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Review

The Experience of Transition from Hospital to Community Care of Patients with Advanced Cancer: A Qualitative Narrative Review of Patients', Families' and Healthcare Professionals' Perspectives

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Abstract: Objective: This narrative review aims to synthesize qualitative research on the experiences of patients, families, and healthcare professionals during the transition of advanced cancer patients from hospital to community care. Methods: A systematic search of qualitative studies published between 2010 and 2023 was conducted. Thirteen studies were selected for their relevance to the transition from hospital to community care. The studies were thematically analysed to identify recurring patterns and significant findings. Results: The analysis revealed six key themes: (1) planning and managing transitions, (2) communication between actors involved in the process of transition, (3) constraints on health systems, (4) family, as a unit of care, (5) needs of patients and families in the process of transition to community care, and (6) emotions and feelings of actors involved in the transition. This review highlighted that transitions are often poorly managed, with inadequate communication, which contributes to anxiety, a sense of loss, and disruption in care continuity. Conclusions: This review emphasizes the importance of better planning, communication, and support during transitions from hospital to community care. A coordinated approach addressing the holistic needs of patients and families, including emotional support and clear communication, is essential for smoother, more effective transitions.

Keywords: hospital-to-home transition; continuity of care; palliative care; patient discharge; advanced cancer patient

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1. Background

During the end-of-life period, a significant number of cancer patients experience changes or transitions in where and by whom they are cared for (Stajduhar 2003). These transitions represent a critical phase in their care journey, as they involve not only physical changes but also emotional and social ones that shape the overall experience.

The word "transition" originates from the Latin word "transire" and means "to go across" (Chick and Meleis 1986). In healthcare, transition is defined as "the coordinated and continuous movement of patients between different care settings, providers or levels of care as their medical condition and care needs change. Similarly, transitional care is defined as a set of actions designed to ensure the coordination and continuity of care as patients transfer between different locations or levels of care" (Coleman and Boult 2003).

This narrative review is dedicated to examining the transition experience from hospital to community care for patients with advanced cancer, focusing on the experiences and perspectives of patients, their informal caregivers, and healthcare professionals. For this study, transitions between care settings are defined specifically as changes in a patient's residence for care, that is, the move from the hospital to the patient's own home.

Recent studies indicate that many patients with advanced cancer in the final phase of life are discharged from hospital without continuity of information and certainty about treatment and aftercare (Van den Block et al. 2016; Gomes and Higginson 2006). These findings highlight that transitions from hospital to community care are often compromised by healthcare system fragmentation and insufficient interprofessional communication. In many healthcare systems, discontinuities in care occur when complex patient information is not effectively transmitted between hospital-based oncology teams and community-based providers, contributing to delays in post-discharge follow-up and increased risk of unplanned hospital readmission during the final phase of life (Hohmann et al. 2020; Tremblay et al. 2017).

In addition, communication between healthcare providers in different settings is suboptimal, affecting continuity and coordination of care (Payne and Hasselaar 2023; Kripalani et al. 2007).

These findings underscore that the negative impacts of poorly managed transitions are multifaceted. For example, inappropriate transfers between hospital and home can have negative effects on patients' quality of life, with advanced cancer patients at high risk due to complex health problems, frequent transitions between care settings and the involvement of multiple professionals (Flierman et al. 2020; Committee on Improving the Quality of Cancer Care 2013).

A further consequence of these disruptions is the significant burden placed on caregivers. When patients are discharged without clearly articulated care plans, family members frequently take on the responsibility for managing complex health needs. Consequently, this sudden shift can exacerbate caregiver stress and lead to additional financial and emotional burdens, as informal caregivers must often dedicate substantial time and resources to care provision (Yabroff and Kim 2009; Wadhwa et al. 2013).

Furthermore, the lack of continuity of care between care settings can also affect professionals. The involvement of multiple and often uncoordinated providers—from hospital-based specialists to community primary care teams—leads to role ambiguity that hampers effective communication and resource allocation (Hohmann et al. 2020; Lundeby et al. 2020). These issues inevitably contribute to an increased workload and staff burnout (Blay et al. 2012).

A study in four European countries showed that the majority of patients with advanced cancer (63%) experienced one or more transitions in the last 3 months of life and that most transitions at the end of life are from home to hospital (48%) (Van den Block et al. 2016; Abarshi et al. 2010), although most patients with advanced cancer and their relatives wish to be cared for in the last stage of life and die at home (Nilsson et al. 2017; Higginson and Sen-Gupta 2000; Higginson et al. 2017; Wheatley and Baker 2007).

Nevertheless, despite the abundance of quantitative studies examining the incidence and types of end-of-life transitions among cancer patients, research exploring and synthesizing the qualitative experiences of such transitions remains limited. Moreover, an initial exploration of the literature, including searches in established registries such as OSF and PROSPERO, did not yield any published reviews that synthesize the perspectives and experiences of patients, families, and healthcare professionals regarding transitions between end-of-life care settings. This absence of a comprehensive synthesis highlights a significant gap in the literature, thereby reinforcing the novelty and timeliness of our current investigation.

