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Barriers Experienced by Community Nurses in Delivering Pain Management to End of Life Adult Cancer Patients

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Abstract

Background: Nurses play an integral role in cancer pain management, alleviating patients' suffering during end-of-life care through the use of pharmacological and complementary interventions. The community setting presents unique challenges for pain management, making it essential to explore nurses' perspectives on this topic.

Aim: The primary aim of this study was to investigate nurses' experiences with barriers to the use of pharmacological and complementary therapies in managing cancer pain in adults receiving end-of-life care in community settings.

Methods: This qualitative research study employed semi-structured interviews with eight nurses working in a National Health Service community care setting focused on end-of-life care. Data were analyzed using a six-stage thematic analysis approach.

Results: Among the eight participants, seven were female, and all held a bachelor's degree. Three main themes and six sub-themes emerged: (1) barriers related to healthcare professionals and services, (2) barriers associated with families and carers, and (3) the need for enhanced education for nurses.

Conclusion: The study recommends that nurses receive adequate training to effectively manage cancer pain using both pharmacological and complementary therapies.

Keywords: Barriers, cancer pain management, community, nurses, palliative care, pharmacological and complementary therapies

Introduction

Cancer pain is one of the most frequently reported issues faced by healthcare professionals. Patients diagnosed with cancer often experience inadequate assessment and management of their pain, despite the availability of training and guidelines on pharmacological and complementary therapies within the community.[1] Nurse knowledge of cancer pain management is crucial for improving care delivery, promoting health, and enhancing the quality of life for patients in end-of-life care.[2] The approach nurses take in using both pharmacological and complementary therapies for cancer pain management in end-of-life care is often guided by patient preferences.[3] Several studies have highlighted that patients suffer from cancer-related pain, which has a negative impact on their quality of life.[4,5] Nurses' understanding of cancer pain management, combined with other influencing factors, directly impacts the effective management of cancer pain in end-of-life care, thereby ensuring that patients remain comfortable and dignified during their final stages of life.[6] End-of-life care refers to the support provided to patients who are nearing the end of their lives and are expected to die within a timeframe ranging from a few weeks to several months or years, with no curative treatment options available.[7] Community Specialist Palliative Care Nurses (CSPCNs), who operate in community settings, provide guidance, support, and home visits to patients receiving end-of-life care. They manage cancer pain using both pharmacological and complementary therapies.[4,8] Pharmacological therapies include oral or injectable anticipatory medications such as morphine, while complementary therapies encompass interventions such as acupuncture, mindfulness, massage, psychological therapies, aromatherapy, reflexology, and meditation.[5,8]

It is essential to explore barriers by examining nurses' views, experiences, and opinions to gain a deeper understanding of the challenges they face. The effective use of pharmacological and complementary therapies in end-of-life care for patients in the community is

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challenging due to several factors. These include organizational issues, difficulties in collaborating with other healthcare professionals, the training needs for nurses, and patients' cultural and religious beliefs.[3] Despite advancements in pain management and improvements in nurse training related to pharmacological and complementary treatments, significant problems persist in this area of care. The primary aim of this research was to investigate nurses' experiences with pharmacological and complementary therapies in managing cancer pain in adults receiving end-of-life care in the community. Additionally, the study sought to identify the barriers to implementing these therapies and to explore strategies to address these barriers in practice.

Research Questions

1. What are nurses' experiences with pharmacological and complementary therapies in adult cancer pain management in end-of-life care?
2. What are the barriers to implementing these pharmacological and complementary therapies?

Materials and Methods

Study Design and Setting

This qualitative study was conducted within a Community Specialist Palliative Care (CSPC) Team, part of a London National Health Care Trust. The team provides specialist palliative and end-of-life care to patients with life-limiting illness, as well as their families and carers, within the community. The role of the Community Specialist Palliative Care team includes processing referrals from healthcare professionals and patients, organizing home visits, and delivering pain management interventions such as administering syringe driver pumps, injections, and oral medications. The team also coordinates medication requests from patient's general practitioners, facilitates and/or refers patients for alternative therapies, and conducts death verification at home. The team is not based in a hospice but operates from a community-based office.

