

ROLE OF NURSES AS BEDSIDE CARE PROVIDERS IN TERTIARY CARE HOSPITALS OF ISLAMABAD AND RAWALPINDI, PAKISTAN: A DESCRIPTIVE EXPLORATORY QUALITATIVE STUDY

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Abstract

Background: Bedside nurses are the main point of contact between patients and the health system, yet in Pakistan they work with severe staff shortages, heavy workloads and limited resources. Little qualitative evidence describes how bedside nurses in the tertiary care hospitals of Islamabad and Rawalpindi understand and carry out their role. This study explored the role of nurses as bedside care providers in these hospitals.

Methods: A descriptive exploratory qualitative design was used. Six registered nurses providing bedside care in two tertiary care hospitals in Rawalpindi and Islamabad were recruited through purposive sampling. Data were collected through semi-structured, face-to-face, audio-recorded interviews, transcribed verbatim and analyzed using qualitative content analysis.

Results: Four categories emerged: (1) scope of nursing care practice in tertiary care hospitals; (2) challenges to providing patient-centered quality nursing care; (3) psychosocial challenges of nurses; and (4) need for continued professional development of nurses. Participants described responsibilities ranging from handover, assessment and medication administration to family counseling, discharge planning and patient advocacy. They reported high nurse-to-patient ratios, excessive workload, shortages of staff, equipment and medicines, weak institutional support and communication barriers, together with burnout, emotional strain and a lack of respect for the profession. They called for regular training, mentorship and support for evidence-based practice.

Conclusion: Bedside nurses understand their role as broad and holistic, but staffing, resource and organizational constraints limit their ability to deliver it. Safe staffing, adequate resources, administrative support, protection from abuse and structured continuing professional development are needed to strengthen bedside nursing and the quality of patient care.

INTRODUCTION:-

Nursing is widely regarded as the cornerstone of health care delivery, and bedside nurses are the main point of interaction between patients and the health system. In tertiary care hospitals, nurses assess and monitor patients, administer medicines, educate patients and families, coordinate care with other disciplines and provide emotional support. Their continuous presence at the bedside places them in a unique position to observe, evaluate and respond to changes in a patient's condition, and bedside practices such as nursing handover are central to patient safety and continuity of care [1]. Nurses make up more than half of the world's health professionals [2], and qualitative work with patients, nurses and nursing students in Pakistan has shown that caring is understood as a purposeful, holistic approach shaped by the nurse-patient relationship, professional socialization and the cultural environment, with gaps between the caring behaviors that patients expect and those that nurses are able to show [3]. The nursing profession in Pakistan faces obstacles that directly affect the standard of bedside care. Pakistan has about 5.2 nurses per 10,000 population, far below the benchmark of 30 per 10,000 used by the World Health Organization, and the health system is described as doctor-centric, with nurses largely excluded from decision-making positions [4]. The nurse-to-patient ratio in the general wards of Pakistani hospitals has been reported as 1:40, against a ratio of 3:10 recommended by the Pakistan Nursing Council [5], and nurses in public sector tertiary hospitals in Islamabad have described caring for 25 to 40 patients during night shifts [6]. Nurses also work within physician-centered organizations in which patriarchal culture and hierarchical structures restrict their autonomy, clinical decision-making and use of evidence-based practice [7], and within a society in which gender norms, religious beliefs and negative public images stigmatize the profession and discourage people from entering or remaining in it [8].

The tertiary care hospitals of the twin cities of Islamabad and Rawalpindi receive referrals from across the country and care for critically ill patients with complex needs. In such settings, heavy workload, understaffing, insufficient resources, a lack of nursing policies and the unavailability of standardized assessment forms have been identified as barriers to the implementation of the nursing process [9]. In Pakistan, cognitive, motivational, environmental and social barriers have been found to prevent nurses from delivering person-centered care to patients with complex needs [10].