The aim of this narrative review is to synthesize and analyse the findings of qualitative studies on the process of the transition of advanced cancer patients from hospital to community care. Through a rigorous examination of emergent themes, this review seeks to elucidate the needs and preferences of patients, families, and healthcare professionals during this critical juncture, while also identifying barriers and facilitators to achieving a high-quality transition.

2. Methods

A narrative review of qualitative studies was conducted (Dixon-Woods et al. 2005) to examine the transition of advanced cancer patients from hospital to (palliative) community care at the end of life. Narrative reviews, also called traditional, standard or descriptive review, aim to identify, analyse, evaluate and interpret knowledge about a specific topic (Green et al. 2006; Coughlan and Cronin 2021). They are often used for topics that require a meaningful synthesis of research evidence that might be complex or broad and that require detailed, nuanced description and interpretation (Sukhera 2022). While a systematic review focuses on a narrow question, with a prespecified method to synthesize findings from similar studies, a narrative review can include a wide variety of studies and provide an overall summary, with interpretation and critique (Greenhalgh et al. 2018).

2.1. Search Strategy

A search was conducted in three databases: PubMed, ScienceDirect and Scopus. The selection of ScienceDirect, Scopus, and PubMed as primary platforms for this narrative review was informed by their extensive coverage of peer-reviewed scientific literature and their established reputations for rigor and consistency in indexing research. These databases are widely recognized as comprehensive resources that span multidisciplinary fields and are particularly robust in the health sciences, which makes them ideal for gathering relevant studies in transitional care and advanced cancer research (Gasparyan et al. 2011). Searches were limited to studies of adults over the age of 18 and published in English from January 2010 until January 2023. The choice of the publication date range, 2010–2023, was justified on the basis that the past decade has seen significant evolution in palliative care models, especially concerning the integration of hospital and community care. Limiting the search to studies published in this time frame helps ensure that the narrative review reflects current clinical practices and the latest ethical, organizational, and practical shifts in the transition of advanced cancer care. Using the snowball technique, the bibliographic references of the articles included in this study were scanned for additional articles, to which the same general selection criteria were applied.

The search strategy was designed to capture articles examining the transition from hospital to community care for advanced cancer patients from multiple perspectives. For transparency, the Boolean logic is clarified as follows: the search combined terms representing three core concepts: “Transition”, “Community”, and “Palliative care”, using the Boolean operator AND to ensure that only studies addressing all of these aspects were included. Synonyms and alternative keywords for each concept were also applied (Table 1).

Table 1. Search strategies on different databases for narrative review.

Database	**Concepts**		
	Transition	**Community**	**Palliative Care**
PubMed	Transition Article title	Community Title/abstract	Palliative Title/abstract

Table 1. *Cont.*

Database	Concepts		
	Transition	**Community**	**Palliative Care**
Science Direct	Transition	Community	Palliative Care
Scopus	Transition Title	Community Title, abstract, key word	Palliative Title, abstract, key word

2.2. Study Selection

All results were downloaded into Rayyan software, a smart, intuitive and scalable platform designed to assist researchers conducting literature reviews and systematic reviews in the screening and selection process (Ouzzani et al. 2016) and the database was de-duplicated using the built-in function. To ensure that the selection process remained unbiased and as rigorous as possible, two independent reviewers (FH, CC) performed blind screening of abstracts and, later, the full-text records. In situations where discrepancies or uncertainties arose between the selections—such as differences in the interpretation of inclusion criteria—a third reviewer (DM) was engaged to resolve these conflicts and reach consensus. This strategy is well established in the literature as an effective means to reduce selection bias and enhance the credibility and reliability of the screening process. Included articles had to: (1) be available full text; (2) have an adult population (>18 years) with advanced cancer; (3) contain a qualitative or mixed-method study; (4) approach the experiences and the perspectives of patients, families and healthcare professionals on the transition between care settings; (5) provide information on barriers and facilitators to transition between care settings (Table 2).

Table 2. Inclusion and exclusion criteria.

Inclusion Criteria	Exclusion Criteria
Contain a qualitative or mixed-method study Approach the experiences and the perspectives of patients, families and healthcare professionals on the transition between care settings Provides information on barriers and facilitators to transition between care settings Full-text article Published in English Published between January 2010–January 2023	Approach transitions in goals of care or care management Approach transitions from other care settings than from hospital to community care Non-original articles, literature reviews

Of the 727 studies found, 13 were included, of which 3 were selected after searching via the snowball technique. Study selection is illustrated per PRISMA guidelines (Figure 1).