Sampling, Participants, and Recruitment

Participants were Community Specialist Palliative Care nurses who care for approximately 450 end-of-life patients in the community. These 20 Community Specialist Palliative Care nurses worked a shift pattern that included long days and nights, with each shift lasting 12.5 hours. The inclusion criteria specified all nurses working as CSPC nurses in the community, while the exclusion criteria excluded other healthcare professionals and student nurses. Participants were recruited using a purposive sampling methodology, which allows the researcher to identify and select individuals or groups with specific knowledge or experience relevant to the phenomenon of interest.[9] An email invitation, including a participant information sheet and consent form, was sent by the manager of the community center to all 20 nurses who met the inclusion criteria, inviting them to participate on a voluntary basis. Nurses were instructed to contact the research team directly if they were willing to be interviewed. All eight participants who volunteered were Band 7 nurses. In the United Kingdom, a Band 7 nurse is a senior-level nurse with advanced clinical expertise and/or managerial responsibilities. These nurses develop and implement care plans, conduct advanced clinical assessments, and lead quality improvement initiatives.

Data Collection

Data were collected through semi-structured interviews conducted by the first author between February and November 2023. The interview questions were developed based on a review of the literature and consultations with experts in the field. Examples of the questions included: "What are the challenges in providing pain management in the community?" and "What kind of support and training opportunities does the Trust provide?" The interviews were conducted face-to-face at a convenient time in a private office. The average interview duration was 50 minutes (ranging from 40 to 60 minutes), and the sessions were recorded using a digital recorder. Throughout the interview process, the interviewer maintained a neutral and unbiased stance, refraining from offering personal opinions or views to ensure the data collected was relevant and trustworthy. The interviews were transcribed verbatim.

Data Analysis

The data were analyzed using Braun and Clarke's[10] six-stage thematic analysis method. In the first stage, both authors read and reread the transcripts to become familiar with the data. In the second stage, initial codes were generated to facilitate meaningful organization. Similar codes were then sorted and grouped into categories. The third stage involved searching for themes and organizing the codes into broader thematic groups. During the fourth stage, themes and their relationships were identified, along with relevant sub-themes. The fifth stage involved assessing how each theme contributed to the overall data and naming the themes. In the final stage, the findings were written up. The rigour and trustworthiness of the data and data analysis was ensured with respect to dependability, credibility, confirmability and transferability. To maintain rigour all interviews were conducted by the first author (DM). Audio recording and verbatim transcription of interviews ensured accurate and dependable data collection. The transcriptions were sent to participants to ensure their credibility and veracity. The coding framework was confirmed through agreement by both authors. Regular meetings and discussion between the authors were used to reach consensus on themes and subthemes before the final stage of the data analysis. The use of purposive sampling techniques to produce a representative participant sample ensured the transferability of the findings.

Ethical Considerations

The study received approval from both the NHS Foundation Trust Central North West London Ethics Committee and School of Nursing and Midwifery (Approval Number: NWSC2023MAY02, Date: 02.05.2023), and the community management team. A participant information sheet detailed the rationale for the study to enable participants to make informed decisions. Participations were informed that they could withdraw their data at any time without providing a reason. Additionally, if any negative feelings arose during the interview, the session could be stopped immediately. All participants signed a written consent form prior to their interview. No financial incentives were offered for participation. Anonymity was ensured during the transcription process, and findings were reported using pseudonyms. Participants were informed about data protection measures, including how their information would be stored securely and kept confidential. This study adhered to the principles of the Declaration of Helsinki.[11]

Results

Of the eight participants in the study, seven were female, with work experience ranging from 3 to 6 years, and all held a bachelor's degree (Table 1).

Table 1. Participant Demographics

Participant	Grade	Sex	Years of Experience as a Clinical Specialist Palliative Nurse (CSPN)	Education Level
1	Band 7	Female	5 years	BSc
2	Band 7	Female	3 years	BSc
3	Band 7	Female	4 years	BSc
4	Band 7	Female	6 years	BSc
5	Band 7	Female	3 years	BSc
6	Band 7	Male	5 years	BSc
7	Band 7	Female	4.5 years	BSc
8	Band 7	Female	3 years	BSc

Three main themes and six sub-themes were identified: (1) barriers from healthcare professionals and services, (2) barriers from family and carers, and (3) educational needs for nurses (Table 2).

Theme 1: Barriers from Healthcare Professionals and Services

Subtheme 1: Teamwork and Communication Issues

Participants highlighted the importance of effective teamwork and communication among healthcare teams.

