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Registered nurses' perceptions of their roles in medical-surgical units: A qualitative study

Evy Nazon[1] | Isabelle St-Pierre[1] | Denise Pangop[2]

[1]Nursing Science Department, Université du Québec en Outaouais, Gatineau, Quebec, Canada

[2]Agente de Planification, de Programmation et de Recherche, Centre Intégré de Santé et de Services Sociaux de l'Outaouais, Gatineau, Quebec, Canada

Correspondence
Evy Nazon, Nursing Science Department, Université du Québec en Outaouais, 283, boulevard Alexandre-Taché, pièce C-1813, C.P. 1250, Succursale Hull, Gatineau, Québec, J8X 3X7, Canada.
Email: evy.nazon@uqo.ca

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Abstract

Aim: The aim of this study was to gain insight into the perception of nurses about their roles in medical-surgical units.

Background: As a result of ever-changing work environments, medical-surgical nurses find it difficult to know and practice according to the full scope of their roles.

Design: A qualitative descriptive study.

Methods: Semi-structured individual interviews were conducted with 21 nurses on three campuses of a large tertiary care hospital located in Quebec, Canada. Thematic analysis was used to construe meaning from the interviews. This research adheres to the Standards for Reporting Qualitative Research guidelines and checklist.

Results: The data analysis resulted in three main themes: (i) confusion in nurses' roles and scope of practice; (ii) challenges in the continuity of care and (iii) factors affecting the roles of nurses in medical-surgical units.

Conclusion: Attention must be paid to the care continuum as it represents a critical element for surgical patients' quality and safety of care.

Relevance to clinical practice: Medical-surgical nurses should understand their roles and the factors that limit their full scope of practice in order to provide and manage complex care situations. Additionally, an interdisciplinary approach is a strategy that may better respond to patients' clinical needs across the surgical journey.

KEYWORDS
continuity of care, nurses' role, postoperative nurses, preadmission nurses, scope of practice

1 | INTRODUCTION

The past several years have seen many changes that have resulted in increased complexity of care such as reductions in the length of hospital stays, increased reliance on healthcare technology and increased patient acuity (Tonelli et al., 2018). Additionally, the worsening working conditions found in hospitals as a result of staff shortages, nurse turnover and high nurse-to-patient ratios are impeding the ability of nurses to provide quality care (Copanitsanou et al., 2017; Phillips, 2020). For example, the high acuity of care required of nurses to take care of surgical patients has resulted in them questioning the very nature of their roles. Little research was found describing the roles of medical-surgical nurses, which serves to justify the current study.

2 | BACKGROUND

Registered nurses are essential healthcare providers on adult medical-surgical units, which include pre-operative (e.g. pre-admission) and postoperative units where care is provided (Academy

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of medical-surgical nurses, 2021; Aiken et al., 2014). In 2020–2021, there were 304,558 registered nurses licensed to practice in Canada and 80,491 licensed to practice in Quebec. Half of those working in general and specialty care, which includes medical-surgical units where they play a critical role in the provision and coordination of complex care (Canadian Institute for Health Information, 2020; Ordre des infirmières et infirmiers du Québec, 2021). Nurses' roles are defined as pre-established expectations in helping individuals, families and groups identify and realize their full physical, mental and social potential based on the requirements acquired through their professional education. Nurses are trained to meet patients' healthcare needs by using current nursing knowledge and skills to improve the delivery of care (White et al., 2008). The Canadian Nurses Association recognized nine roles of the registered nurse required to give competent, safe, ethical, compassionate and evidence-informed nursing care in any practice setting. These are as follows: clinical, professional, collaboration, communication, coordination, advocacy, leader, educator and scholar roles (Almost, 2021). However, it has become increasingly difficult for nurses to understand and articulate their roles, given the ever increasing complexity of care and the unprecedented changes to healthcare service delivery models resulting in many facets of the clinical nursing practice to undergo significant changes (Huber et al., 2021; Kentischer et al., 2018). Sahakyan et al. (2020) highlighted the importance of nurses understanding their own roles in order to improve processes of care, patients' outcomes and work within their scope of practice (Kieft et al., 2014), which reflects the full range of activities, responsibilities and functions, that registered nurses are educated, competent and authorized to perform (White et al., 2008). Since they can either support or hinder practice development, it is important to give opportunities for nurses to develop their professional roles.