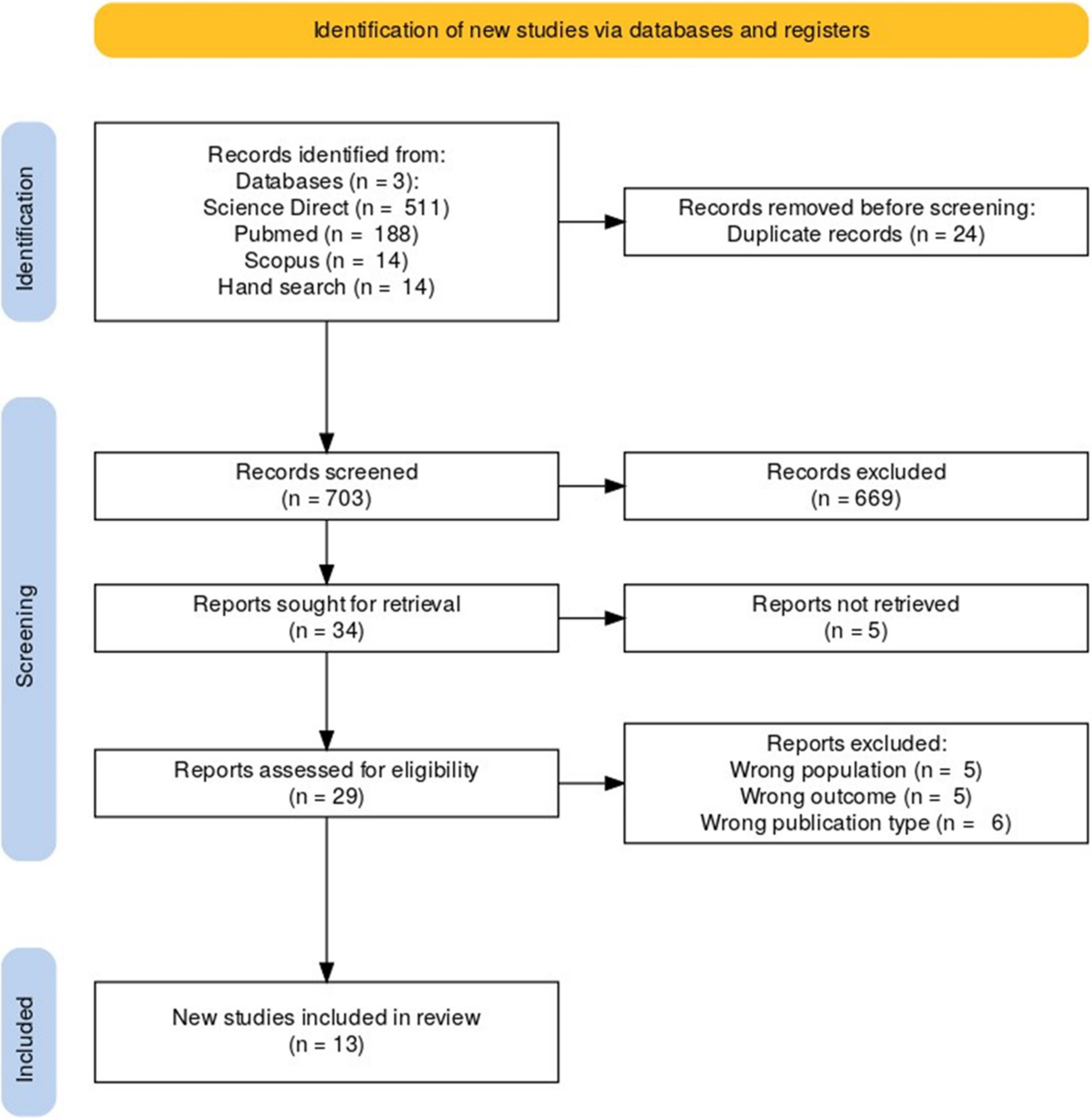

Figure 1. Prisma flow diagram.

2.3. Data Extraction

A predefined data extraction sheet was created in Microsoft Excel in order to systematically collect data from the included articles (Cronin et al. 2008). The excel sheet included study details such as, first author, year of publication, country, title, objective, study design and methodologic underpinnings, sample size, data collection methods, data analysis techniques, results and limitations (Supplementary Materials—Extraction data Table S1). The focus was on the experiences and needs of patients, families and health professionals in the process of transition from hospital to community care, as well as on barriers and facilitators of a quality transition.

2.4. Data Synthesis and Analysis

For the synthesis of findings from the studies included in this review, we followed thematic analysis, which allows for the identification of prominent and recurrent themes in the literature and summarising the findings in thematic headings. Thematic analysis is a widely recognized method in qualitative research that enables researchers to generate patterns from complex datasets by iteratively coding and categorizing data and, thus, integrating both qualitative and quantitative evidence (Dixon-Woods et al. 2005). In our study, initial codes were generated independently by two reviewers (FH, CC), performing detailed, line-by-line coding of the extracted data using NVivo software (version 1.7.2). The process involved developing an initial codebook based on emergent data and refining the set of codes through a series of iterative comparisons and discussions. Discrepancies were discussed collaboratively and if consensus was not reached, a third reviewer (DM) was consulted to ensure consensus and to enhance the reliability of the coding framework. The final codebook captured the most recurrent issues across the included studies, ensuring that the diverse contexts and perspectives within the qualitative evidence were adequately represented. Overall, this rigorous process of coding, collaborative review, and iterative theme refinement increases the transparency of our synthesis and reinforces confidence in our findings.

3. Results

A total of 727 records were identified using search engines or by hand, through reference lists of relevant articles; 703 remaining articles after de-duplication were screened, of which 669 were excluded because they did not meet the inclusion criteria. Of the 34 retained, 5 were removed for various reasons, either because we could not find the full-text article or because it was published in another language. In the current review, 13 original articles were included.