"*Local complementary teams should introduce themselves to teams in the community, which might occasionally be more advantageous than using pharmaceutical methods and reducing the cost of prescription drugs.*" (Participant 3)

"*Most professionals are unsure of precisely when to refer. Furthermore, it depends on the kinds of complementary therapies that are offered.*" (Participant 6)

"*There is a need for improvement in the cooperation and coordination between General practitioners (GPs) and other healthcare professionals (HCPs).*" (Participant 4)

"*There should be clear handovers within the team.*" (Participant 8)

Participants reported communication issues, particularly related to language barriers. Patients noted that staff often used terms they did not understand and raised concerns about the availability and reliability of interpreters.

"*One of the biggest obstacles between patients and staff is the language barrier, particularly when there is no one available to translate or when staff rely on families to interpret for them because they might report wrong information, which could affect patients' choice of therapies to use.*" (Participants 4)

"*I can say the main issue with communication is with GPs because they do not communicate with the teams, giving them updates on how to support the patient after their review or even when they start them on new medications.*" (Participant 8)

Subtheme 2: Medication-Related Issues

Participants identified barriers related to accessing prescription drugs, drug shortages in pharmacies, and the time required to obtain these medications. There has been some degree of discontent with Mar Charts for signing controlled drugs, as they were either incomplete or specified incorrect doses.

"*The process of getting medications in community settings is comparatively more time-consuming than in hospital settings. Unless you have another physician or a Clinical Nurse Specialist (CNS) who is a prescriber, CSPNs must request drugs from the GP over the phone or through emails. Setting up the medication charts is another difficult process. Controlled substances must be signed following trust guidelines.*" (Participant 7)

"*Compared with hospice, care is provided very quickly, but in community settings, patients may need to wait longer to obtain medications.*" (Participant 6)

"*I can say most of our GPs are very reluctant to prescribe anticipatory medications, or if they do, it is done with wrong doses, and you have to spend lots of time fixing the problems. I have noticed that there are more shortages of anticipatory medications ..., forcing them to wait a few days for these drugs.*" (Participant 8)

Subtheme 3: Limited Access to Complementary Therapy Services

Participants discussed challenges in accessing knowledge about complementary therapies and determining whether these therapies are sufficiently evidence-based for use in end-of-life care. They emphasized the need for more training in complementary therapies.

"*The barriers to complementary therapies are mainly about not having access to them and not keeping up with training. There is no evidence-based practice to support staff availability or suitability for the patient. Nothing significant has been shown to us, though it may be helpful in some way; still, we may require additional training in that area.*" (Participant 1)

Table 2. Main Themes and Subthemes

Theme 1: Barriers from Healthcare Professionals and Services	Theme 2: Barriers from Families and Caregivers According to Nurses	Theme 3: Educational Needs for Healthcare Professionals
Teamwork and Communication Issues	Concerns Over Pharmacological Side Effects and Addiction	
Medication-Related Issues	Cultural Beliefs of Patients and Their Families	
Limited Access to Complementary Therapy Services		
Lack of Pharmacological Knowledge Among Nurses		

" *I do not think everyone is aware of complementary therapies.*" (Participant 3)

"*I feel that having some expertise or background in complementary therapies would be very beneficial, but I have very little experience in this area.*" (Participant 4)

"*I believe that rather than complementary therapies, pharmaceutical inputs have become more familiar to CSPNs. On the other hand, we lack access to complementary therapies and the necessary equipment.*" (Participant 6)

Subtheme 4: Lack of Pharmacological Knowledge Among Nurses

Participants reported that a significant barrier to effective cancer pain management in the community for adult patients in end-of-life care was a lack of pharmacological knowledge among nurses, as well as the need to educate patients about medication.

"*I believe it is about the lack of knowledge about the medication that has been administered. So, it is more on us to just know how to explain to patients and carers and make them aware and understand what it is for, how they work.*" (Participant 2)

"*There are times when taking pain medications regularly or when carers fail to give medication on time causes a delay in behavior.*" (Participant 4)

"*Patients and carers lack knowledge about how these medications work and their side effects to manage their cancer pain.*" (Participant 8)

Participants revealed that, based on their experiences, they have certain fears regarding the use of opioid medicines for cancer pain management in end-of-life care within the community.

