**Role of the nurse in the design, delivery, monitoring and coordination of cancer survivorship care plans: An integrative review**

**ABSTRACT**

Aim. Survivorship Care Plans (SCPs) are recommended as a tool for care of cancer survivors. SCPs have been implemented with a multidisciplinary approach; however, the specific role of nurses in the SCP is unknown. Our aim was to determine the role of nurses and their degree of participation in cancer SCP.

Design. Integrative review of the literature with systematic methodology.

Data sources. PubMed, CINAHL, PsycINFO, Web of Science, Cochrane and Cancerlit databases were reviewed. Articles published up to March 2021 were included. The websites of the most representative scientific societies related to cancer survival were also reviewed.

Review method. Of 2,638 publications identified, 22 studies met our inclusion criteria. Quality of included studies was assessed using Joanna Briggs Institute quality assessment tools. Data were organized according to comprehensive thematic analysis.

Results. The studies showed that nurses play a key role and participate in different phases of the SCP, including design, delivery, monitoring and coordination among different levels of care. Nurses participate in the different phases of the SCP (design, delivery, monitoring and coordination) with varying degrees of involvement and responsibility and in which design and delivery of SCP are the phases with the highest nurse participation (18 out of 22 studies). The majority of SCPs are implemented in specialized, hospital-based care and focus on short-term cancer survivors, who are actively undergoing oncological treatments.

Conclusion. This review shows that nurses actively participate in the design, implementation, and coordination of SCPs. However, SCPs focus on the acute survival and treatment phases, and there is a gap in their use in long-term cancer survivorship. This gap may be one reason the needs of long-term cancer survivors are not covered.

Impact. This review contributes to the current body of knowledge by addressing the role of nurses in cancer SCPs. We recommend the involvement of an advanced practice nurse as SCP coordinator to improve communication between cancer specialists and primary care providers, and to promote continued care throughout the different phases of cancer survivorship, including long-term survival.

**KEYWORDS**

Oncology, survivorship, care plan, nurse, role, participation.

**1. INTRODUCTION**

The latest figures from the Global Cancer Observatory show a progressive increase in the incidence and prevalence of cancer in 2018, with 9.5 million deaths and 18.1 million new cases (Bray et al., 2018). However, advances in early diagnosis and more effective treatments are favouring an increase in cancer survivors (Siegel, Miller, & Jemal, 2019).

Cancer survivors comprise a new population that requires health care that responds to their specific needs, as described for the first time in the report “From Cancer Patient to Cancer Survivor: Lost in Transition”, published in 2005 by the US Institute of Medicine (IOM) (Hewitt, Greenfield, & Stovall, 2005). Cancer survivorship care looks at a person's life from the cancer diagnosis. Three stages of survival have been described: 1) acute, 2) extended, and 3) permanent or long-term survival. Once the disease has remitted, the patient is considered to be in a permanent survival phase, also known as long-term cancer survivor (LSC) (Hewitt et al., 2005). For this review, a LSC is defined as a person who has lived more than five years without evidence of disease after being diagnosed with cancer and who, despite being free of symptoms, may suffer physical, psychological, social, spiritual and sexual sequelae due to cancer (Hewitt et al., 2005). The report from the US Institute of Medicine includes the need to implement initiatives for the effective coordination of levels of health care (specialist and primary healthcare) and to promote security and continuity of care to meet the health needs of cancer survivors (Hewitt et al., 2005).

**1.1 Background**

Approximately a decade after the publication of the IOM report (Hewitt et al., 2005), new models of cancer survivor care have been developed and implemented, first in the United States (Rowland et al., 2013) and more recently in Europe (Lagergren et al., 2019).