Included studies (n = 13) were published between 2011 and 2022, and most of them were based in the UK (n = 4) (Guo et al. 2022; Hanratty et al. 2012; Smith et al. 2019; Venkatasalu et al. 2015) and Canada (n = 4) (Isenberg et al. 2021; Morey et al. 2021; Saunders et al. 2021; Wilson and Birch 2018), the others in the USA (n = 1) (Dose et al. 2011), the Netherlands (n = 1) (Flierman et al. 2020), Belgium (n = 1), (Mertens et al. 2022) Columbia (n = 1) (Rocío et al. 2017) and Germany (n = 1) (Kasdorf et al. 2021). Twelve studies applied a qualitative design (n = 12) (Dose et al. 2011; Flierman et al. 2020; Guo et al. 2022; Hanratty et al. 2012; Isenberg et al. 2021; Kasdorf et al. 2021; Mertens et al. 2022; Morey et al. 2021; Rocío et al. 2017; Smith et al. 2019; Venkatasalu et al. 2015; Wilson and Birch 2018), and one study included a qualitative component as part of a mixed-methods design (n = 1) (Saunders et al. 2021). Only four studies (n = 4) (Venkatasalu et al. 2015; Wilson and Birch 2018; Dose et al. 2011; Rocío et al. 2017) report a specific methodological underpinning, and the most common data collection methods were interviews, individual and/or dyads (n = 12) (Ouzzani et al. 2016; Cronin et al. 2008; Guo et al. 2022; Hanratty et al. 2012; Smith et al. 2019; Venkatasalu et al. 2015; Isenberg et al. 2021; Morey et al. 2021; Saunders et al. 2021; Wilson and Birch 2018; Dose et al. 2011; Mertens et al. 2022). Six studies examined the perspectives and experiences of patients and families (Guo et al. 2022; Isenberg et al. 2021; Morey et al. 2021; Saunders et al. 2021; Dose et al. 2011; Rocío et al. 2017), two studies of patients (Hanratty et al. 2012; Mertens et al. 2022), two studies of healthcare professionals (Flierman et al. 2020; Kasdorf et al. 2021), one study of patients and healthcare professionals (Smith et al. 2019), one study of healthcare professionals and families (Venkatasalu et al. 2015), and one study of all actors involved in the process of transition (Wilson and Birch 2018).

This rigorous procedure facilitated the detection of recurring patterns across diverse studies, enabling the emergence of six main themes that capture critical aspects of transitions in care. These themes are as follows: (1) planning and managing transitions; (2) communication between actors involved in the process of transition; (3) constraints related to health systems; (4) family, the unit of care; (5) emotions and feelings of actors involved in the transition; and (6) needs of patients and families in the process of transition to community care (Figure 2).

