



Nurses Knowledge on Pain Assessment and Practices of Pain Management Among Cancer Patients in Imo State University Teaching Hospital (IMSUTH) Orlu

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Abstract

This study assessed nurses' knowledge of pain assessment and their pain management practices among cancer patients at Imo State University Teaching Hospital (IMSUTH), Orlu. A descriptive cross-sectional survey design was adopted. The study was guided by three research questions, and 101 nurses were selected using a stratified random sampling technique. Data were collected using a self-structured questionnaire developed in line with the study objectives, with a reliability coefficient of 0.70. Data were analyzed using frequency counts, percentages, and mean scores, while the chi-square test was used to test the hypothesis at the 0.05 level of significance. The findings revealed that the majority of respondents had good knowledge of pain assessment and management, with a mean knowledge score of 3.47 on a four-point Likert scale. However, the level of pain management practice was relatively low, with a mean score of 2.40. Major factors reported to impede effective pain management included inadequate staffing, insufficient training, limited availability of analgesics, and heavy workload. Educational qualification was significantly associated with nurses' knowledge of pain assessment and management ($p < 0.05$). The study concludes that although nurses demonstrated good knowledge of pain assessment and management, this knowledge was not adequately reflected in clinical practice. It is therefore recommended that hospital management strengthen institutional support for cancer pain management through regular in-service training, improved availability of analgesics, adequate staffing, manageable workloads, and supportive pain management policies and guidelines.

Keywords: Nurses; Knowledge; Pain; Assessment Management; Cancer Patients; Orlu

Introduction

Cancer is a serious global health concern characterised by uncontrolled and aberrant cell proliferation and remains a leading cause of morbidity and mortality globally. Its burden continues to rise, particularly in low- and middle-income countries where late diagnosis, restricted access to therapy and inadequate supportive and palliative care contribute significantly to poor outcomes [1]. Pain is one of the most prevalent and debilitating of the many consequences associated with cancer having major effects on patients' physical functioning, psychological well-being, emotional health, social interaction and overall quality of life [2].

Cancer pain may be directly or indirectly caused by cancer growth and subsequent tissue and nerve damage as well as diagnostic and therapeutic procedures. Surgical operations can lead to acute or chronic post-operative pain. Chemotherapy and radiotherapy can induce painful toxicities. Certain chemotherapeutic drugs, especially platinum compounds and taxanes, can develop Chemotherapy-Induced Peripheral Neuropathy (CIPN) in about 30-40% of individuals receiving these treatments [3]. Radiotherapy can also cause discomfort through mucositis, fibrosis, inflammation or nerve damage. Pain in cancer patients can also be caused by infection, immobility, muscle atrophy, treatment-related problems, and other concomitant conditions [4].

Pain in cancer stays fairly prominent throughout the cancer trajectory. In a major systematic review and meta-analysis of 444 studies, the total prevalence of pain among cancer patients was 44.5%, with about 30.6% suffering moderate-to-severe pain [5]. The burden of pain usually increases

with the advancement of disease and those with advanced, metastatic or terminal cancer may face pain prevalence, from 60 to 70%. A major problem for cancer survivors is persistent long-term pain. A recent worldwide meta-analysis found that about 41% of cancer survivors endure persistent pain with significant regional differences [6].

Cancer pain is of particular concern in poor and medium income nations where it is more likely to be undertreated than in high income settings. The reported prevalence of chronic cancer pain in Africa was about 59% as compared to 28% in North America and 30% in Oceania. This gap is due to a number of variables such as late presentation, poor pain evaluation, restricted availability and access to analgesics, concerns about opioids, inadequate palliative care services, and a lack of well-trained health care workers [7]. Likewise, the World Health Organization (WHO) has observed that low- and middle-income nations, which represent a large fraction of worldwide cancer deaths, still face discrepancies in access to cancer pain management, especially opioid analgesics [8].

Cancer pain is a major clinical and public health problem in Nigeria, particularly as many patients present with advanced disease. In a recent Nigerian study, neuropathic pain was identified in 23% of cancer patients and was associated with disease progression and functional impairment [9]. Earlier research from Nigerian oncology settings have likewise revealed a high prevalence of moderate to severe pain among cancer patients, including a considerable proportion with significant pain during the first assessment. The National Cancer Control Plan also acknowledges the considerable proportion of patients presenting with advanced stage cancer, within which pain may be particularly frequent and difficult to [10].