Currently there are two main models of long-term follow-up care for cancer survivors. The first is the specialized care model in which follow-up care occurs in the oncology setting with treating specialist (oncologist, cancer nurses, etc). It can be implemented in private practice, hospitals or specific cancer centres (Mateo & Garcia-Vivar, 2019). The second is the model of shared care, which includes the model of simultaneous care by cancer specialist and primary healthcare professionals and the sequential model, in which care for the cancer survivor is transferred to the primary care once the initial treatment by the oncology service is completed (Mateo & Garcia-Vivar, 2019). The Survivorship Care Plan (SCP), as a tool designed to meet the survivors´ needs, can be used in both survivorship care models: the specialized model and the shared care model. For both models, the use of the SCP seeks to improve coordination and continuity in cancer care (Hewitt et al., 2005).

The SCP is a document that includes a summary of treatments, guidelines for follow-up (diagnostic tests and reviews), comprehensive care for the survivor in the short, medium and long term, and health recommendations (Hewitt et al., 2005). It is designed to guarantee the quality, follow-up and continuity of care for cancer survivors and their families (American Society of Clinical Oncology, 2017). Besides, SCPs are an important tool for cancer survivors and their families as they transition into follow-up care. Having a written SCP that can be shared between cancer survivors and family members provides guidelines to meet new family challenges after finalising cancer treatment (Hewitt et al., 2005).

There is a strong need for survivors to receive follow‐up care by nurses to manage their late effects symptoms and advise survivors on how to cope with fears and life after cancer. Evidence has shown the positive impact of nursing interventions in survivor's quality of life (Colombani et al., 2019; Leeuw & Larsson, 2013). Therefore, cancer survivors must be provided with a multidisciplinary survivorship care plan, in which nurses are actively involved to assess the physical, psychological and social needs survivors may have and to offer health education to manage the long-term condition of cancer.

The main American scientific societies (American Society of Clinical Oncology, 2017; Hewitt et al., 2005; Minnesota Cancer Alliance, 2013) have proposed SCP models that are currently being implemented with active participation of nurses as part of the multidisciplinary team (de Leeuw & Larsson, 2013; Fenlon & Foster, 2009; Author blinded, 2019; Lewis et al., 2009). The proposals focus on models of shared care, include the main elements of the plan, and guide the practical implementation of the plan (Table 1).

Along the same lines, in Europe, cancer care is a priority (Author blinded, 2005; Lagergren et al., 2019); medical societies advocate for shared models of care in which the nurse is part of the team (Hewitt et al., 2005; De Leeuw & Larsson, 2013; Sociedad Española de Oncología Médica SEOM, 2011) and highlight the positive effects of specific nursing interventions on the quality of life of cancer survivors (Colombani et al., 2019; De Leeuw & Larsson, 2013). New advanced nursing roles such as the nurse-led model in cancer management are recommended roles because of the potential benefits in terms of improved efficiency, quality of care and reduced costs over traditional follow-up (Corner, 2003). Compared with physician-led follow-up, nurse-led follow-up was found to have similar results in terms of safety, satisfactory detection of recurrent cancer, equal health related QoL and patient satisfaction, and reduced costs (Corner, 2003; de Leeuw& Larsson, 2013). In cancer survival in particular, the nurse-led cancer survivorship care also appears beneficial for cancer survivors for cognitive and social quality of life and fatigue (Monterroso et al., 2019). However, although the systematic review and meta-analysis by Montorosso et al. (2019) contributes to new evidence on the effectiveness of nurse-led cancer survivorship care on patient reported outcomes for cancer survivors, no evidence is provided on the nurse role in SCPs. The degree of participation (involvement and autonomy) and the specific role of nurses in the development, implementation and evaluation of SCPs are unknown. Therefore, this article seeks to deepen the role and participation of nurses in caring for cancer survivors and to identify gaps in the knowledge on the subject.

For this review, the concept of nurse participation refers to being part of and being in coordination with the multidisciplinary survivorship care team, and in which the nurse performs specific interventions as part of the SCP (prevention of cancer recurrence, monitoring of symptoms, and communication and coordination of care) (Grant, Economou & Ferrell, 2010).

**2. THE REVIEW**

**2.1 Aim**

The aim of this integrative literature was to determine the role and degree of participation of nurses in cancer SCPs.