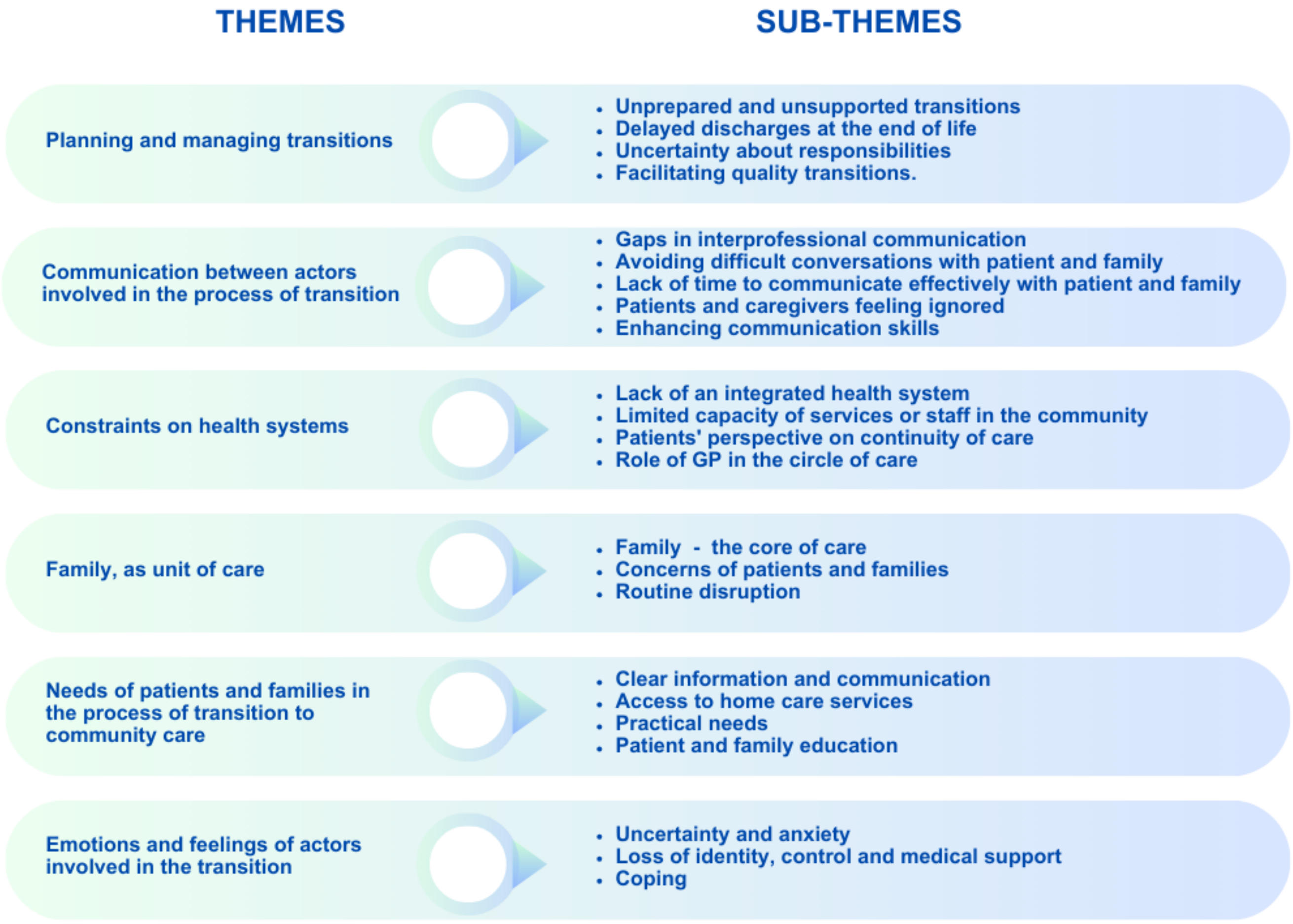

Figure 2. Themes and subthemes.

3.1. Planning and Managing Transitions

3.1.1. Unprepared and Unsupported Transitions

Discharge experiences ranged from "well organized" to "inadequate", inefficiently and incompletely organized or even "a disaster when it comes to the transition from hospital to home" (Flierman et al. 2020; Hanratty et al. 2012; Wilson and Birch 2018; Mertens et al. 2022). Health professionals considered that the hospital discharge letter focuses on physical aspects and omits information about other areas of palliative care, such as spiritual, psychological and social, which would improve care or follow-up in the community by primary care (Flierman et al. 2020). Moreover, patients' wishes and preferences for future care are not always considered in the transition process (Flierman et al. 2020). Some older patients felt they were discharged from hospital without sufficient time to prepare, with insufficient community support in place and little knowledge of how to access the services they needed, indicating a lack of participation in discharge planning (Hanratty et al. 2012). Neither patients nor family carers described the transition experience as complete (Dose et al. 2011).

3.1.2. Delayed Discharges at the End of Life

There were several causes of delayed discharges of patients with advanced cancer. Some were administrative, such as lack of equipment at patients' homes (Dose et al. 2011), lack of information about support in the community or availability of community services (Venkatasalu et al. 2015). Others were related to the healthcare system—the curative-centred culture in hospital settings (Venkatasalu et al. 2015; Kasdorf et al. 2021), or the lack of designated people, processes and effective methods to facilitate transitions (Wilson and Birch 2018). Lack of knowledge in palliative care among junior doctors and also lack of clarity about patients in the palliative phase (Flierman et al. 2020; Venkatasalu et al. 2015; Wilson and Birch 2018; Kasdorf et al. 2021) were other barriers to timely discharges. And there were situations where delayed discharges were somehow justified, when patients were too weak or had symptoms that are difficult to control at home (Smith et al. 2019; Venkatasalu et al. 2015; Saunders et al. 2021; Mertens et al. 2022).

3.1.3. Uncertainty About Responsibilities

Professionals described the transition between care settings as a clear transfer of tasks and responsibilities. In reality, responsibilities for care coordination are often unclear to community healthcare professionals due to poor communication and coordination. Also, the patient is often confused about care responsibilities, not knowing whom to call when needed (Flierman et al. 2020; Isenberg et al. 2021; Saunders et al. 2021).

3.1.4. Facilitating Quality Transitions

Healthcare professionals recommend that discharges should be facilitated by a discharge service, a coordinator or a navigator, who has time to talk to the family, has the information about the services available in the community and can handle the practical issues, in order to provide a smooth transition to community care (Venkatasalu et al. 2015; Dose et al. 2011). Moreover, in order for this transfer between care settings at the end of life to be more readily accepted by patients and also to be effective, it should be prepared in advance by the discharge service and approached gradually (Smith et al. 2019; Venkatasalu et al. 2015; Dose et al. 2011). Face-to-face or at least telephone communication between professionals involved in the care of the advanced cancer patient from different settings could also facilitate a quality transition, even if there are some constraints, such as lack of time, shift work, confidentiality issues or high costs for the health system (Flierman et al. 2020).

3.2. Communication Between Actors Involved in the Process of Transition

3.2.1. Gaps in Interprofessional Communication

Six studies (Hanratty et al. 2012; Isenberg et al. 2021; Morey et al. 2021; Wilson and Birch 2018; Mertens et al. 2022; Kasdorf et al. 2021) found gaps in interprofessional communication or communication between different care settings. Often, sharing information between care teams about patients' medical histories is lacking (Morey et al. 2021; Wilson and Birch 2018; Mertens et al. 2022). Many reported an over-reliance on written communication, with few team meetings or face-to-face meetings, mainly due to a lack of time and high workload (Wilson and Birch 2018; Kasdorf et al. 2021). The confidentiality of information is another barrier to effective communication between professionals, not knowing who is in the patient's circle of care and, therefore, to whom information can be shared (Wilson and Birch 2018; Kasdorf et al. 2021).