Several studies have explored the roles of nurses in different contexts. *Intensive Care Unit (ICU)*: In a literature review of 20 articles, Noome et al. (2016) noted that while ICU nurses had a critical role during end-of-life care, their exact roles pertaining to the interaction between patients, family and nurses remained unknown, unclear and ambiguous. They concluded that developing clear roles for ICU nurses may be helpful in preventing anxiety, stress and depression in patients and family members. *Palliative care*: In the context of palliative care, Johansen and Helgesen (2021) found that nurses played an important role in hospitals and community palliative care in facilitating reflection and collaboration in the palliative care team, promoting high-quality palliative care and contributing to ethical awareness about end-of-life issues. Moreover, by sharing their knowledge and experience and being role models, nurses working in palliative care reinforced their colleagues' confidence and skills in palliative care and contributed to a shared view of the quality of care. Similarly, Sekse et al. (2018) conducted a qualitative meta-synthesis of 28 articles to explore how nurses describe their roles in palliative care. They stated that it was difficult to precisely define those roles because nurses' work is complex, partly invisible and taken for granted. They also found that the nurse's roles are integrated into all dimensions of care: practical, relational and moral, which makes it even more important for nurses to clarify their roles. *Primary health care*. In primary health care, Halcomb et al. (2020) found that despite nurses having clear roles in infection prevention and control where they support people in the community to maintain health through education around infection control, key supports such as additional staffing and standardized care protocols were required to optimize their roles in the follow-up of chronic diseases and mostly during health crises such as pandemics (e.g. COVID-19).

2.1 | Perioperative care

Studies have also explored the roles of nurses during perioperative care. For example, an Australian study by Iddrisu et al. (2018) found that nurses felt confident about their clinical assessment skills and monitoring but had a limited understanding of their role in recognizing and responding to clinical deterioration in surgical patients. According to Di Santo (2019), cognitive deterioration is common in perioperative settings, and the roles of nurses to recognize and act on it are of great importance and should be emphasized. For example, during pre- and postoperative periods, nurses have to intervene by managing stressors that can trigger symptoms and assess for predisposing factors and types of surgery to evaluate the risk of developing cognitive changes. In a study on the role of nurses in orthopaedic surgery, Copanitsanou and Santy-Tomlinson (2021) highlighted the importance for nurses to understand how to accurately carry out their role effectively as part of surgical wound infection care and surveillance during the ambulatory/outpatient, pre-operative, perioperative, postoperative and postdischarge care. Early recognition and diagnosis of surgical wound infection is part of the process of wound monitoring and healing and is central to the prompt treatment of wounds. Ielapi et al. (2020) found similar results with respect to the roles of vascular surgery nurses. They noted their pivotal role in optimizing patients' clinical outcomes by providing skilled and advanced care to reduce possible adverse events such as postoperative myocardial infarction or vascular access complication rate. Several studies also explored the roles of nurses in surgical units during the implementation of enhanced recovery after surgery (ERAS) protocols – a multimodal, multidisciplinary programme that aims to limit surgical stress during the perioperative period. Pignot (2019) highlighted that nurses in medical-surgical units using ERAS protocols had several major roles to play such as reducing the consequences of surgical stress by focusing on core aspects of surgical recovery to accelerate patient recovery times; ensuring the coordination of care amidst the various healthcare professionals; planning and preparing discharge and supporting patients in regaining their autonomy.

2.2 | Three categories of nursing roles

As part of the *Nursing Role Effectiveness Model*, Doran et al. (2002) classified the nursing role as independent, dependant and interdependent. The independent nursing role pertains to the role functions

for which nurses are held accountable. It includes the activities of patient assessment, decision-making, intervention and follow-up activities (e.g. assessment of patients' physical and mental condition and patient positioning). Nurses' dependent role includes the functions and responsibilities associated with implementing medical orders and treatments (e.g. performing and adjusting medical treatments as prescribed). Nurses' interdependent role relates to the functions and responsibilities that are partially or totally contingent on other healthcare providers (e.g. mobilization exercises). This classification was used in the current study.

Given their multiple interactions with other healthcare professionals as part of a multidisciplinary team and with patients and their families, the need to better understand medical-surgical nurses' perceptions of their roles is crucial. The aim of this study was therefore to explore the perception of nurses about their roles in medical-surgical units. The two research questions were as follows: (i) How do nurses describe and perceive their role as caregivers in medical-surgical units? (ii) What are the factors that influence the roles of nurses in these units?