Managing cancer pain effectively is a multifaceted process that requires accurate assessment, suitable action, ongoing monitoring, documentation and review. Pain evaluation offers the basis for identifying the severity, features, and impact of pain and for selecting relevant treatment interventions. Standardised assessment methods such as numerical rating scales, visual analogue scales and other validated tools give healthcare workers an objective way of assessing pain and monitoring patients' responses to treatment. Inaccurate and inconsistent pain assessment can result in delayed action, improper therapy, lack of documentation, and continued suffering of the patient [11].

Due to their frequent and direct contacts with patients nurses are the key professional in the management of cancer pain. They are often the first health professionals to detect changes in pain intensity, to evaluate patient responses to treatment, to administer prescribed analgesics, to implement non-pharmacological interventions, to record pain-related information and to communicate patient needs to other members of the multidisciplinary team. Nurses' knowledge of pain processes, assessment methods, analgesic pharmacology, opioid use, side-effect monitoring and non-pharmacological techniques are critical to effective pain management and good patient outcomes [12].

Nursing has a key role in cancer pain management, there is evidence that lack of knowledge and clinical practice continue to be a barrier to effectiveness. A recent scoping review found that many nurses lack knowledge and abilities in pain assessment, opioid use and evidence-based pain treatment, which contributes to sub-optimal pain control in cancer patients [13]. Inadequate education and inadequate chances for continuous professional development have been cited as key impediments to successful pain management. A recent cross-

sectional survey among oncology nurses revealed significant deficits in terms of knowledge and attitudes about cancer pain management, and only a tiny minority had sufficient proficiency. The studies also revealed that the educational background and professional training influences the preparedness of nurses to properly deal with pain connected to cancer [14].

Another key issue is the lack of usage of standardised pain assessment techniques. Accurate and regular assessment is required to guide individualised treatment, however nurses may not always use validated assessment instruments or fully document pain-related findings. In the hectic clinical environment with high patient volumes, poor personnel, and competing clinical obligations, pain evaluation may be overlooked. Such situations may lead to delay in treatment and poor control of cancer pain [15].

The challenges are often compounded in resource-limited health-care settings, where there may be limited access to pain management guidelines, poor continuing professional education, limited availability of analgesics, misconceptions about opioid use, inadequate staffing and heavy workloads that can all impede the delivery of optimal pain care. These constraints may impair nurses' confidence and skill in managing complex pain circumstances and increase the chances of prolonged moderate-to-severe pain in cancer patients. Strategies to improve nurses' competence and patient outcomes have been recommended, including structured in-service training, regular professional development, better access to analgesics, supportive institutional policies, and integration of evidence-based pain management into nursing education [16].

The ripple effects of inadequately managed cancer pain reach far beyond the initial suffering. Chronic pain can impact sleep, mobility, nutritional intake and psychological well-being, and can affect treatment adherence and social function, all of which can lead to a reduced quality of life for patients. Inadequate pain management can also lead to longer hospitalisation, increased costs of healthcare and dissatisfaction with healthcare services [17]. The implications include that it is important to ensure that pain assessment and management are integrated into normal cancer care.

Nurses in Imo State University Teaching Hospital (IMSUTH), Orlu offer care for patients in a health care setting where the demand for services could be more than the available human and material resources. These problems may make it difficult to diagnose and manage pain consistently and comprehensively [18] Given the important role of nurses in the care of cancer patients and the repercussions of insufficient pain control, it is imperative to assess nurses' knowledge and real pain management practices. Finding out whether adequate information leads to suitable clinical practice may help to pinpoint specific areas that require attention.

The persistence of cancer pain despite available pain assessment strategies and evidence-based pain management procedures highlights the necessity for periodic review of healthcare providers' knowledge and practices. Assessment of nurses' knowledge of pain assessment and practices of pain management among cancer patients at IMSUTH, Orlu will offer evidence of the existing level of competency and also identify institutional and professional issues that may hamper effective pain control. This information may be used as a guide for focused educational intervention, reinforce institutional support systems, promote the right use of pain assessment instruments and analgesics, and ultimately improve quality of care and quality of life of

cancer patients. Against this background, this study was carried out to evaluate the understanding of pain assessment and pain treatment procedures among nurses caring for cancer patients at Imo State University Teaching Hospital, Orlu.

Materials and Methods

Study design

A descriptive cross-sectional survey design was adopted for the study. The design was considered appropriate because it enabled the researchers to assess nurses' knowledge of pain assessment and their pain management practices among cancer patients at a single point in time without manipulating any study variables. It also permitted the collection of quantitative data from nurses working in different clinical units involved in the care of cancer patients.