3.2.2. Avoiding Difficult Conversations with Patient and Family

Hospital healthcare professionals often avoid difficult conversations about the palliative or dying phase or communicate this information in a language that is difficult for patients and their families to understand (Flierman et al. 2020; Wilson and Birch 2018; Kasdorf et al. 2021). Moreover, primary care professionals have difficulties communicating and providing care for their patients if, during hospitalization, caregivers do not identify and, therefore, communicate the palliative phase prior to transfer to community care (Flierman et al. 2020).

3.2.3. Lack of Time to Communicate Effectively with Patient and Family

Five studies (Flierman et al. 2020; Hanratty et al. 2012; Wilson and Birch 2018; Rocío et al. 2017; Kasdorf et al. 2021) found that the lack of time is one of the causes of poor communication, both between professionals and with patients. For some patients, the perception that no one has time to talk has created a potential barrier to understand their condition and prognosis and, for caregivers, a barrier to effective communication (Hanratty et al. 2012; Rocío et al. 2017). Hospital professionals described not having time to have conversations with patients about care preferences during hospitalization, due to high workload. It is often said that people are very busy and that time is needed for effective communication, and this may explain the limited capacity of healthcare professionals to engage in open and honest end-of-life conversations (Flierman et al. 2020; Wilson and Birch 2018).

3.2.4. Patients and Caregivers Feeling Ignored

Patients and caregivers often experienced feelings of not being heard—patients when they were admitted to or discharged from hospital, and their families when they tried to advocate for changes in their relatives' care or when they tried to discuss their problems in delivering care (Hanratty et al. 2012; Rocío et al. 2017). Moreover, there were reports that patients were literally not heard when they asked for help with toileting or other essential aspects of hospital life (Hanratty et al. 2012).

3.2.5. Enhancing Communication Skills

Only one study (Guo et al. 2022) showed the need for communication training for healthcare professionals, although communication gaps were found in almost all studies.

3.3. Constraints on Health Systems

3.3.1. Lack of an Integrated Health System

Healthcare systems are highly fragmented, separated, with strict regulations, and poor hospital discharge management often occurs as a consequence of these regulations (Morey et al. 2021; Mertens et al. 2022). Morey et al. (2021) and Mertens et al. (2022) provide substantial evidence that this fragmentation within healthcare systems has a huge impact on transitions of care. Morey et al. (2021) demonstrate that the lack of shared electronic health records across institutions creates significant barriers to the seamless exchange of patient information.

In parallel, Mertens et al. (2022) highlight that fragmentation further manifests in the process of discharge planning. Their analysis reveals that the inadequate participation of key stakeholders—such as patients, primary care providers, and hospital staff—in discharge planning results in incomplete or unclear directives for post-discharge care.

3.3.2. Limited Capacity of Services or Staff in the Community

Some patients and families need services or resources that are not available in the community or are limited (Smith et al. 2019; Wilson and Birch 2018). Thus, patients end up being readmitted (to the emergency department) because of symptoms that cannot be managed at home or because the family comes to burnout or because community care teams lack adequate knowledge to manage the oncologic disease (Wilson and Birch 2018).

And even though a range of services or facilities are available in the community to support patients and family members—medical care, domestic and family support services—the way in which these have been implemented has not always fully met the needs of patients (Hanratty et al. 2012; Mertens et al. 2022). Furthermore, even if patients wish to die at home, there is often insufficient staff in the community to support the patient and family at home, and they end up dying in hospital (Wilson and Birch 2018).

3.3.3. Patients' Perspective on Continuity of Care

Continuity of care means, for patients and/or caregivers, seeing the same healthcare providers and having a small team of providers (Morey et al. 2021). Patients and families stated that they were tired of telling their story over and over again to the professionals involved in their care, emphasizing the importance of timely and correct transfer of patient information, medical notes, and medication prescriptions when transferring from one care setting to another (Guo et al. 2022; Morey et al. 2021). Several patients emphasized that to maintain continuity of care, they would prefer to remain in their current care setting and not transfer to another setting unless necessary, or to seek private healthcare (Guo et al. 2022; Morey et al. 2021; Kasdorf et al. 2021).

3.3.4. Role of GP in the Circle of Care

There is an over-reliance on the GP to plan, coordinate and provide end-of-life care in order to prevent readmissions (Wilson and Birch 2018; Mertens et al. 2022; Kasdorf et al. 2021). Many patients expect their GP to be informed of any changes in their medical record and to ensure continuity of care after discharge, but, in reality, this is not happening (Mertens et al. 2022). For some, the GP has assumed a central role as a counsellor, fully involved; for others, it is a rather background role—available on demand; for a few patients, it is a minimal role—an insignificant position, not involved in the case (Wilson and Birch 2018; Mertens et al. 2022). On the other hand, despite the long-standing relationship with their GP, some cancer patients contact the oncologist directly for advice and assistance when something goes wrong, thus bypassing the GP, assuming that they will just get a referral anyway.