3 | METHODS

3.1 | Design

A qualitative descriptive methodology was used in this study. According to Miles et al. (2020), qualitative data "are a source of well-grounded, rich descriptions and explanations of processes in identifiable local contexts. With qualitative data, one can preserve chronological flow, see precisely which events lead to which consequences, and derive fruitful explanations." (p. 3) Qualitative descriptive studies offer a straightforward descriptive summary of the data in everyday language and are characterized by lower levels of interpretation (Colorafi & Evans, 2016). The Standards for Reporting Qualitative Research was chosen for this study.

3.2 | Data collection and analysis

3.2.1 | Recruitment

A total of 21 nurses from three campuses took part in the study: HH ($n = 10$), HG ($n = 5$) and HP ($n = 6$). Participants were nurses working on medical-surgical units including pre-admission and postoperative units. More specifically, four nurses worked in pre-operative care (pre-admission clinics) where patients are referred prior to surgery to help them prepare for the procedure, and 17 worked in post-operative units where patients are recovering following a surgical procedure (postoperative care). Participants were between 25 and 60 years of age. Nineteen were women and two were men. They averaged 14 years of experience in the nursing profession. The majority of participants had completed their undergraduate nursing education and were employed full-time.

Participants were recruited using a number of strategies: (i) distribution of recruitment fliers on the three campuses; (ii) meetings with medical-surgical unit managers to inform them about the study and ask them to promote it to the nursing staff and (iii) five visits by the main researcher to the medical-surgical units to inform nurses about the research and invite them to participate. Sampling included convenience and snowball sampling to increase the sample size. Participants were eligible to participate in the study if they were registered nurses, able to speak French and working in a medical-surgical unit on one of three campuses.

3.2.2 | Data collection

Data collection was between April 2019 and March 2020 when data saturation was achieved. One-on-one semi-structured interviews were conducted at a place and time that was convenient for participants. The interview guide consisted of eight to nine open-ended questions (Table 1). Following each interview, field notes and

TABLE 1 Summary of interview questions

Pre-admission nurses:
1. What do you understand by the term nursing roles?
2. How do you understand your roles as nurses on the preadmission units in your daily work?
3. Can you describe any instances of your independent roles in clinical practice?
4. Can you describe any instances of your dependent roles in clinical practice?
5. Can you describe any instances of your interdependent roles in clinical practice?
6. What do you know about the roles of postoperative nurses in the wards?
7. What are the factors that influence your nursing roles in your unit?
8. If you could provide strategies, which ones should be put in place to enable nurses to fulfill their roles and scope of practice?
Postoperative nurses:
1. What do you understand by the term nursing roles?
2. How do you understand your roles as nurses on the postoperative units in your daily work?
3. Can you describe any instances of your independent roles in clinical practice?
4. Can you describe any instances of your dependent roles in clinical practice?
5. Can you describe any instances of your interdependent roles in clinical practice?
6. What do you know about the roles of preadmission nurses?
7. How easy or difficult is it to exercise your nursing roles in your unit/hospital?
8. What are the factors that influence the roles of nurses in your units?
9. If you could provide strategies, which ones should be put in place to enable nurses to fulfill their roles and scope of practice?

reflective memos were written to allow the researcher to reflect on the interview process and whether some interview questions should be added or modified before the next one. Interviews lasted between 30 min and 1 hr and were digitally recorded and later transcribed. Audio files and transcripts were then stored securely on the main researcher's password-protected computer.

3.2.3 | Data analysis

A three-step qualitative thematic analysis as described by Sundler et al. (2019) was used in this study. The first step required the researchers to independently read the transcripts several times with an open mind to become familiar with the data and its meanings. The second step consisted of moving back and forth in the text to search for meanings and themes about nurses' perceptions of their roles. Researchers searched for patterns by relating meanings to each other. Memos and notes were written in the margins to identify emerging themes which were then compared among researchers to test reliability and to avoid relying on the subjective judgements and interpretations of one researcher. This step was to understand the essence of meanings. As part of the third step, results were written and rewritten to achieve meaningful wholeness and to further consolidate themes. The themes and subthemes were then discussed and compared between researchers to bring to light similarities and differences. When there was disagreement, the discrepancies were discussed and themes were renamed, merged or deleted.

4 | RESULTS

Three main themes were identified from the analysis; confusion in nurses' roles and scope of practice, challenges in the continuity of care and factors affecting the roles of medical-surgical nurses (Table 2). The following sections explore each of the themes in more detail.