"*I can say that sometimes as nurses, we get those internal fears, you know, of using opioid medicines. I think they are too sedative, and it is difficult afterwards to reassess their effectiveness because the patients become too sleepy for a few hours.*" (Participant 8)

"*I think sometimes I get afraid to administer anticipatory medications (AMs), even though they are the correct doses, because I fear they might kill the patient before their time to die.*" (Participant 5)

Theme 2: Barriers from Families and Caregivers According to Nurses

Subtheme 1: Concerns Over Pharmacological Side Effects and Addiction

Participants highlighted the fear of side effects, addiction, and allergies, as expressed by patients and families. Participants also noted their own anxieties about administering anticipatory medications due to the challenges of managing side effects.

"*There are certain patients and their families who cause barriers because they are frightened of commencing opioids because they believe it would kill them before they are ready to leave the world.*" (Participant 1)

"*In terms of medications, patients can also have a fear of addiction, so they might not want to take these strong analgesics because of the risks of becoming addicted.*" (Participant 7)

"*I think barriers are associated with patients' and families' fear and lack of knowledge about the medications used, how they work, and their side effects.*" (Participant 5)

"*Some people may even say that they would rather go through their agony than develop an addiction.*" (Participant 8)

Subtheme 2: Cultural Beliefs of Patients and Their Families

Participants noted that cultural attitudes and beliefs held by patients and their families often negatively impacted the effectiveness of pharmacological and complementary therapies. These concerns were primarily centered around the use of strong painkillers.

"*It has to do with what they believe about certain medications, for example, morphine. The word 'morphine' already poses a threat, like it is a killer. Also, some cultures do not believe in certain medications, and they will challenge you when you try to give them to control the patient's symptoms.*" (Participant 1)

"*There are some cultures or religions that are adamant about giving the patients stronger painkillers, which is sometimes challenging for CSPNs.*" (Participant 2)

"*I think that patients' culture and religion might affect the effectiveness of complementary therapies. For example, if the professional providing the complementary therapies is male and the patient is female, there may be problems with female patients allowing male professionals to provide the service.*" (Participant 6)

Theme 3: Educational Needs for Healthcare Professionals

Participants highlighted the importance of education in supporting community-based end-of-life care, particularly in managing cancer pain using both pharmacological and complementary therapies.

"*The staff needs more training, education, and awareness, especially on complementary therapies; they are not well known because people concentrate more on pharmacological therapies.*" (Participant 1)

"*We need support in terms of training for alternative therapies. The same applies to pharmacological therapies; we had training already….. it is just to keep updating ourselves with new developments happening around us.*" (Participant 2)

"*I think that basic training is needed, especially with complementary therapies, showing how to do them. I know because I have taken a little course in it. I have been shown how to do massage and head massage, and I am pretty good at it, but when it comes to patients, it is a whole different ball game. You need a bit of paper to prove that it is done properly. So, training would be really good—ongoing updates, webinars, and presentations for staff.*" (Participant 3)

"*I know that in our trust, there are lots of training sessions, almost every week. These are either under palliative care or provided by external teams. The challenge with that is probably finding the time for the HCPs to attend them.*" (Participant 6)

Discussion

This study explored the experiences of Community Specialist Palliative Care nurses regarding barriers to the use of pharmacological and complementary therapies in managing adult cancer pain during end-of-life care in the community. Participants emphasized the importance of cooperation and teamwork among healthcare professionals, while also identifying existing barriers. Effective teamwork in end-of-life care was highlighted as an important element of healthcare practice, with partnerships between specialists shown to enhance holistic care and improve quality of life.[12] Collaboration with other healthcare professionals, such as GPs, was considered essential for improving holistic patient care in the community. Previous studies have shown that medication-related issues, including difficulties in obtaining prescriptions from GPs, often result in delays in medication administration.[13,14] Participants identified GPs' reluctance to prescribe anticipatory medications as a barrier to effective cancer pain management in end-of-life care. These findings are similar to other studies indicating that GPs are often unwilling to prescribe opioid analgesics due to a lack of information about patient deterioration, concerns over accountability for drug misuse or errors, and the cost of unused medications.[14-16] This reluctance significantly impacts cancer pain management in end-of-life care within the community, forcing patients to endure pain rather than passing away comfortably.[15] A shortage of anticipatory medications in pharmacies was also identified as a reason for difficulty obtaining opioids. This shortage has a profound effect on end-of-life cancer pain care in the community, leading to unnecessary hospitalizations and increasing distress for patients and carers managing cancer pain at home.[16] Additionally, issues such as inaccurate dosing on Mar Charts were noted as problematic. Waiting times, which were reported in several studies, were consistent with our findings.[17-19] Another key issue raised by our participants was the fear of administering anticipatory medications due to concerns about managing side effects, such as excessive sedation, in a community setting. This apprehension was similarly observed in several studies.[20,21]