3.4. Family, as Unit of Care

3.4.1. Family—Essential Support in Care

Family members often act as advocates in healthcare, and most participants specified that they needed support from family and friends not only in the practical area, such as arranging transportation or coordinating care, but also emotional support (Guo et al. 2022).

3.4.2. Concerns of Patients and Families

Both patients and caregivers have many concerns about home care: on one hand, that they will not be able to receive the same treatments at home as in hospital (Morey et al. 2021), on the other hand, patients have expressed concerns about their ability to manage routines safely and independently, and families about their ability to administer medications, handle medical devices and monitor patients (Isenberg et al. 2021).

3.4.3. Routine Disruption

Usual routines and patterns were disrupted by visits from hospice staff, visits from family or friends or care of the patient by family (Dose et al. 2011). Therefore, an important aspect emphasized by both patients and their families is related to maintaining a sense of normality when everything changes (Guo et al. 2022).

3.5. Needs of Patients and Families in the Process of Transition to Community Care

3.5.1. Clear Information and Communication

One of the most important needs that patients and their families have in the transition from hospital to community-based care relates to information and communication, with participants emphasizing that clear and effective communication is as important as quality of care (Guo et al. 2022). It is important to find a common language that is understood by both parties and that the right information is given at the right time and place. This will help patients and caregivers to better understand the diagnosis, prognosis and care plan, thus reducing worries and anxiety (Guo et al. 2022; Rocío et al. 2017).

3.5.2. Access to Home Care Services

Once transferred to community care, patients highlighted the need for a 24/24 medical helpline and to have the guarantee of temporary or permanent transfer to hospital when symptoms become unbearable or when caregivers can no longer respond to their needs (Mertens et al. 2022; Rocío et al. 2017). They also consider it very important to have a consistent team of IP professionals visiting them at home (Morey et al. 2021).

3.5.3. Practical Needs

Most of the participants specified that they need a lot of support from family and friends to meet practical needs, such as organizing transportation, setting up the home for care, procuring medicine, establishing healthcare providers in the home (Isenberg et al. 2021; Dose et al. 2011; Guo et al. 2022). Also, the support from the community, not only in the practical field but also as a factor that can contribute to a state of well-being, emerged as an important theme in two studies (Isenberg et al. 2021; Saunders et al. 2021).

3.5.4. Patient and Family Education

Last but not least, there is a great need for patient and family education before discharge to carry out home care, in order to prevent unnecessary end-of-life admissions and the burden of caregiving (Isenberg et al. 2021; Rocío et al. 2017; Kasdorf et al. 2021). However, despite the recognition of patient and family educations' importance, the current state of discharge education remains inadequately described, with limitations including inconsistencies in content delivery, variability in stakeholder engagement, and insufficient standardization of educational practices that hinder its overall effectiveness.

3.6. Emotions and Feelings of Actors Involved in the Transition

3.6.1. Uncertainty and Anxiety

Patients and families experience feelings of uncertainty and anxiety when care does not meet patients' needs, when they do not have enough information about the discharge plan or what community care entails or about the medical support available in the new care setting (Guo et al. 2022; Isenberg et al. 2021; Saunders et al. 2021; Dose et al. 2011; Mertens et al. 2022; Rocío et al. 2017).

3.6.2. Loss of Identity, Control, and Medical Support

The process of transition from hospital to community care is accompanied by a sense of loss that patients experience—loss due to discontinuation of treatment (last consultation (Smith et al. 2019), loss of 'self', loss of control and independence (Guo et al. 2022). The loss is not only felt by patients but also by oncology physicians, due to the breaking of trusting relationships between patient and physician (Smith et al. 2019).

3.6.3. Coping

Considering the condition of the patient and the helplessness of the caregiver, both live in a permanent crisis (Rocío et al. 2017). For both patients and caregivers, changes in care needs and treatments after transition, disruption in the continuity of care, require periods of adjustment and new ways of coping (Guo et al. 2022).

4. Discussion

The findings of this review suggest that the transition from hospital to community-based palliative care at the end of life is a challenging process, often associated with significant emotional, logistical, and practical challenges for patients, families, and healthcare professionals, as other studies revealed (Coleman and Boult 2003; Jeffs et al. 2012; Naylor et al. 2011; Saunders et al. 2019).

Importantly, patients frequently experience significant emotional distress, uncertainty and feelings of disruption during the transition from hospital to home palliative care. The disruption from a structured hospital environment to home care can induce feelings of vulnerability and fear of inadequate support. In this respect, several studies highlight these unexpected disruptions that diminish quality of life and the associated emotional challenges (Duggleby et al. 2010; Berterö et al. 2008; Syrén et al. 2006). Furthermore, patients may encounter a sense of abandonment once hospital care is discontinued, which exacerbates their psychological burden.