4.1 | Confusion in nurses' roles and scope of practice

This first theme pertains to the inability of nurses to explain the role they play beyond the completion of clinical tasks or the contribution [added value] they bring to the medical-surgical units. Postoperative nurses struggled to articulate the independent, dependent and interdependent roles they play in these units. They stated that learning about their roles predominantly occurred as part of their initial training to become nurses, and more specifically, during their clinical placements while observing other nurses and realizing what was expected of them. They perceived their roles as very broad, as a series of tasks that needed to be performed on a daily basis to prevent postoperative complications. They identified the clinical assessment of patients as the main focus of their roles. "Assessment is the core of nursing in the sense that it's not something you're going to ask a nursing assistant to do" (Participant 12). Postoperative participants reported that they regularly had to perform non-nursing tasks or tasks for which they did not have the experience or skills to perform, potentially having an impact on the quality of care and patient safety.

> It's hard to explain my role… in this medical-surgical unit my role is much more on the floor. I do a lot of dressings, I mobilize patients, I do lifts, panty changes, hygienic care, and everything… In addition, we sometimes play the role of stretcher bearer. These do not necessarily fit into the role of the clinical nurse. So, there can be impacts on patients. (Participant 7) [free translation].

TABLE 2 Summary of themes and subthemes

Master themes	Subthemes
Theme 1 Confusion in nurses' roles and scope of practice	Inability for nurses to explain their functions (1, 6, 7, 16, 17) Increasing difficulty in explaining their independent, dependent and interdependent roles (1, 3, 6, 7, 4, 9, 11, 12, 13, 14, 16, 17, 18) Nurses as executors (1, 12) Understanding the roles of the pre-admission nurse (2, 5, 10, 18)
Theme 2 Challenges in the continuity of care	Lack of follow-up in the care process (2, 3, 4, 5, 8, 10, 11, 14, 21) Interprofessional communication (2, 4, 14) Lack of standardization of patient management tools (3, 14, 21) Working in silos (1, 3, 5, 10)
Theme 3 Factors affecting the roles of nurses in medical-surgical units	Working conditions: workload, understaffing, high nurse-to-patient ratio and work environment (1, 2, 3, 5, 6, 9, 11, 12, 14, 16, 18) Lack of nurse retention strategies (3, 11, 16) Few experienced nurses and stable staff (1, 2, 3, 11, 12, 13, 17) Polyvalent nurses (7, 19) Administrative duties and documentation (21) Team spirit (2, 3, 7)

Postoperative participants said concerns about management viewing nurses as "a nurse is a nurse is a nurse" rather than valuing specific clinical expertise, thus preventing nurses from working to their full scope of practice.

> Every nurse has a little more of a specialty, except that the way the work is distributed here, people do not work according to their expertise because we have to go to all the medical-surgical units. Therefore, people's potential is not optimally exploited. (…) In fact, they ask people to be really versatile. I do not see that as an advantage. They do. It's certain that the unit manager wants us to be versatile so that she can move us to her liking. I think that we cannot be good at everything…You only have to be good in a few places because people develop an expertise, and at some point, if you do not allow them to develop an expertise, people become less involved. (…) If someone is more dedicated to a specialty, he will be more involved. Someone who goes around everywhere takes less ownership of his role. (Participant 19) [free translation].

In terms of the perception of the nurses' independent roles, the data showed that postoperative nurses were aware that they could practice independently by performing tasks that could be undertaken without physicians' orders. They described exercising their autonomy [independent roles] when performing specific nursing activities such as patients' assessment and education, clinical judgement, surveillance and clinical follow-up 24 hr a day.

> In the case of a patient who has a bowel obstruction with a nasogastric tube, for example, if I see the blood in the suction tubing, I'm not going to wait for the physician, I will stop it right away. I do not need the physician's prescription to stop it. (…) I'm not going to call the doctor for everything. I will always make my clinical judgement first and […] I will say [to the doctor] here's what I've done, do you want us to continue or not. I do not take the place of a doctor, but I think I give my opinion because I am closer to the patient than the doctor. There are things that I see that he cannot see. There are things I know that he does not. Most of the time we are the ones who give the information to the doctors. (Participant 11) [free translation].

In some instances, the ability to enact their independent roles will depend on the surgical specialty. In postoperative units where there are standardized protocols, clinical pathways, evidence-based interdisciplinary care and management plans, the nurses know exactly which interventions to do and when:

> In this orthopaedic surgical unit, everything is performed according to the protocols and clinical pathways. But, the assessment of the patient is autonomous and in terms of teaching before discharge, it is certain that each surgeon has his own specificities that he wants the patient to receive as information, but teaching the patient is also … [part of the] autonomous role of the nurse. (Participant 19) [free translation].

