimal delivery of transitional care (Jahn et al., 2014; Kvale et al., 2016).

In the organizational factors, sufficient facilities and time for care, appropriate workload, optimal plans to be compatible with patient's needs, learning, coaching and training for the nurse in care follow-up were found (Houlihan, 2009; Kvale et al., 2016; Lewis et al., 2009; Thomson et al., 2015). Access to adequate facilities during the transition of people with cancer, appropriate communication with the patient and enough time were important facilitators of successful transitional care (Kvale et al., 2016; Lewis et al., 2009; Moore et al., 2006). Time constraints, heavy workloads of caregivers, and lack of proper transitional care planning caused poor transitional care for people with cancer (Thomson et al., 2015).

3.4 | Consequences of the concept of transitional care for people with cancer

They were what happened because of or as the result of the concept (Rodgers & Knafl, 1999). The consequences of transitional care were two main categories of 'psychological' and 'objective' consequences.

3.4.1 | Psychological consequences

Psychological consequences included the improvement of positive psychological components and reduction in negative psychological symptoms. The improvement of positive psychological components included enhanced satisfaction among the patient, caregiver and family. It also encompassed an increase in life control and life planning, family coordination, peace of mind in expressing problems, quality of life, adaptation and acceptance, feeling of real care, trust in caregivers, feeling to be heard and better emotional performance (Ang et al., 2016; Aubin et al., 2012; Beaver et al., 2010; Brant et al., 2016; Kvale et al., 2016; Lewis et al., 2009; Moore et al., 2006).

The reduction in negative symptoms such as distress, depression and anxiety, the fear of making mistakes among nurses and diminished severity of pain were mentioned (Ang et al., 2016; Aubin et al., 2012; Cox & Wilson, 2003; Cusack & Taylor, 2010; Franco et al., 2016; Jahn et al., 2014; Kvale et al., 2016; Lithner et al., 2015; Young et al., 2013).

3.4.2 | Objective consequences

This category included increased capabilities and economic consequences. The increased capabilities consisted of symptom management such as better control of cancer pain; adherence to the treatment regimen; increasing the patient's knowledge and understanding of care continuity; family involvement; decreasing poor health outcomes and increasing patient's ability to lead care; and improving functional performance such as physical, role and social capabilities (Ang et al., 2016; Aubin et al., 2012; Carrillo et al., 2018; Chao et al., 2020; Cox & Wilson, 2003; Cusack & Taylor, 2010; Goldenberg et al., 2020; Jahn et al., 2014; Lewis et al., 2009; Montero et al., 2016; Singh-Carlson et al., 2018).

In the economic consequences, reducing emergency referrals, readmissions and healthcare costs and improving post-discharge consequences were mentioned (Ang et al., 2016; Carrillo et al., 2018; Cox & Wilson, 2003; Cusack & Taylor, 2010; Montero et al., 2016; Shimada et al., 2017; Tuggey & Lewin, 2014; Young et al., 2013).

3.5 | Operational definition of the concept

Based on the literature review, transitional care for people with cancer is operationally defined as a complex, multidimensional and interactive process with nurse-related attributes, patient-related attributes and organization-related attributes. It involves patient-related antecedents and caregiver-related antecedents leading to the improvement of positive psychological symptoms, reduction in negative psychological symptoms, increase in functional capabilities and positive economic consequences.

4 | DISCUSSION

This review aimed to analyse the concept of transitional care for people with cancer by determining its dimensions. This concept had different elements and implications. Therefore, Rogers' evolutionary concept analysis with an in-depth analysis of existing texts was used to provide a clear description of the concept and identify related and alternative terms, antecedents, related attributes and consequences.

The unavoidable role of nurses in transitional care was found as an attribute. It covered a range of measures taken by nurses before discharge, during discharge, transition to primary care and follow-up. Also, interventions to deal with the complications of cancer and its treatment and care coordination were considered. Current innovative transitional care models aim at improving the quality and safety of care, patient and family experiences about healthcare and its consequences, such as increasing capabilities and the functional performance of people with cancer, and reducing healthcare costs. Nurses play a pivotal role in these models (Enderlin et al., 2013; Hirschman et al., 2015; Howell et al., 2012; Mardani et al., 2020; Parrish et al., 2009).