Although quantitative studies have documented staffing ratios and workloads, little qualitative evidence describes how bedside nurses in the tertiary care hospitals of Islamabad and Rawalpindi view their role, manage their responsibilities and experience the obstacles to providing high-quality care. Without such context-specific understanding, it is difficult to design interventions, policies and workforce plans that respond to nurses' realities. The aim of this study was therefore to explore the role of nurses as bedside care providers in tertiary care hospitals of Islamabad and Rawalpindi, including the responsibilities they carry, the challenges they face and what they believe is needed to improve bedside care.

Materials and Methods:-**Study design**

A descriptive exploratory qualitative design was used. Qualitative description is suited to obtaining a straightforward, comprehensive account of experiences in the participants' own words, staying close to the data rather than developing theory [11]. The study is reported in line with the Consolidated Criteria for Reporting Qualitative Research (COREQ) [12].

Setting

The study was conducted in two tertiary care hospitals in the twin cities: a tertiary care hospital in Rawalpindi and Farooq Hospital, Islamabad. Both hospitals provide specialist inpatient care to

large numbers of patients. The study was completed over four months in 2026.

Participants and sampling

The study population consisted of registered nurses providing bedside care in the two hospitals. Participants were selected by purposive (non-probability) sampling to include nurses able to describe bedside practice from direct experience. Nurses were eligible if they held valid registration with the Pakistan Nursing Council, had more than one year of clinical experience, were working at the bedside and were willing to participate voluntarily. Nurses on long leave or probation, nursing interns and students, and nurses in managerial or educational roles (head nurses, team leaders, educators and supervisors) were excluded. Eligible nurses were invited to take part and were given information about the study before giving consent. Sample size was guided by data saturation, and recruitment stopped when further interviews were not producing new codes; six nurses took part.

Data collection

Data were collected through semi-structured, face-to-face, in-depth interviews using an interview guide developed by the research team from the literature. The guide began with demographic items (years of nursing experience, current title and ward or unit, qualification and hospital type) followed by ten open-ended questions. These asked participants to describe a typical working day and how they prioritize their duties; how they view their role in patient care and which aspects patients, families and colleagues value most; the main obstacles to high-quality bedside care; how workload affects the time they spend at the bedside; their experience of the hospital hierarchy and their interaction with nursing management and doctors; the resources, systems and relationships that help them; the influence of sociocultural factors such as gender norms, family expectations and the public image of nursing; communication with patients and families; how they protect their own wellbeing and prevent burnout; and how nursing leadership, hospital

administration and legislators could strengthen bedside nursing. Probing questions were used to clarify and deepen responses.

Interviews were conducted by members of the research team, who were registered nurses enrolled in a post-registration nursing degree programme and had no supervisory relationship with the participants. Interviews were held at the participants' hospitals at times convenient to them. With participants' permission, all interviews were audio-recorded and transcribed verbatim for analysis.

Data analysis

Data were analyzed using qualitative content analysis as described by Graneheim and Lundman [13]. Each transcript was read several times to gain a sense of the whole. Meaning units relating to the study aim were identified, condensed and labeled with initial codes. Initial codes were compared within and across interviews, and codes with similar meanings were merged. The merged codes were then grouped into subcategories and categories according to their similarities and differences, and the categories were reviewed against the transcripts to make sure they reflected the data. Analysis was carried out by the research team, and the codes and categories were reviewed with the research supervisors. Table 1 shows the categories, subcategories and examples of the initial codes from which they were developed.

Trustworthiness

Trustworthiness was addressed using the criteria of credibility, dependability, confirmability and transferability [14], together with authenticity. Credibility was supported by verbatim transcription, by staying close to participants' own words, and by discussing the emerging codes and categories with the research supervisors. Dependability and confirmability were supported by keeping a record of how initial codes were merged and grouped into categories, so that each category can be traced back to the participants' words, and by discussing the coding within the research team and with the supervisors.

Transferability was supported by describing the setting, participants and sampling so that readers can judge the relevance of the findings to other settings. Authenticity was supported by presenting verbatim quotations that reflect the range of participants' views.