A few participants working on postoperative units described the challenges associated with exercising their independent roles. For example, novice nurses, those with less experience in assessing, teaching or using clinical judgement – elements they are still developing and have not mastered well yet – reported feeling less confident and less competent. They were aware of the increased responsibilities that come with experience and the need to keep acquiring knowledge and skills to practice more independently. The ability to refer to experienced nurses when in doubt was considered vital to playing their independent roles. Because experienced nurses can easily rely on their skills and clinical judgement, they can assist novice nurses in understanding the nurses' roles and what needs to be done:

> You know, sometimes you do not know what the problem is or what you should do, but you know that the experienced nurse right away she's going to assess the patient. She will say: Ah! I'm sure that's what's going on, we'll call the doctor or it's normal in this patient's situation. They act very much as a referral tool. But, of course, when you have less experience you can miss things, or you did not see that there was a problem […]. Sometimes you can even create problems when in fact there were not any. (Participant 1) [free translation].

As for their dependent roles, participants acknowledged that depending on their inpatient postoperative units, the nurse's roles could truly be dependent on the physician. They commented on the lack of confidence and self-doubt experienced by some nurses when faced with physicians' prescriptions. For example, poorly written medical orders or those containing errors, time wasted locating a physician to have a prescription ordered or renewed and a basic lack of communication all impacted the dependent roles of the nurse. Participants expressed the importance of questioning physicians' prescriptions and using their clinical judgement before delivering "prescribed" care.

> I think that many nurses unfortunately apply, execute without questioning… to be relegated to just taking vitals signs and giving medications is very reductive for nurses. […] Sometimes we are obliged to follow medical prescriptions even if we can be personally in conflict… or have an internal conflict

> by saying well I do not really understand why this medication has been prescribed. The first thing to do is to discuss it with the doctor if you have the opportunity. [...] It proves that there is a reflection behind it [execution of the task] rather than to do it stupidly without questioning. (Participant 12) [free translation].

In terms of their interdependent roles, some nurses working in postoperative units viewed the enactment of these roles as part of interprofessional collaboration and as having mostly positive implications for patients. They recognized that they play a pivotal role in facilitating referrals and as a liaison among the many disciplines to ensure continuity of care. Together with physiotherapists, occupational therapists, social workers and physicians, they are able to give holistic and safe patient care. Other participants considered this collaboration to be indirect since the head nurse, and not the frontline nurse, is usually the one who is made aware of these multidisciplinary interventions:

> Is the collaboration with other professionals going well? I would say yes and no. In my unit, I find that we do not have much of a relationship with the physiotherapists, occupational therapists, etc. It's more with the head nurse that they'll talk... it's very rare that I get feedback from them. Sometimes I find that I'm missing information. I'd like to know what they are going to do because the patients are mine too. So, I wait until they are done to go read their notes. (Participant 21) [free translation].

According to some participants, nurses' heavy workloads do not allow them to take the time to discuss with other professionals about a patient's health status. Nurses working in postoperative units also noted that collaboration with physicians can sometimes be difficult, especially when they do not take into consideration nurses' assessments:

> Collaboration with other professionals... I really think there is a lack of time to do that. I do not have time to sit down and read the physiotherapist's note for example. We'll communicate quickly in the hallway. When we make referrals for the patient to be seen by the physiotherapist, we do not have time to make sure that patients are actually seen. Also, we make nursing notes, and, seriously it's rare that the doctors read my notes. Sometimes to make sure they read my nursing notes, I'll write a little note on the top of the chart to get Dr. X or Dr. Y's attention. (Participant 8) [free translation].

For their part, pre-admission nurses were able to articulate their perceptions of their independent, dependent and interdependent roles. The four participants clearly described three main roles: preparing patients for surgery by providing the necessary education to ensure a safe return home, reviewing the patient's health condition and the medications to be taken or not taken prior to surgery and verifying that the results from the required medical exams are on file and whether other(s) are needed. They mentioned that it is the role of the pre-admission nurse to ensure that pre-operative examinations are done to reduce the risk of postoperative complications:

> My role in pre-admission is patient assessment. That is... I'm the one who prepares them for surgery, who tells them what they have to do... we have to teach them too. We do all the preadmission questionnaires, blood works, EKG, really all the preoperative tests. We also prepare [them] for the post-op. That's my role. (Participant 18) [free translation].