**2.2 Methods**

**2.2.1 Design**

This was an integrative review following the model of Whittemore and Knafl (2005) that sought to synthesize existing knowledge about the participation of nurses in SCPs and identify gaps in the knowledge. This type of review guarantees the methodological rigor necessary for literature reviews and favours the inclusion of studies with different methodological approaches.

**2.2.2 Search method**

A search was conducted in the following electronic databases: PubMed, CINAHL, PsycINFO, Web of Science, Cochrane and Cancerlit. The search limits were articles published in English and Spanish and the inclusion of adult populations (> 18 years). No limit on publication year was established because the topic is novel and relatively recent; therefore, the search papers published up to March 2021 were included. In addition, the websites of the most representative scientific societies related to survival were reviewed, including the American Society of Clinical Oncology, National Institutes of Health, Livestrong and the Centers for Disease Control and Prevention.

The search was performed with controlled language terms and keywords and their synonyms, and Boolean operators were used. Keywords were truncated according to database settings to allow for several endings for these words. The main search terms were cancer, models of care, care plans, nurs\*, nurse's role, participation, survivor, self-care and relapse prevention.

The inclusion criteria were as follows: (1) Studies related to outcomes following implementation of SCPs in clinical practice and with the participation of nurses; (2) Studies aimed at improving the quality and continuity of care for cancer survivors at any stage of survival; (3) systematic and bibliographic reviews; and (4) grey literature on recommendations and guidelines for cancer survivorship care published by the main scientific societies of oncology. The exclusion criteria were as follows: (1) studies that addressed issues related to cancer survival (incidence, needs, etc.) but did not include care plans directed towards the survivor; and (2) studies in which there was no nurse participation.

**2.2.3 Search outcome**

A total of 2.638 articles were identified, of which 376 were excluded because they were duplicates (Figure 1). After the titles and abstracts were read, 81 articles were selected, and those that met the established selection criteria were identified; 22 studies were included for analysis and review. The main characteristics of the 22 selected studies are presented in Table 2.

**2.3. Quality appraisal**

The methodological quality, shown in Table 2, was determined with the quality assessment tools proposed by the Joanna Briggs Institute (Joanna Briggs Institute, 2017). Risk of bias of included studies were independently assessed by two reviewers. Consensus was sought by three authors to resolve any discrepancies that arose. All articles reached the minimum acceptable quality level to be included in the review.

**2.4. Data extraction and synthesis**

The management of the bibliographic citations obtained was performed with the Note X07.7 Clarivate Analysis package. In the first phase, the titles and abstracts of all articles were independently assessed by two reviewers according to the selection criteria, and the full text was obtained for articles that were classified as potentially relevant. Publication information including authors name, country and year of publication, aim, sample, design, type of SCP, type of nurse participation in SCPs and main findings were extracted from each included paper by the first author and were checked by two authors (Table 2). Any discrepancies were discussed among all the authors until a consensus was reached. Thematic analysis approach was followed as set out in Whittemore and Knafl's framework (2005).

**3. RESULTS**

Four themes were identified in this review that present how nurses actively participate in the four consecutive phases of the SCP: 1. Design and data collection; 2. Delivery and discussion with the survivor; 3. Referral to primary care and; 4. Monitoring and coordination of the plan (Figure 2).