Ethical considerations

The study was reviewed by the Institutional Research and Ethics Board (IREB) of Islamabad Medical and Dental College, Islamabad, which granted an exemption under Category II (Ref. No. 291/IMDC/IREB-2026, dated 24 September 2026), with the condition that written informed consent be obtained from all participants. Participants were informed of the purpose of the study, that participation was voluntary and that they could withdraw at any time without consequences. Each participant gave written informed consent, including consent to audio

recording, before the interview. Names were not recorded in the transcripts, quotations are presented without identifying details, and the data were used only for research purposes.

Results:-

Participant characteristics

Six registered nurses providing bedside care in the two hospitals took part. In line with the inclusion criteria, all held valid Pakistan Nursing Council registration and had more than one year of clinical experience.

Overview of the findings

The analysis produced four categories and fourteen subcategories (Table 1; Figure 1): (1) scope of nursing care practice in tertiary care hospitals; (2) challenges to providing patient-centered quality nursing care; (3) psychosocial challenges of nurses; and (4) need for continued professional development of nurses.

Table 1: Categories, subcategories and examples of initial codes

Category	Subcategories	Examples of initial codes
1. Scope of nursing care practice in tertiary care hospitals	Routine patient assessment and interventions	Initial patient assessment after handover; active intervention for health problems; routine clinical duties; lack of autonomy to implement nursing care protocols
	Routine nursing care practice	Job description of nurses; extended role in patient and family care; hierarchical communication for incident reporting; consultation with senior nurses
	Family counseling and discharge planning	Counseling the patient's family; providing a discharge plan; educating family on follow-up, medicines and home care
	Ethical practice and patient advocacy	Ensuring patient autonomy; taking patients' consent; providing patient advocacy; ensuring beneficence
2. Challenges to providing patient-centered quality nursing care	Lack of patient-centered quality care	Working environment influences patient care; teamwork enhances quality of care; interprofessional collaboration; timely medication and therapeutic relationships
	High nurse-to-patient ratio and overwork	High patient-nurse ratio; increased workload reduces efficiency of care; staff shortages reduce time for patient care

Category	Subcategories	Examples of initial codes
	Lack of adherence to patient safety guidelines	Need to follow aseptic techniques; need to follow medication safety guidelines; ensuring patient safety
	Lack of institutional and administrative support	Lack of resources and equipment; essential medication shortages; need for administrative and government initiatives; need for institutional support mechanisms
	Lack of cultural respect and effective communication	Consideration of local language; simple communication with patients; respectful communication; improving understanding through simple explanations
3. Psychosocial challenges of nurses	Societal devaluation and lack of respect for nurses	Lack of appreciation for nursing and nurses' work; lack of expected respect from patients and families; limited societal understanding of nursing
	Burnout and emotional strain among nurses	Staff shortage linked to burnout; experiencing emotional strain; need to become emotionally strong
4. Need for continued professional development of nurses	Limited opportunities for training and capacity building	Attended BLS course; attending seminars and workshops; need to offer short courses; need to arrange training for nurses
	Need for professional development of nurses	Competency-based training; role of mentorship and support; positive workplace culture; professional motivation
	Professional development to foster evidence-based practice	Need for evidence-based practice; need to build capacity for evidence-based practice

BLS, Basic Life Support.