Participants also reported that in pre-admission settings, nurses perceived their independent roles to be minimal as it could only be performed during the patient's initial assessment or when requesting a consultation. Conversely, dependent roles were very present since these nurses have to follow protocols or decisional algorithms written by surgeons and anaesthetists. Regarding the interdependent roles, pre-admission nurses acknowledged the positive collaboration they have with physicians, physiotherapists or other health providers. These nurses felt confident in their interdependent or dependent roles:

> For the doctors, once the patients are in preadmission, they forget them, it's us who do the follow-ups. (...) Having a lot of interdependent or dependent roles... oh dear! I think it's even safer in pre-admission to have things like that [surgery protocols] to decrease the risk of complications. (Participant 5) [free translation].

4.2 | Challenges in the continuity of care

This theme refers to the challenges associated with service delivery to patients in a coherent, logical and timely fashion. Some postoperative units' participants viewed continuity of care as the prolongation of the care that was started in the pre-admission unit (before the surgery) and the recovery room (immediately after surgery):

> For my part, depending on vital signs for example, I refer to the patient pre-admission file to see how he was before and I will refer also to the recovery room notes to see how he was after the surgery. I try to see the continuity between the pre-admission and what has now changed. (...) I have to check for what has happened...get a global idea of the patient's condition. (Participant 7) [free translation].

Pre-admission nurses noted that when patients are transferred to the postoperative units, there appears to be a disconnect between care received in pre-admission clinics and the continuity of care in postoperative units. They wondered whether postoperative nurses took the time to read the patients' charts. They believed that the documentation and reports found in the pre-admission section of the chart make it possible to follow the care process and ensure continuity of care:

> As I say... I send what's available, all my documentation. Sometimes I go to the nurse who's going to take care of the patient [on the postoperative unit] and I tell her "look I've put the file together. Everything is complete for tomorrow, you're going to send it to the OR tomorrow morning. My data collection is there, everything is there". They're always very happy to get it. But what they are going to do next, I cannot say. (Participant 10) [free translation].

More importantly, pre-admission nurses and those working on postoperative units do not seem to really understand and often do not even know what each other's job is. Each group of nurses seems to work in silos, as explained by a pre-admission nurse:

> I do not think our roles is understood by the nurses on the floors, (...) If you want my perception, it seems that it's not the same reality, I think it's two worlds. (...) What we do before they see the patients, all the paperwork. Nurses do not see all the work that is done before the patient arrives on their unit (Participant 5) [free translation].

In fact, most nurses in postoperative units stated that they only took into consideration the assessments and data documented in the recovery room. They indicated that they did not even know where to find pre-admission data and whether these would in fact make a difference in patients' care. Postoperative nurses recognized that they are working in silos without necessarily having any connection with pre-admission nurses:

> In pre-admission... I know there are forms that are filled out, but I do not really check those forms. I do not even think I know where they are in the patient's chart. (...) I personally do not feel that my role as a nurse on the surgical wards is a follow-up to that of the preadmission nurses... because I really do not have any idea what is done in preadmission. (Participant 1) [free translation].

> It depends on the patient's case. If it's a complex case with multiple co-morbidities, yes, I'll look at the preadmission file to know what to expect because complications arise not only from the surgery, but also from previous illnesses. Then if there are social issues, I'll also read it to see if I need a social worker or someone else for the discharge. But often there's no time (...) and sometimes there's no need [to look at the pre-admission file]. (Participant 3) [free translation].

Additionally, novice nurses working on postoperative units sometimes reported difficulty in understanding their roles in the management of a postoperative patient, which made it difficult to ensure continuity of care. Informal verbal communication with experienced nurses seemed to be how these nurses ensured patients' continuity of care. Postsurgical complications appeared to be more frequent in units lacking surgical protocols or standard postoperative follow-up forms. Thus, a priority to ensure continuity of care for the organization was to put in place clear guidelines and clinical pathways for postoperative nurses, particularly novice nurses, so they could plan their tasks according to patients' individual needs:

> If the patient does not experience surgical complications, he does not stay long. But, there was one who developed an abscess that got super infected, she stayed a month in the hospital. (...) I feel like ... It's disorganized on my unit, there's no structure. You know, it's nobody's fault really... it's probably the lack of staff. I think that's why we do not have any guidelines as well. (...) As a nurse, you work according to what you think. On our unit, we have major and super super varied surgeries, so maybe that's because of that too. (...) It might be a good thing to have some guidelines (Participant 1) [free translation].