**3.1 Design and data collection**

19 of the 22 articles noted that all SCPs begin with the design of the plan and the selection of the content that will be included (Clarke et al., 2020; Coyle et al., 2014; de Rooij et al., 2017, 2019; DeGuzman, Colliton, Nail, & Keim-Malpass, 2014; Ezendam et al., 2014; Glaser et al., 2019; Hawkins-Taylor et al., 2019; Jefford et al., 2013; Jeppesen et al., 2018; Mayer et al., 2016, 2014; Miller, 2008; Nicolaije et al., 2015, 2013; Nolte et al., 2016; Reb et al., 2017; Singh-Carlson, Wong, & Oshan, 2018; Sprague et al., 2013). The included studies indicated that each health centre chose and developed its own specific SCP based on the different models proposed by the main scientific societies mentioned above (Brant, Blaseg, Aders, Oliver, & Grey, EvanDudley, 2016; Clarke et al., 2020; Coyle et al., 2014; Glaser et al., 2019; Hawkins-Taylor et al., 2019; Jefford et al., 2013; Miller, 2008; Reb et al., 2017; Singh-Carlson et al., 2018). Despite the heterogeneity of the SCPs, all of them were based on proposals designed from the IOM report. In 11 of the 22 studies, the nurse was the main professional responsible for this first design phase (Boekhout et al., 2015; Brant et al., 2016; Coyle et al., 2014; DeGuzman et al., 2014; Jefford et al., 2013; Maly, Liang, Liu, Griggs, & Ganz, 2017a; Mayer et al., 2014, 2016; Miller, 2008; Nolte et al., 2016; Reb et al., 2017). After the content to be included in the SCP was selected, a template was designed that would be filled in with the data for each survivor. Two different methods for data collection were described: selection from multiple options provided (Sprague et al., 2013) and automatic data extraction from the patient’s computerized clinical history (de Rooij et al., 2017; Ezendam et al., 2014; Jeppesen et al., 2018; Nicolaije et al., 2015, 2013). Regarding automatic data extraction, two studies (Mayer et al., 2014; Nicolaije et al., 2013) indicate the risk of obtaining plans that are too extensive and propose the agglutination of clinical data in elective modules (example: a lymphedema module, an asthenia and fatigue module). In this way, the professional responsible for developing the plan would choose among the different modules and adapt the care process to the specific needs of each cancer survivor (Nicolaije et al., 2013). Therefore, the specific participation of the nurse was on the design of the SCP.

**3.2. Delivery and discussion with the survivor**

This second phase occurs between the end of active treatment and the first month after treatment ends (DeGuzman et al., 2014; Ezendam et al., 2014; Jefford et al., 2013; Maly, Liang, Liu, Griggs, & Ganz, 2017b; Mayer et al., 2014, 2016; Miller, 2008; Nolte et al., 2016; Reb et al., 2017). The SCP is printed and delivered in person by a nurse in the hospital setting. Only one study in the present review described the plan as developed and followed-up by the primary care provider but without specifying whether the nurse participation was autonomous or collaborative (Clarke et al., 2020). Besides, 16 studies described the sharing of the SCP with the survivor as key to the patient’s understanding of the plan and to the discussion and establishment of care priorities and possible needs (Brant et al., 2016; Coyle et al., 2014; de Rooij et al., 2017; DeGuzman et al., 2014; Ezendam et al., 2014; Jefford et al., 2013; Jeppesen et al., 2018; Levine et al., 2015; Maly et al., 2017a; Mayer et al., 2014, 2016; Miller, 2008; Nicolaije et al., 2015, 2013; Nolte et al., 2016; Reb et al., 2017; Sprague et al., 2013). In particular, two of studies emphasized for professionals to receive adequate training to address this key moment in a way that is effective and understandable for the patient (Clarke et al., 2020; Nicolaije et al., 2013). On occasion, the delivery of the SCP can be complemented and reinforced by supporting teaching materials, such as dietary hygiene measures for the prevention of asthenia and fatigue (Boekhout et al., 2015).

The time dedicated to the delivery and discussion of the SCP with the survivor ranged from 30-120 minutes (Boekhout et al., 2015; Mayer et al., 2014; Nolte et al., 2016; Reb et al., 2017). This time can be greater than the time devoted to survival issues when an SCP is not used, and costs may increase accordingly (Coyle et al., 2014). However, it was alsoindicated that the small increase in in-person consultation time is compensated by the presence of a more structured, orderly and effective consultation (Mayer et al., 2014). To avoid prolonged SCP delivery times, Nolte et al. (2016) proposed stratifying cancer survivors according to specific oncological processes and their consequent needs so that delivery times are individualized and adjusted as much as possible. Other authors, in response to an economic evaluation of SCP use, proposed the delivery of SCPs in group sessions rather than individual consultations (Coyle et al., 2014). The need for individualization of SCPs was also discussed (Coyle et al., 2014; DeGuzman et al., 2014; Ezendam et al., 2014; Jeppesen et al., 2018; Mayer et al., 2016, 2014; Reb et al., 2017). These studies focused less on the need for individualization in terms of time management and more on the importance of individualization to ensure that patients understand the plan, a factor that is more necessary in groups with a low socioeconomic level (DeGuzman et al., 2014) and in groups of immigrants with language barriers (Maly et al., 2017a; Singh-Carlson et al., 2018). Finally, only one of the 22 studies (Brant et al., 2016) included the main caregiver in the SCP delivery and discussion phase. Not including caregivers and/or family in the overall planning for survivorship care resulted in lower adherence to treatment in breast cancer survivors whose partners were not involved (Maly et al., 2017a).