Collaboration between different health caregivers for successful transitional care was another attribute. Cancer is a very complex disease and the care needs of patients have become increasingly complex. These patients often should receive care in various settings such as the hospital, outpatient clinic and home care under the supervision of health caregivers. Optimal interdisciplinary and multidisciplinary collaboration during transitional care besides timely access to coordinated care can increase patients' and their families' comfort (Chakurian & Popejoy, 2021; Tuggey & Lewin, 2014).

Our review emphasized the importance of patient participation in transitional care. It can be reached through the conscious

and coherent efforts of specialists and healthcare systems that improve transitional care consequences (Hansen et al., 2021). Patients' perspectives, needs and abilities should be evaluated during transitional care, and patient participation should be increased through joint decision-making about care programmes. Relationships between patients and health caregivers based on mutual trust and respect should be established (Naylor et al., 2017).

The consequences of optimal transitional care for people with cancer enhanced quality of life, satisfaction with care, increased capabilities and functional performance of people with cancer and reduction of referrals to emergency settings and readmissions to hospitals. Individual interventions during discharge, discharge planning, self-management training and post-discharge follow-up can reduce the hospitalization rate and healthcare costs for people with cancer (Mardani et al., 2020; Verhaegh et al., 2014). Therefore, transitional care interventions for people with cancer should be of high quality and include the coordination of care by health caregivers, relationship between the hospital and the primary caregiver and follow-up on the first day after discharge (Federman et al., 2018; Hesselink et al., 2012; Verhaegh et al., 2014).

4.1 | Limitations

The concept analysis of transitional care for all types of cancers instead of remaining focused on a specific type of cancer is a limitation of this research. Also, all retrieved studies were related to research papers published in journals, and no grey literature was included. It could potentially undermine a richer understanding of the dimensions of this concept. Nevertheless, searches on international valid databases using precise and appropriate keywords, and inclusion of studies published 20 years ago helped with reducing the impact of this limitation on the search results. On the other hand, the majority of included studies used the qualitative research design or were systematic reviews, which enriched our findings. Regarding the analysis strategy in Rogers's evolutionary concept analysis method, it appears to be a linear process with the separation of data collection from the analysis that may threaten the reliability and validity of data by considering surrogate (identical) and related (similar) terms as exceptions. Therefore, the chance to enhance conceptual boundaries is reduced (Weaver & Mitcham, 2008) leading to the loss of relevant resources and hindering the proper explanation of the concept.

5 | CLINICAL APPLICATION OF FINDINGS AND CONCLUSIONS

Advances in cancer treatment in recent decades have increased the number of cancer survivors. The shorter hospitalization period and more complications associated with cancer treatments have attracted researchers' attention to the concept of transitional care. Therefore, the knowledge of people with cancer about transitional care and their roles and responsibilities should be increased.

The concept analysis of transitional care for people with cancer elucidated its antecedents, attributes and consequences. Understanding this concept can eliminate inconsistencies in cancer care and clarify gaps in our current knowledge about it. It can give a conceptual basis for further research to understand patients' needs in transitional care settings. In addition, explaining this concept can develop related tools to assess the success of transitional care interventions. Moreover, effective strategies to facilitate transitional care, improve patient care outcomes and reduce the readmission rate can be devised.

AUTHOR CONTRIBUTIONS

All authors listed have made a substantial, direct and intellectual contribution to the work and approved it for publication.

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CONFLICT OF INTEREST STATEMENT

The authors have no conflict of interest to declare.

DATA AVAILABILITY STATEMENT

Access to the dataset used for the data analysis and research synthesis in this review is possible upon reasonable request to the corresponsing author.

ETHICS STATEMENT

Not applicable.

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SUPPORTING INFORMATION

Additional supporting information can be found online in the Supporting Information section at the end of this article.

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