Communication is a vital aspect of end-of-life care as it fosters trust between the patient and the Community Specialist Palliative Care Nurse, thereby enhancing the effectiveness of cancer pain management through pharmacological and complementary therapies.[22,23] Our participants emphasized that effective communication involves using lay terms, discussing treatment options, and involving patients in the assessment process. Several studies have reported that language barriers between staff, patients, and carers—particularly when non-English-speaking patients lack access to an interpreter—can significantly affect the quality of care.[24,25] However, these communication challenges may be mitigated by fostering strong patient-nurse relationships and using professional interpreters. Relying on family members as interpreters, on the other hand, presents its own set of challenges.[26,27]

Participants also highlighted that limited access to and awareness of complementary therapies is a barrier to effective cancer pain management in the community. This aligns with findings from other research, which indicates that both patients and staff are often unaware of complementary therapies—such as massage, relaxation, and mindfulness techniques—that are considered effective for managing cancer pain.[28,29] The lack of evidence supporting complementary therapies was also identified as a concern. Combining pharmacological and complementary therapies has been shown to maximize the effectiveness of pain management.[3,30-32] Therefore, Community Specialist Palliative Care nurses who take the initiative to seek accessible training on complementary therapies can benefit from enhanced knowledge and skills, enabling them to select optimal therapy combinations for their patients.[15,33]

Participants in this study reported barriers related to families and patients, primarily concerns about opioid-related side effects and fears of addiction. Despite the availability of resources in end-of-life care to educate families and patients on the effectiveness of opioids for cancer pain management, resistance remains high, highlighting the need for continued efforts to address these negative perceptions.[34] A study found that a lack of pharmacological knowledge is a key reason behind these concerns. It emphasized the importance of healthcare professionals educating patients and families on the appropriate use of analgesics to maximize their benefits in end-of-life care.[20] To reduce the stigma associated with opioid use, public awareness campaigns and training programs about opioid analgesics should be considered.[35] Additionally, healthcare professionals must acknowledge that cultural and religious values can act as barriers to cancer pain management, even when nurse aim to optimize comfort for end-of-life care patients.[36-38] Participants emphasized that values should be respected in all situations, such as when male patients decline complementary therapies from female nurses, or vice versa.

Education needs for not only nurses but also patients and families were emphasized by all participants. Training on pharmacological and complementary therapies, including addressing side effects, must be tailored to the specific factors relevant to community settings. Several studies have indicated that such training can improve the management of cancer pain.[15,38] Community Specialist Palliative Care nurses play an essential role in coordinating care and effectively managing cancer pain for end-of-life patients in the community.[39]

Study Limitations

While this study provides valuable insights, it is important to acknowledge its limitations. The focus on a single community palliative team and the inclusion of only one male participant may limit the broader applicability of the results. Additionally, participants' familiarity with the researchers might have influenced their responses, potentially affecting the validity of the data collected. However, although the interviewer possessed relevant clinical expertise, care was taken to ensure that this did not influence the conduct of the interviews.

Conclusion

There are several possible improvements to key areas of practice that could enhance pain management for end-of-life care patients in the community. This study emphasized the importance of effective teamwork and collaboration. Communication skills are critical among GPs and other healthcare professionals during handovers and decision-making, especially when prescribing anticipatory medications on Mar Charts. These skills help reduce the possibility of errors, minimize the time spent resolving issues, and improve the administration of appropriate cancer pain treatments.[40] The participants recommended that healthcare professionals and nurses cultivate strong nurse-patient relationships to promote complementary therapy regimens in cancer pain management.

This study highlighted the importance of service availability and accessibility, as these factors encourage holistic cancer pain management. Staff should have access to resources that enhance cancer patient treatment options by integrating pharmacological and complementary therapies into end-of-life care. Additionally, acknowledging and respecting cultural and religious beliefs is essential, as this represents a critical aspect of positive patient care practices.[41] Training and educational opportunities focused on pharmacological and complementary therapies for staff, patients, and families are key to improving the overall quality of care.

Ethics Committee Approval: This study received ethical approval from the NHS Foundation Trust Central North West London Ethics Committee and School of Nursing and Midwifery (Approval Number: NWSC2023MAY02, Date: 02.05.2023).

Informed Consent: All participants signed a written consent form prior to their interview.

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