4.3 | Factors affecting the roles of nurses in medical-surgical units

This last theme illustrates how the healthcare organization can positively or negatively influence nurses' perception of their roles. Working conditions such as understaffing and high nurse-to-patient ratios were perceived as impeding nurses' roles. A registered nurse paired with a registered practical nurse sometimes shares 12 or 13 postoperative patients, thus prioritizing treatment becomes the only way to ensure a basic level of care. As the workload increases, the risk of errors increases as less time and attention are paid to tasks, resulting in negative patient outcomes. Participants reported that on days when there is a staff shortage, postoperative nurses find it difficult to regularly assess patients and deal with issues compared to days when there is proper staffing. While it cannot be contested that administrative duties take nurses away from patient care, participants' perception was that administrative activities were so burdensome and time-consuming that little time remained for nurses to interact with patients:

> If one day all the nurses are there, it's fine. But, usually it's a really heavy workload... there's a lot to do on

> the unit. A lot of times you have to prioritize. If there are things that absolutely have to be done today, you are not going to go take care of things that you can leave. For example, leaving the dressing for the evening shift. (...) Sometimes I realize after my shift that I've just been executing, just doing techniques, so we take less time to spend with our patients. Yes, I would like to spend more time with my patients, to support them morally, we do not have the time to do that. You cannot sit down with your file, and think about why this, why that, get a general picture of your patient... it has a great impact on the health of the patients. But that's how it is! Then... there are a lot of people leaving because it's hard to work on the units. (Participant 4) [free translation].

Postoperative nurses perceived that having to reinput patient information in multiple forms can lead to documentation being duplicated and wasted time. These nurses reported that they often do not have time to complete all the administrative paperwork because of the complexity of patient care and the lack of adequate staffing on the units.

> I assess the patient's history quickly...I do not have time to look at every file, it's impossible...it goes fast. We're on a unit where you have to be quick on the uptake, the workload is heavy... and there's a lot of paperwork that needs to be filled out, but it's not filled out, not because we do not want to, but because there are other priorities and I think it's more important to get my patient up than to fill out forms. For sure, I'll write my nursing notes; for problematic patients, I'll definitely make a note, but I'll work on his problem first. (Participant 8) [free translation].

Concern was also expressed about the inability of casual staff nurses or float nurses to work to their full capacity because of their unfamiliarity with the unit, patients, equipment and material. When these nurses are working on units, permanent nurses to the units have to cover by performing extra duties as they are the only ones with the most up-to-date information about the patients or the functioning of the unit.

For their part, pre-admission nurses perceived their work environment to be helpful and collaborative. Nevertheless, they were frustrated about time constraints, as per organizational guidelines, specifying how much time to spend with the patients depending on the type of surgery. They also experienced heavy workloads and are often understaffed resulting in having to see a large number of patients per day. They mentioned that it was important that enough time be allocated to give quality education so that patients could fully understand the surgical procedure they were to undergo and its associated care:

> Let us talk about the workload. As I said before, we have about 20 minutes for our appointment, sometimes it's enough, but it's very rare... 20 minutes to manage to do everything: take vital signs, fill in forms and then explain the surgery to the patient, teaching them., that's what takes the longest, especially if the patient has questions. [...] 20 minutes will turn into 30 or 40 minutes. So, I will be late with my next appointment, [...]. And on top of that, we have follow-up calls to make. (Participant 2) [free translation].

Moreover, pre-admission nurses reported the importance for the organization to have a culture of learning by facilitating access to continuing education to ensure their knowledge remains current and the care they provide is evidence based:

> Often only CPR training is offered. Nothing else. Training is needed to prevent and avoid postoperative complications and to ensure that the nursing staff is kept up to date. Even when changes are made to surgical procedures or to the equipment used during surgeries, there is no training to ensure nurses to learn about these changes. The employer tells us to sign up for training, but they do not do much. (Participant 18) [free translation].

Both pre-admission and postoperative nurses deplored the lack of nursing retention strategies put in place by the organization. For example, participants reported that offering standardizing processes and tools and clinical support for new nurses could promote staff retention, thus ensuring sufficient human resources and manageable workloads. Conversely, participants also commented on how managers' attitudes such as demonstrating flexibility, empathy and understanding contributed to a more positive work environment:

> The workload on our medical-surgical unit is [that of a] heavier unit ... I think. Maybe that's why we lose nurses too because of the heaviness of the tasks. But our unit manager is great! (...). He bought new equipment, new materials. So slowly it's getting better [...] Equipment that works is very important. And he has organized our staff room, which helps. Even though we are so short of staff, he is flexible in terms of schedules. We can talk with him. We can organize ourselves. (Participant 3) [free translation].