Study setting

The study was conducted at Imo State University Teaching Hospital (IMSUTH), located in Umuna, Orlu Local Government Area of Imo State, Nigeria. The hospital occupies approximately 360 hectares of land and was established in 2004 as a teaching hospital for students of the Faculty of Medicine and Health Sciences of Imo State University, as well as a healthcare facility for the surrounding communities. IMSUTH serves as a major referral hospital for neighbouring communities and provides a range of healthcare services, including emergency care, maternal and child health services, medical and surgical services, specialist care, and diagnostic services.

Study population

The study population comprised registered nurses working at IMSUTH, particularly those involved in the care of cancer patients in relevant clinical units. These included nurses working in oncology, medical, and surgical wards, where patients with cancer may receive assessment, treatment, and supportive care.

Inclusion criteria

Eligible participants were registered professional nurses who were actively employed at IMSUTH, Orlu, were involved in the care of cancer patients, and consented to participate in the study.

Exclusion criteria

Student nurses and interns, nurses who were not directly involved in the care of cancer patients, nurses who were on leave during the period of data collection, and nurses who were not registered or actively employed at IMSUTH were excluded from the study.

Sample size determination

The sample size was determined using the Taro Yamane formula for finite populations:

$$[n = \frac{N}{1+N(e)^2}]$$

where n represents the required sample size, N represents the total population of nurses, and e represents the level of precision.

With a total nursing population of 120 and a precision level of 0.05:

$$[n = \frac{120}{1+120(0.05)^2}]$$

$$[n = \frac{120}{1+120(0.0025)}]$$

$$[n = \frac{120}{1.3}=92.3]$$

Thus, the minimum calculated sample size was approximately

92 nurses. To compensate for possible non-response or incomplete questionnaires, 10% of the calculated sample size was added:

$$[10\% \times 92 = 9.2 \approx 9]$$

Therefore, the final sample size was:

$$[92+9=101]$$

Accordingly, 101 nurses were recruited for the study.

Sampling technique

A stratified random sampling technique was used. The nurses were first grouped into strata according to their clinical units, particularly units involved in the care of cancer patients, such as oncology, medical, and surgical wards. The number of nurses selected from each stratum was determined proportionately according to the size of the nursing population in that unit. Thereafter, simple random sampling using the balloting method was employed to select participants from each stratum. This approach ensured representation of nurses from the relevant clinical units.

Instrument for data collection

Data were collected using a structured, self-administered questionnaire developed by the researchers based on the objectives of the study and relevant literature on cancer pain assessment and management. The questionnaire contained five sections and 31 items.

Section A consisted of five items assessing the socio-demographic characteristics of respondents, including age, sex, educational qualification, years of professional experience, and unit of practice.

Section B contained eight items assessing nurses' knowledge of pain assessment. Responses were presented in dichotomous form as "Yes" or "No" and were used to assess knowledge of basic concepts and principles of pain assessment.

Section C comprised seven items assessing pain assessment practices using a four-point frequency scale: Always, Often, Rarely, and Never.

Section D consisted of seven items assessing pain management practices using the same four-point frequency scale: Always, Often, Rarely, and Never.

Section E contained four items assessing perceived factors affecting effective pain management. Responses were measured using a four-point Likert scale ranging from Strongly Agree to Strongly Disagree.

Validity of the instrument

The questionnaire was subjected to face and content validation. Three experts - two lecturers in Nursing Science and one specialist in research methodology - reviewed the instrument for clarity, relevance, adequacy of content coverage, appropriateness of language, and alignment with the study objectives. Their observations and recommendations were incorporated into the final version of the questionnaire, including revision of ambiguous items and restructuring of selected statements to improve clarity and comprehension.

Reliability of the instrument

The reliability of the questionnaire was assessed through a pilot study involving 10 nurses in a tertiary healthcare facility outside the study area. The questionnaire was administered on two occasions separated by a two-week interval. The responses were evaluated to

Table 1: Demographic characteristics of the respondents.

Variables	Options	Frequency = 101	Percentage
Age in years	20-29	11	10.90
	30-39	51	50.50
	40-49	19	18.80
	50 and above	20	19.80
Gender	Male	17	16.80
	Female	84	83.20
Highest educational qualification	RN	0	
	RM	50	49.50
	BNSc	41	40.60
	MSc	10	9.90
	Others	0	
Years of experience	1-5 years	21	20.80
	6-10 years	54	53.50
	11-15 years	16	15.80
	Above 15 years	10	9.90

establish the consistency of the instrument, and a reliability coefficient of 0.70 or greater was considered acceptable. The reported reliability coefficient of the instrument was 0.70.