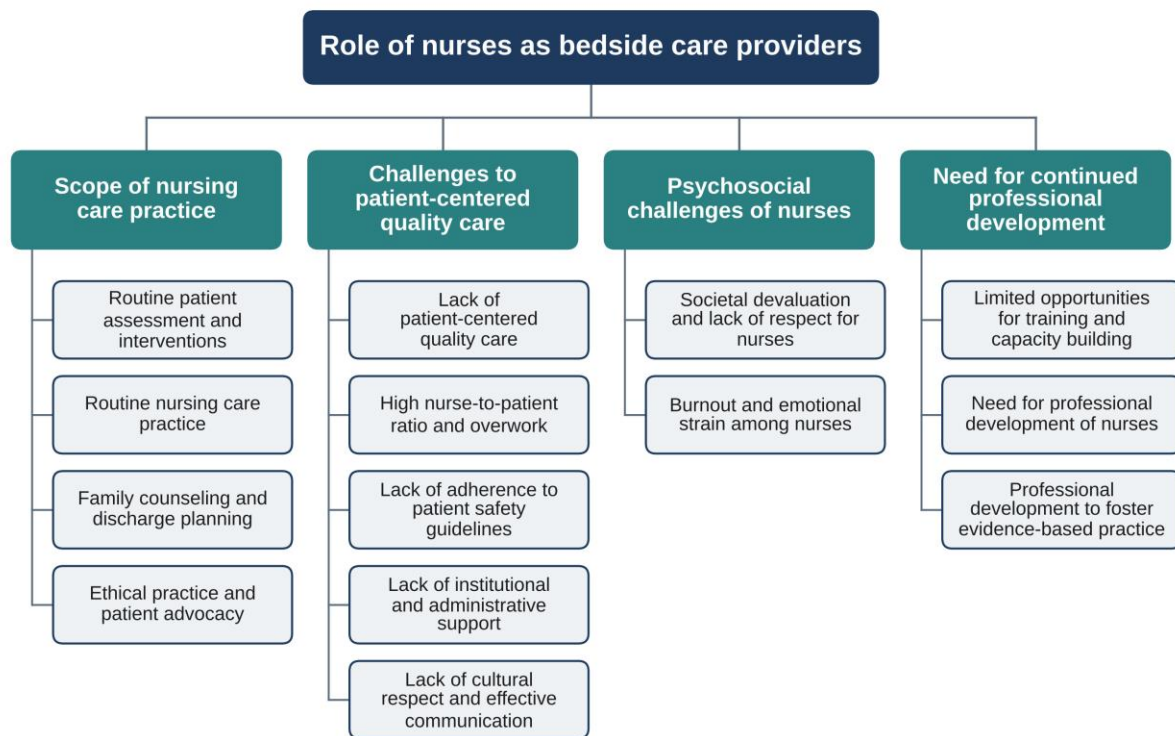


Figure 1: Categories and subcategories describing the role of nurses as bedside care providers in tertiary care hospitals of Islamabad and Rawalpindi

Category 1: Scope of nursing care practice in tertiary care hospitals

This category describes the clinical, ethical and organizational responsibilities that make up the bedside nurse's role. Participants described a structured routine that begins with handover and assessment and continues with timely medication and monitoring:

"When I start my duty, first of all I do my patient's handing taking [handover]. After that I do my patient's assessment and medication on time."

Participants saw their role as extending beyond physical tasks to keeping the patient stable, communicating with the wider team and providing holistic care:

"My main role is to make my patient vitally stable and informing all the important

information regarding his health to my senior staff and doctors. And the most important is that avoiding any harm to my patient and providing him holistic care."

Routine practice also involved working through the hospital hierarchy, consulting senior nurses and following hierarchical channels for incident reporting, and one participant described a lack of autonomy to implement nursing care protocols. Family counseling and discharge planning were described as essential for continuity of care after the patient leaves hospital:

"The most important thing in this is that you have to educate the patient's family regarding his discharge plan. You have to tell them about his follow-ups and medicines. You have to guide them on

how to provide them with good care at home."

Finally, participants described ethical practice and patient advocacy, including respecting autonomy, obtaining consent and acting in the patient's best interest:

"Before taking any decision, the patient has the right to refuse. So, first of all, if you are performing any procedure, you have to inform the patient about it."

Category 2: Challenges to providing patient-centered quality nursing care

This category covers the systemic, administrative and environmental barriers that prevent nurses from delivering individualized, high-quality care. Participants linked quality of care to the working environment, teamwork, interprofessional collaboration and the ability to give medicines on time and build therapeutic relationships, but reported that these conditions were often missing. The most frequently described barrier was a high nurse-to-patient ratio combined with overwork, which reduced the time available for each patient:

"First of all, the patient ratio is more and on-duty staff is less. Secondly, resources are not available to give proper care to the patient. As the patient ratio is more, we cannot give proper time to each patient."