In parallel, family members also experience significant emotional stress as they have to adopt new roles and responsibilities and be a support for the person with palliative care needs. Therefore, the transition to community care is marked by heightened anxiety, fear of the unknown, and the burden of responsibility for their loved one's care, as other studies have demonstrated (Berterö et al. 2008; Syrén et al. 2006; Waldrop et al. 2005). These findings highlight the need for comprehensive emotional support, clear guidance and timely information from healthcare professionals to navigate this challenging time.

Healthcare professionals, including oncologists, palliative care specialists, and nurses, also express concerns regarding the continuity and quality of care during these transitions. As Killackey et al. (2020) highlighted, these healthcare professionals have to find a balance between managing clinical risk, assessing the capacity of informal caregivers to care for patients, honouring patient and family preferences, and conforming to systemic demands. Consequently, many experience a profound sense of professional and ethical responsibility towards their patients, fearing that the transition might compromise patient well-being. Therefore, a well-coordinated care plan is essential to guarantee continuous support for both patients and families.

Effective communication and coordination of care emerge as interdependent pillars in ensuring successful transitions between care settings. Studies revealed that poor communication between healthcare professionals and providers often affects continuity and coordination of care and leads to confusion (Flierman et al. 2020; Oosterveld-Vlug et al. 2019; Aamodt et al. 2013). Patients and families frequently report scarce communication or its late start and receiving insufficient information about future care, available resources, or managing symptoms at home (Murray 2002; Rabow et al. 2004). These situations generate anxiety for patients and families, difficulties in handling certain situations at home and confusion in recognizing the professional roles (Instituto Nacional de Cancerología E.S.E. et al. 2015; Benzar et al. 2011; McIlfatrick 2007).

In this context, clear and consistent communication is critical, not only for reducing anxiety among patients and informal caregivers but also for maintaining continuity throughout the care trajectory.

Moreover, systemic barriers such as fragmented healthcare services (Wilson and Birch 2018; Kasdorf et al. 2021), limited capacity of services or staff in the community (Hanratty et al. 2012; Smith et al. 2019; Mertens et al. 2022; Duggleby et al. 2010) and bureaucratic constraints significantly impact the transition process. Patients and families often struggle to navigate the complex healthcare system, leading to delays and gaps in care. Our findings emphasize that the implementation of a discharge coordinator, navigator or a discharge facilitation service can ensure a smooth transition to patients (Venkatasalu et al. 2015; Dose et al. 2011). Similarly, Coombs et al. (2015) and Moback et al. (2011) suggested that the transition should be facilitated by a coordinator who could lead the transfer to home care and who has the time, knowledge and skills to liaise across clinical settings and geographical boundaries.

In addition to the challenge of care coordination, our qualitative synthesis highlighted the importance of clearly defined roles and responsibilities within the care team to prevent care fragmentation and confusion (Flierman et al. 2020; Isenberg et al. 2021; Saunders et al. 2021), which was also emphasized by other studies (Ho et al. 2016; Oishi and Murtagh 2014).

Furthermore, the availability and accessibility of support services, such as home care or a 24/24 helpline, are crucial for an effective transition to community care (Flierman et al. 2020; Morey et al. 2021; Mertens et al. 2022). However, many patients and families report a paucity of adequate support services, which can significantly impact the quality of life and overall well-being. Therefore, as seen in other studies (Moore et al. 2013; Stajduhar et al. 2013), providing comprehensive support and resources, including education to carry out home care for family, is essential for easing the burden of caregiving.

4.1. Limitations

Readers should note that this review is limited to English-language studies, which may exclude relevant research published in other languages. Additionally, although the search strategy included PubMed, Scopus and ScienceDirect—and was supplemented by snowballing—it might not have captured the full breadth of available literature. Finally, given the qualitative nature of the studies included, the findings cannot be generalized to different contexts, populations, or settings. The richness of qualitative data is context-dependent, making it difficult to draw general conclusions. Due to restrictions in time and space, this study was unable to incorporate a detailed visual or conceptual mapping of the structural relationships between the identified themes and subthemes. Although the list format effectively presents the data, a visual map such as a concept map or network diagram could enhance comprehension of the thematic interconnections, and future research should address these limitations.

4.2. Implications

Future research should focus on developing and testing interventions that facilitate smoother transitions and provide better support for all stakeholders. Policy reforms aimed at improving the integration of hospital and community care services, reducing bureaucratic barriers, and ensuring equitable access to resources are essential for enhancing the transition experience and outcomes for palliative care patients. By addressing these challenges and implementing targeted interventions, healthcare systems can significantly improve the quality of life for patients and families during the critical transition from hospital to community-based palliative care.

5. Conclusions

This review identified six key themes that underpin the complexity of advanced cancer patients' transitions from hospital to community care: planning and managing transitions, communication among actors, limitations imposed by health systems, the role of the family as a unit of care, the specific needs of patients and families, and the emotional experiences of all involved. The findings reveal that transitions are frequently characterized by inconsistent management and insufficient communication, leading to anxiety, a sense of loss, and discontinuity in care. These results underscore the urgent need for a coordinated, holistic approach that not only enhances logistical planning and communication but also prioritizes the emotional and psychosocial support of patients and their families. Addressing these critical issues is essential to ensure high-quality end-of-life transitions and to foster a smoother integration of hospital and community care practices.

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