Ethical considerations

Ethical approval was obtained from the Ethical Review Committee of Imo State University Teaching Hospital before commencement of data collection. Institutional permission was also obtained from the hospital management following submission of the introductory letter from the Department of Nursing Science.

Participation was voluntary, and each respondent was informed of the purpose of the study and their right to decline participation or withdraw at any stage without penalty. Written informed consent was obtained before administration of the questionnaire. Anonymity was maintained by excluding names and other personal identifiers from the questionnaire. Information obtained from participants was treated confidentially and used solely for academic purposes. The study involved no physical or psychological intervention, and appropriate ethical principles governing research involving human participants were observed throughout the study.

Data collection procedure

An introductory letter was obtained from the Department of Nursing Science and presented to the management of IMSUTH to obtain permission to conduct the study. Following approval, the researchers visited the selected clinical units and administered the questionnaires directly to eligible nurses. The purpose and procedures of the study were explained to the participants, and informed consent was obtained before questionnaire administration.

A total of 101 questionnaires were distributed. Respondents were given adequate time to complete the questionnaires, after which the

completed instruments were collected immediately or within an agreed period. Appropriate follow-up was undertaken to facilitate retrieval of the questionnaires.

Measurement and scoring of variables

For knowledge of pain assessment, correct responses were assigned a score of 1, whereas incorrect responses were assigned a score of 0. The individual scores were summed to obtain the overall knowledge score, which was used to classify respondents according to their level of knowledge.

For pain assessment and pain management practices, responses were scored as follows: Always = 4, Often = 3, Rarely = 2, and Never = 1. Mean scores were calculated for individual items, with a mean score of 2.5 serving as the decision point. Scores of ≥ 2.5 were interpreted as good practice, whereas scores < 2.5 were interpreted as poor practice.

For factors affecting pain management, responses were scored as Strongly Agree = 4, Agree = 3, Disagree = 2, and Strongly Disagree = 1. A mean score of ≥ 2.5 indicated agreement that the factor affected pain management, whereas a mean score < 2.5 indicated disagreement.

Data analysis

Completed questionnaires were coded and entered into the Statistical Package for the Social Sciences (SPSS), version 25, for analysis. Descriptive statistics, including frequencies, percentages, means, and standard deviations, were used to summarize the socio-demographic characteristics of respondents and the study variables. The chi-square test was used to determine associations between relevant categorical variables and to test the study hypothesis. Statistical significance was set at $p < 0.05$. The results were presented in tables.

Results

Table 1 show the socio-demographic characteristics of the respondents. From the data, it can be seen that majority of the respondents are aged 30-39 years (50.50%). There are more females (83.20%) than males (16.80%) among the respondents. Majority of the respondents are RM certificate holders (49.50%) and majority of the respondents have 6-10 years of work experience (53.50%).

Table 2 show the responses of the respondents on their knowledge of pain assessment and management among cancer patients in IMSUTH Orlu. The questionnaire is answered in a 4-point Likert format implying that mean responses above the criterion mean of 2.50 show high agreement with the statements. From the table, it is seen that all the items have their mean scores above 2.50 which suggests that majority of the nurses are in agreement with the statements in

Table 2: Level of knowledge of pain assessment and pain management among nurses in IMSUTH criterion mean = 2.50.

S/N	Items	Mean	Std. dev	Remark
1	Pain is a subjective experience best described by the patient	3.57	0.32	Agree
2	Cancer pain can be acute or chronic	3.72	0.38	Agree
3	Pain assessment should be done regularly in cancer patients	2.98	0.60	Agree
4	Pain assessment tools (e.g., numeric rating scale) are essential in practice	3.76	0.89	Agree
5	Vital signs alone are not sufficient to assess pain	3.00	0.56	Agree
6	Cultural beliefs can influence pain expression	3.56	0.98	Agree
7	Non-verbal cues are important in assessing pain	3.49	0.60	Agree
8	Pain should be assessed before and after intervention	3.72	0.38	Agree
	Grand mean	3.47		

Table 3: Pain management practices of nurses for cancer patients in IMSUTH criterion mean = 2.50.