In the delivery and communication of SCPs, the nurse actively participates in the prevention of recurrent cancers and in the management and monitoring of symptoms through the establishment of care priorities and follow-up visits.

**3.3 Sending the SCP to the primary care provider**

All of the studies selected for this review addressed cancer survivors in the acute or extended phase. That is, 16 of the studies addressed the role of nurses in SCPs for survivors who were in treatment and receiving specialized care that addressed both acute survival and short-term survival without considering extended survival or long-term survival and the role of primary care (Coyle et al., 2014; de Rooij et al., 2017; DeGuzman et al., 2014; Ezendam et al., 2014; Jefford et al., 2013; Jeppesen et al., 2018; Maly et al., 2017a; Mayer et al., 2014, 2016; Miller, 2008; Nicolaije et al., 2015, 2013; Nolte et al., 2016; Reb et al., 2017; Singh-Carlson et al., 2018; Sprague et al., 2013). In only a few cases, SCPs were routinely shared with primary care teams (Boekhout et al., 2015; Jefford et al., 2013; Jeppesen et al., 2018; Nolte et al., 2016; Reb et al., 2017), favouring coordination and continuity of care. To conclude, the following practical matters were mentioned in only two of the included studies: the use of email to send the plan to the included teams (Jeppesen et al., 2018) and the possibility of creating different versions of the same SCP, a more abbreviated one for the patient and another, more extensive one for the primary care professional (Reb et al., 2017). In addition, one of the studies (Hawkins-Taylor et al., 2019) allowed the survivor to choose whether to share the plan with his or her primary care provider without actually carrying it out.

**3.4 Monitoring and coordination**

SCP monitoring took place through telephone nursing consultations (Boekhout et al., 2015) and face-to-face nursing consultations (Brant et al., 2016; Ezendam et al., 2014). Both types of follow-up were planned and integrated into a follow-up schedule with durations ranging from the delivery of the SCP to three years postdiagnosis. Consecutive follow-up visits over time had the objective of updating the SCP based on the dynamic needs and diagnostic test results of each survivor (Brant et al., 2016; Jefford et al., 2013; Nolte et al., 2016). Specifically, one of the studies identified in the review proposed that advanced practice nurses specializing in specific oncological processes should provide quality follow-up care for cancer survivors (de Rooij et al., 2019).

Four of the 22 studies (Boekhout et al., 2015; Brant et al., 2016; Jeppesen et al., 2018; Miller, 2008) indicated that the SCP was implemented entirely by nurses working in the context of a multidisciplinary team. In particular, some studies define advanced practice nurses as the optimal professionals to assume leadership in cancer survivorship care (Coyle et al., 2014; Mayer et al., 2016). Furthermore, Brant et al. (2016) defined nurses as the key facilitators of cancer survivor care who not only improve the care of the survivor but also simultaneously favour continuity of care.

**4. DISCUSSION**

This integrative review provides a synthesis of the role of nurses in the different phases of the SCP and contributes to new understanding about the degree of participation in the design, implementation, monitoring and care coordination of SCPs for cancer survivors.

**4.1. Promoting nurses´ role as care coordinator of SCPs**

The studies showed that nurses play a key role and participate in all the phases of the SCP (design, delivery, monitoring and coordination) with varying degrees of involvement and responsibility and in which design and delivery are the phases with the highest nurse participation (18 out of 22 studies).