Participants pointed out that unequal workloads produced unequal care:

"If two patients are being given to one nurse and 40-30 patients are being given to the other nurse, then it is very common that the care that is being provided to those two patients will be very different from the care that is being provided to those 40-30 patients."

A lack of institutional and administrative support appeared as shortages of staff, equipment and essential medicines, and as a need for administrative and government action on workload and staffing:

"Sometimes, if there is a shortage of necessary items and the duty is long, the

nurses are less and if there are more patients, the work becomes difficult."

Participants also emphasized the need to follow aseptic technique, medication safety and patient safety guidelines, implying that adherence was difficult to maintain under these conditions. Communication with patients and families was a further challenge; nurses described adapting their language, using the local language and simple explanations to bridge gaps in health literacy:

"We try to make it easy for the patients and their attendants. Most of the people are ignorant. They do not understand professional language."

Category 3: Psychosocial challenges of nurses

This category captures the emotional toll of bedside work and the lack of social recognition of nursing. Participants described a lack of appreciation for the profession and for nurses' work:

"There are a lot of people who don't appreciate the nursing profession. They don't appreciate the hard work of the nurses."

"Even in this century, there are some people who do not understand the field of nursing well."

Staff shortages were linked to burnout, and daily exposure to death and suffering required nurses to set aside their own concerns and build emotional strength:

"Apart from this, there are many expiries on a daily basis. So, it is very challenging to bring an emotional strength into yourself. There are many incidents in our personal life that we have to neglect during patient care."

These pressures were made worse by harsh or rude behavior from patients and their families:

"Sometimes, you have to tolerate the harsh words of the family or the patient or their rude behavior. So, these are all the challenges that we face on a daily basis."

Category 4: Need for continued professional development of nurses

This category reflects participants' wish for ongoing education, training and capacity building. Some had attended Basic Life Support courses, seminars and workshops, but they described such opportunities as limited and asked for regular, structured learning linked to evidence-based practice:

"The main thing is that if you give bedside nurses weekly or monthly short courses, or if there are weekly educational classes, it is very beneficial for them. Your theory should also be very strong to provide evidence-based practice."

Participants associated professional development with mentorship, a positive workplace culture and professional motivation, and described a need for guidance on new protocols in the context of staff shortages and turnover:

"I feel that we need someone to tell us what to do and provide guide us about the new protocols and staffing rules, as in Pakistan, we are currently having shortage of nurses which are making us burnout and that is turnover rate is high."

Capacity building was seen as requiring both more staff and better preparation in standard operating procedures (SOPs) and equipment:

"The situation is that more and more nurses should be hired. The facilities should be more and the new nurses should know more about SOPs. They should know how to use new machinery."

Discussion:-

This study explored the role of nurses as bedside care providers in two tertiary care hospitals of Islamabad and Rawalpindi. Participants described a broad, holistic understanding of their role but reported that staffing shortages, workload, resource gaps, organizational hierarchy and social devaluation prevented them from fulfilling it, and they identified continued professional development as a priority.

Scope of bedside nursing practice

Participants described a scope of practice that extends well beyond procedural tasks, from handover, assessment and monitoring to medication administration, family education, discharge planning and patient advocacy. Their emphasis on handover and initial assessment is consistent with the meta-synthesis by Anshasi and Almayasi, which identified bedside handover as central to patient safety and continuity of care [1]. The importance participants gave to holistic care, family education and respect for patients' rights also reflects the Pakistani evidence that caring is understood as a purposeful, all-encompassing approach [3]. At the same time, participants described working through hierarchical channels and, in one case, lacking the autonomy to implement nursing protocols. This tension between a broad professional self-understanding and a restrictive organizational reality mirrors earlier findings that physician-centered, hierarchical structures in Pakistani hospitals confine nurses to subordinate, task-oriented roles [7]. Enabling nurses to practice to the full scope they already understand would require greater participation of nurses in decision-making and more collaborative interprofessional working [4].