S/N	Items	Mean	Std. dev	Remark
1	I administer prescribed analgesics promptly	3.31	0.32	Good
2	I follow the WHO analgesic ladder in pain management	2.00	0.38	Poor
3	I use non-pharmacological methods (e.g., relaxation, positioning)	2.21	0.60	Poor
4	I educate patients about pain management	2.32	0.89	Poor
5	I monitor patients for side effects of analgesics	2.83	0.56	Good
6	I collaborate with other healthcare professionals in pain management	2.00	0.98	Poor
7	I evaluate the effectiveness of pain interventions	2.13	0.60	Poor
	Grand mean	2.40		

Table 4: Factors influencing pain management practices criterion mean = 2.50.

S/N	Items	Mean	Std. dev	Remark
1	Inadequate staffing affects pain management	3.57	0.32	Agree
2	Lack of training affects pain assessment practices	3.00	0.38	Agree
3	Limited availability of analgesics affects care	2.67	0.60	Agree
4	Heavy workload reduces proper pain assessment	3.76	0.89	Agree
	Grand mean	3.25		

Table 5: Chi-square test of significant relationship between knowledge of pain management and demographic characteristics of nurses.

		Knowledge Category				Total		X ²	Df	p-value
		Good		Poor						
		N	%	N	%	N	%			
Age	20-29	6	35.2%	5	25.3%	11	27.5%			
	30-39	47	16.7%	4	27.4%	51	25.0%			
	40-49	15	5.6%	4	22.6%	19	18.8%	1.382	4	0.211
	50 and above	18	20.4%	2	17.7%	20	18.3%			
Total		86	100.0%	15	100.0%	101	100.0%			
						Total		X ²	Df	p-value
		Good		Poor						
		N	%	N	%	N	%			
Gender	Male	10	59.3%	7	55.9%	17	56.7%			
	female	76	40.7%	8	44.1%	84	43.3%	0.991	1	0.756
Total		86	100.0%	15	100.0%	101	100.0%			
						Total		X ²	Df	p-value
		Good		Poor						
		N	%	N	%	N	%			
Qualification	RM	45	29.6%	5	22.0%	50	23.8%			
	BNSc	36	51.9%	5	65.1%	41	62.1%			
	MSc	5	0.0%	5	6.5%	10	5.0%	12.321	3	0.006
Total		86	100.0%	15	100.0%	240	100.0%			

the questionnaire. The grand mean is 3.47 which is also above 2.50. This clearly implies that majority of the respondents have good knowledge of pain assessment and management for cancer patients in IMSUTH Orlu.

Table 3 shows the pain management practices of nurses for cancer patients in IMSUTH Orlu. The scale was answered on a 4-point Likert

scale of Always, Sometimes, Rarely and never, giving a criterion mean of 2.50. This implies that mean scores equal to or above 2.50 show agreement with the statements and *vice versa*. The data shows that only items 1 and 5 have their mean scores above 2.50 which imply that majority of the nurses give analgesics promptly (3.31) and monitor patients for side effects of analgesics. However, other items have their mean scores below 2.50 which implies that majority do not comply

with the corresponding statements. Generally, the grand mean of the nurses' responses is 2.40 which is less than 2.50 and this implies that the practice of pain management among the nurses in IMSUTH Orlu for cancer patients is low.

Table 4 show theresponses of the nurses on factors influencing pain management practices for cancer patients in IMSUTH Orlu. All the items have their mean scores above 2.50 which imply widespread agreement with the corresponding items. This means that the factors influencing pain management practices of nurses include: inadequate staffing (3.57), lack of training (3.00), limited analgesics (2.67), and heavy workload (3.76).

Table 5 show the chi-square analysis of significant relationship between knowledge of pain assessment and management and sociodemographic variables of the nurses. From the table, it is seen that the p-value for age and gender are 0.211 and 0.756 respectively which are greater than 0.05, implying that age and gender of the nurses do not significantly influence knowledge of pain assessment and management for cancer patients. On the other hand, the p-value for educational qualification is 0.006 which is less than the 0.05 level of significance and this entails that nurses' qualification significantly influences their knowledge of pain assessment and management for cancer patients in IMSUTH Orlu.

Discussion

The study found that the majority of the nurses who were sampled had strong understanding of pain evaluation and pain treatment for cancer patients . The average knowledge score of 3.47 on a four-point likert scale shows that nurses at Imo State University Teaching Hospital (IMSUTH), Orlu, generally have a decent level of knowledge on cancer pain evaluation and management. This finding indicated that the nurses had high theoretical knowledge concerning concepts of pain assessment and management. This could be due to their professional education, clinical exposure and experience in caring for patients with cancer. Adequate knowledge is a vital prerequisite for the management of pain since it enables nurses to recognise pain effectively, to apply appropriate evaluation methods and select or implement appropriate interventions.