The degree and type of participation are variable depending on how each centre works. The failure to establish a specific methodology for the design of the SCP generates plans that vary according to each health centre, which can lead to confusing, long and difficult-to-understand plans (de Rooij et al., 2017; Ezendam et al., 2014; Jeppesen et al., 2018; Nicolaije et al., 2015, 2013). A global and strategic approach to SCPs would help standardize their design and allow explorations of their effectiveness, which could result in plans with more appropriate content and length, thereby improving management for nurses in any field.

One of the objectives of the implementation of the SCP is to improve coordination among the different levels of care (American Society of Clinical Oncology, 2017) to ensure that the cancer survivor is not “lost in the transition” between the disease process and active treatment or in his or her new survivor status (Hewitt et al., 2005). In this review, only five articles that implemented shared care models were found, since most of the design and implementation of SCPs occurs only in the hospital setting. In addition, the few studies that presented shared models described primary care professionals (nurses and family physicians) as having a passive role in these plans, in which they were only involved in receiving information (Coyle et al., 2014; DeGuzman et al., 2014; Jeppesen et al., 2018; Mayer et al., 2016; Reb et al., 2017). This fact is directly related to the difficulties of ensuring smooth transitions from specialized care to primary care (Glaser et al., 2019). This difficulty of transition occurs in different medical specialties and in care for chronic processes, although the impact on cancer survivors is greater, in part because of the emotional burden of the disease itself (Boekhout et al., 2015). To improve the coordination and transition of care, studies have proposed that nurses with advanced practice roles in oncology serve as coordinators of the plans (Boekhout et al., 2015; Brant et al., 2016; Ezendam et al., 2014; Jeppesen et al., 2018). A coordination role which provides continuity and comprehensive cancer care, in particular at the transition from the specialist to the survivorship program in primary care, may be a required component of the survivorship model based on shared care. As experts in the delivery of holistic care, oncology advanced practice nurses are key professionals to address the physical and psychosocial needs of cancer survivors and are positioned to plan, deliver and coordinate survivorship care plans through innovative models (Corcoran, Dunne & McCabe, 2015). Besides, nurses have the support of the multidisciplinary team and the trust of the cancer survivor (Brant et al., 2016; de Rooij et al., 2017; Lawn, Fallon-Ferguson, & Koczwara, 2017; Miller, 2008; Nolte et al., 2016; Reb et al., 2017).

**4.2. Expanding nurses´ role in SCP to primary care**

For good cancer survivorship care, specific training is needed to develop nurses’ role in coordinating the SCP; such training should address communication skills, self-care, symptom management, prevention and health promotion (Jeppesen et al., 2018; Nicolaije et al., 2015; Reb et al., 2017). All of the studies identified to date focused on the role of nurses in specialized, hospital-based care in survival, leaving a gap in the transfer of SCPs to primary care services. However, it is noteworthy that the skills described above are specific to primary care nurses (Jost, Bonnell, Chacko, & Parkinson, 2010), who can play a key role in improving continuity of care and the follow-up of long-term cancer survivors in primary care (Author blinded, 2019).

The role of primary care nurses aims at achieving health promotion, prevention, recovery and rehabilitation of diseases, in such a way as to place services within the reach of the individual, the family and the community. To achieve this, primary care nurses implement their competencies in health education to help patients with chronic conditions self-manage their disease and promote their health and well-being. Similarly, primary care nurses can play a key role in ensuring that the cancer survivor’s health needs are meet through the implementation and delivery of the essential components of SCP, including: prevention of recurrent cancers; assessment of physical and psychological late effects (such as pain, fatigue, psychological distress experienced by survivors and their family members); concerns associated to employment and health insurance; and coordination between cancer specialists and primary care professionals (Corcoran et al. 2015).