Challenges to patient-centered quality care

High nurse-to-patient ratios and overwork were the most prominent barriers described. Participants' accounts of caring for 30 to 40 patients bring to life the national figures on nurse density [4] and ward staffing [5], and they echo earlier reports from Islamabad of nurses caring for 25 to 40 patients on night shifts [6]. Participants also linked these conditions to shortages of equipment and medicines, weak administrative support and difficulty in following safety guidelines, which is consistent with evidence that workload, understaffing, a lack of policies and insufficient resources hinder the nursing process in Pakistani tertiary hospitals [9]. Similar organizational barriers to person-centered care have been reported in other Pakistani settings [10]. The communication difficulties participants described, including the need to

translate professional language for patients and families with limited health literacy, take time that is scarce in understaffed wards. Together, these findings suggest that the barriers to patient-centered care lie mainly in the organization of work rather than in nurses' competence or willingness. Safe staffing standards, reliable supply of essential equipment and medicines, and clear channels of communication between management and frontline staff are therefore priorities.

Psychosocial challenges

Participants described emotional strain from daily exposure to death and suffering, burnout linked to staff shortages, a lack of public appreciation and rude or harsh behavior from patients and families. These accounts are consistent with qualitative evidence that patriarchal social structures, cultural stigma and negative public images damage the reputation of nursing in Pakistan [8], and with reports that verbal and other forms of workplace violence are a widespread problem for Pakistani nurses [15]. Burnout is common among nurses worldwide [16], and in the present study it was closely tied to understaffing, suggesting that psychosocial and organizational problems reinforce each other. Hospitals could respond by enforcing policies against abuse of staff, offering counseling and debriefing after distressing events, and supporting public awareness of the role of nurses.

Need for continued professional development

Participants wanted regular short courses, educational sessions, mentorship and training in protocols, SOPs and new equipment, and they linked strong theoretical knowledge to evidence-based practice. This agrees with evidence that continuing professional development supports nurses' competence, confidence and the quality of care, and that it depends on organizational support, protected time and a positive learning culture [17]. The barriers to evidence-based practice that participants implied are also consistent with reports that hierarchical cultures and rising workloads limit Pakistani nurses'

ability to apply evidence [7], and that the absence of standardized policies and forms hampers systematic nursing care [9]. Structured in-service education with protected time, ward-based clinical educators or preceptors, and standardized protocols could help close these gaps and may also support retention.

Strengths and limitations

This study gives voice to bedside nurses in two tertiary care hospitals of the twin cities, a group whose perspectives are rarely captured in Pakistani research. Its limitations should be considered when interpreting the findings. The sample was small (six nurses) and drawn from two hospitals, so the findings may not be transferable to other settings. Participants volunteered, and nurses with stronger views may have been more willing to take part. Data were collected only through individual interviews, without observation or other sources that could have added depth. Future research could include more hospitals and regions, combine interviews with observation, and include the views of patients, families and nurse managers.

Conclusion:-

Bedside nurses in tertiary care hospitals of Islamabad and Rawalpindi understand their role as comprehensive, encompassing clinical care, family education, discharge planning and patient advocacy. However, high nurse-to-patient ratios, excessive workload, shortages of resources, limited administrative support, hierarchical structures and social devaluation restrict their ability to provide patient-centered care and contribute to burnout. Hospital administrators, nursing leaders and policymakers should enforce safe staffing ratios, ensure the availability of essential resources, protect nurses from abuse and invest in continuous, structured professional development so that bedside nurses can practice to their full scope and patients receive safe, high-quality care.

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Ethics Statement:-

This study was reviewed by the Institutional Research and Ethics Board of Islamabad Medical and Dental College (Ref. No. 291/IMDC/IREB-2026, dated 24 September 2026; Category II exemption). Written informed consent, including consent to audio recording, was obtained from all participants.

Conflict of Interest:-

The authors declare no financial or personal relationships that could have influenced the submitted work.

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Data Availability:-

Interview transcripts are not publicly available in order to protect participant confidentiality. De-identified excerpts are available from the corresponding author on reasonable request.

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