However, good information does not automatically transfer into optimal clinical practice. This outcome of the study is contrary to that of [19] who observed sub-optimal understanding of pain treatment procedures among nurses in Akwa Ibom State. The difference may be due to differences in the location of the study, educational background, professional experience, the availability of continuing education, and institutional support for pain management. The substantially better knowledge shown in nurses in the present study may be a reflection of increased exposure to cancer patients or better comprehension of contemporary pain management approaches. However, for information to be effectively translated into practice, it must be sustained through ongoing professional education and supportive clinical environments.

The study found that there was a mismatch between the nurses' knowledge and actual pain management techniques. The knowledge of the respondents was good but the practice level was relatively low with a mean practice score of 2.40. This implies that just having sufficient knowledge is not adequate for successful management of pain among cancer patients. The gap between knowledge and practice may be attributed to institutional constraints, lack of resources, heavy workload, poor staffing, limited availability of analgesics, and other

contextual elements that may inhibit the practical use of acquired knowledge.

This conclusion is similar with [20], who observed poor adherence to pain treatment procedures among health care staff. The reasons for poor practice may be specific to healthcare context. The evidence suggests that poor clinical implementation may remain even if health workers have some degree of theoretical knowledge. This underscores the need of progressing from knowledge acquisition to an enabling clinical setting where nurses may consistently implement evidence-based pain assessment and management strategies. Regular supervision, clinical audits, supportive leadership, availability of standardised pain assessment tools and defined institutional standards may therefore be important in closing the knowledge-practice gap.

In addition, inadequate staffing, lack of training, restricted availability of analgesics and severe workload were indicated as significant impediments to effective pain management. The results show that, in addition to the individual knowledge and skill of the nurses, organisational and health system factors influence the ability of nurses to offer effective pain care. Inadequate staffing and workload may result in less time to do a complete pain evaluation, documentation, reassessment, patient education, and implementation of non-pharmacological therapies. Likewise, a lack of access to suitable analgesics may make it impossible for nurses to carry out otherwise suitable pain management strategies.

These findings are consistent with [21] who reported severe workload, paucity of experienced nurses, and lack of opportunity for continued professional training as key impediments to the use of pain treatment techniques. Similarly, issues associated with workload and inadequate or poor quality of analgesics available were cited as factors influencing successful pain management in hospital settings. The consistency of these data suggests that a multi-pronged approach to improve cancer pain management is warranted, one that tackles both individual competency and larger institutional restrictions [22].

Educational qualification was also found to be substantially associated with the knowledge of pain evaluation and management among nurses ($p < 0.05$). It implies that the degree of education might improve nurses' awareness of the principles of pain evaluation and evidence-based therapy options. Formal education gives chances for nurses to increase their knowledge about pain physiology, pharmacological and non-pharmacological therapies, and the use of standardised pain assessment tools. However, formal educational qualifications need to be supplemented by ongoing professional development as cancer pain management is a developing area of clinical practice. Periodic in-service training, workshops, seminars and competency-based updates may help nurses stay current in knowledge and improve translation of knowledge to practice.

The data suggest that the issue of adequate cancer pain management at IMSUTH, Orlu is not a knowledge deficit among nurses but the challenge of transferring information into sustained clinical practice. This gap could be addressed by strengthening institutional support, enhancing workforce levels, assuring dependable access to suitable analgesics, decreasing excessive workload, and providing frequent professional training. Such approaches could improve the quality and consistency of pain assessment and management, and ultimately the comfort, functional status and quality of life of cancer patients.

Conclusion

This study showed that nurses in Imo State University Teaching

Hospital, Orlu, have good understanding of pain assessment and pain management among cancer patients. But in practice, their actual use of pain treatment was rather low, demonstrating a significant gap between knowledge and clinical practice. Important impediments identified to successful pain management were lack of staffing, inadequate training, limited availability of analgesics and severe workload. Nurses' level of knowledge was also found to be substantially linked with educational qualification.

The findings highlight the significance of measures that enhance the professional competence of nurses as well as the institutional conditions under which cancer treatment is given. To improve the practice of evidence-based pain management, regular continuing professional education, adequate staffing, better access to appropriate analgesics, moderate workloads, standardised pain assessment techniques and supportive hospital policies are advised. By addressing these variables, nurses will be better able to put their knowledge to practice, and ultimately may be able to improve pain control and the overall quality of care for cancer patients.

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