Following successful experiences in the implementation of new models, some studies proposed a strategy similar to that developed for the care of chronic conditions by primary care nurses (Fuentes, Lambird, George, & Merry, 2017; Jacobs & Shulman, 2017). The current models of chronic care focus on nurses because they are considered the health professionals with the best training for coordinating this type of care (Fuentes et al., 2017; Smolowitz et al., 2015). Therefore, considering cancer survival from the perspective of chronicity, primary care nurses have the appropriate competencies to lead care plans for cancer survivors and their families (Author blinded, 2019; Ezendam et al., 2014; Poghosyan, Norful, Liu, & Friedberg, 2018). Given the limited evidence identified in this review, studies that describe the specific competencies needed for nurses who coordinate survivor care should be carried out. Similarly, it is necessary to identify the impact of this new profile of advanced practice on satisfaction with survivorship care (Mayer et al., 2016), coordination and effectiveness in terms of cost reduction, efficiency and improvement in the quality of care.

**4.3. Implementing SCPs in the long-term cancer survivorship**

This review contributes to the identification of existing gaps in the evidence regarding the implementation of SCPs. Despite the growing evidence on models of care for survivors, most of the studies address a solely theoretical perspective, with this review showing the scarcity of studies that describe the outcomes of the implementation of SCPs.

Furthermore, the use of SCPs has not been extended to long-term cancer survivorship care and has focused on early stages of survival, despite a progressive increase in the number of long-term survivors (Siegel et al., 2019). This fact may be due to the slow pace of evolution in the trajectory of the SCP themselves, proposed since 2005 with the IOM report "From Cancer Patient to Cancer Survivor: Lost in Transition" (Hewitt et al., 2005) and its implementation began in practice since 2015. On the other hand, most studies are focused on the field of specialized, hospital-based care, which justifies having acute survival as the focus of attention. Thus, to address all phases of cancer survival, this review proposes the use of SCP as a flexible tool, beginning its use at the time of cancer diagnosis by specialized care professionals and continuing with adequate transfer to primary care and the advanced practice nurse in primary care as a survivorship coordinator.

**4.4. Expanding knowledge about outcomes of SCP implementation**

In this review, included articles are limited to five countries (the United States, the Netherlands, Canada, Australia and the United Kingdom; despite promoting the implementation of the SCP, these countries show little planning and a lack of coordination of care (Smolowitz et al., 2015). Therefore, based on the results obtained in this review, the generalization of the SCP to other countries is proposed so that it can be implemented according to their own models and health systems (for example Mediterranean countries, such as Spain and Portugal, which have models based on primary care) and its impact can be determined.

**4.5. Raising awareness about the inclusion of family members in SCPs**

The SCPs included in this review did not include the family of the survivor, an aspect highlighted in the IOM report on survival (Hewitt et al. 2005). Similarly, the main cancer organizations, such as the American Society Clinical Oncology (2017) and the Minnesota Cancer Alliance (2013), encourage the inclusion of the family in survivorship care and the development of future research in this regard. All this derives from the statement that cancer is a “family experience” throughout its trajectory, including long survivorship (Cavallar Oriol & García-Vivar, 2019).

**4.1 Strengths and limitations**

This review performed a comprehensive search of the main health sciences databases and the websites of the most representative scientific societies related to cancer survivorship. However, only five countries are represented in the review: The United States, Canada, the Netherlands, Australia and the United Kingdom. This suggests that the generalizability of the results may be limited because most of the studies were developed in the American health system, which differs in terms of the management, financing and organization of care coordination from the European and Canadian health systems. Furthermore, SCPs were implemented differently in each health organization; the practical aspects of implementation were not provided, and specific details were not specified. Besides, we acknowledge this review was limited by the focus on English and Spanish articles; thus, findings may reflect a publication bias.

**5. CONCLUSION**

Knowing nurses’ role and degree of participation in SCPs will help develop health policies that promote innovative roles and advanced nursing practice that acknowledges a comprehensive strategy for cancer care. In-depth knowledge of nurses’ participation and involvement in caring for cancer survivors and their families via the SCP will favour better management and planning of survivorship care and an increase in the quality of care. This is clearly an emerging area that requires more knowledge and research to provide evidence for strategic decision-making regarding care in the acute, extended and long-term phases of cancer survivorship.

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