Participants also mentioned how having a positive and supportive team helped make a difference in their work environment:

> When the recovery room does not send us all the patients at the same time, it's fine. But if there is a patient who is not doing well, everything falls apart (...) it's then that we have to stick together. There has

> to be a team spirit. When I see that there is another nurse who is super busy with a patient who is not doing so well, I'm going to go see her [and ask]: do you want me to do something? That's the team spirit. (Participant 13) [free translation].

The study finding shows that nurses in pre-admission and postoperative units perceived challenges with the enactment of their roles resulting in them not working to their full scope of practice. This is problematic given the complexity of patient care and the shortage of healthcare professionals.

5 | DISCUSSION

The aim of this study was to gain further insight into the perception of nurses about their roles as medical-surgical nurses. Our findings align with that of previous studies which showed that nurses tend to perceive their professional roles as vague (Allen, 2020; Bittner, 2018). In a review of the literature including 103 articles, reports and other documents about nurses' role ambiguity and its impact among nurses in Alberta, Canada, Tycholiz (2021) explained that role ambiguity characterized by lack of clarity about roles, responsibilities and/or procedures to achieve what is expected of them, can contribute to role confusion, role overlap, decreased collaboration, ineffective workforce planning, diminished professionalism and inefficiencies. The inability of nurses to explain their roles can also lead them to feel uncertain or confused about how their tasks or activities should be accomplished, resulting in negative patient outcomes (Blanco-Donoso et al., 2019). Additionally, while studies showed that nurses' roles and subsequent performance can be explained by variables such as nurses' level of education (Doran et al., 2002; Furåker, 2008), our study showed no difference between the roles of medical-surgical nurses with a bachelor's degree and those with a college education. Rather, the vagueness and confusion about the nursing roles was found in these two groups.

Our study showed that patients' assessments were perceived to be the most important clinical role enacted by medical-surgical nurses. However, it is well documented in the literature that nurses do a lot more than assess patients, as described by the nine nurses' roles identified by Almost (2021) for the Canadian Nurses Association. For example, she and others have reported that nurses are professional leaders with independent roles, who educate clients/families, ensure cohesive and coordinated care, collaborate in curing diseases, participate in rehabilitation and provide support and advocate for the patients to name a few (Choi, 2015; Kang et al., 2020; Luther et al., 2019).

In this study, medical-surgical nurses are concerned about the underutilization of their scope of practice and performing non-nursing tasks. Frogner et al. (2020) identified two major consequences associated with restricting the scope of practice of qualified and competent workers like nurses who are trained to safely and efficiently provide services: (i) skills are not used to their full extent and (ii) workers do not meet patient's care needs. According to Déry et al. (2022), nurses should be able to practice to their full scope to maximize their contribution in the healthcare system and to ensure accessibility and continuity of care.

The study also identified a lack of continuity of care as a challenge. Study participants acknowledged that they were working in "silos" and not maximizing the use of the information collected throughout the perioperative continuum. This result was surprising given the importance of the information collected as part of the pre-operative assessment which is known to help establish a baseline for surgical patients by becoming aware of their vulnerabilities (Akhtar et al., 2013) and identifying their needs and risk factors (McShane & Honeysett, 2013). Malley et al. (2015) reported similar findings where the urgency to complete tasks and lack of communication when transitioning patients to the next level of care rendered the work of pre-operative nurses invisible.

Finally, the findings from the current study which highlights that the working conditions and the work environment of nurses can negatively affect their performance and their ability to fully enact their three categories of roles (independent, dependent and interdependent) are consistent with that of other studies that found similar results (Er & Sökmen, 2018; Shao et al., 2018). In fact, the dependent and interdependent roles were perceived by pre-admission nurses and novice nurses working on the postoperative units as safeguards to prevent them from making errors. Experienced nurses stressed the importance for nurses to master their independent roles because the dependent and interdependent roles were perceived as a barrier to nurse autonomy. In their study, Pursio et al. (2021) found that when nurses have professional autonomy, they are more satisfied with their work and are more occupationally committed and empowered when they can prioritize, schedule and pace their tasks. Health organizations have a responsibility for providing the necessary means for nurses to act autonomously by communicating clear roles and enhancing practice and decision-making to ultimately improve nursing performance, quality of care and patient outcomes (Cho & Han, 2018; Oshodi et al., 2019). Research have also highlighted the risks to nurses' physical and mental health (e.g. burnout and anxiety) and an increased intention to leave when having to practice in poor working conditions (Havaei et al., 2020; Nantsupawat et al., 2017). However, because these have been the reality of nurses for so long, there is now a normalization of these deviant practices (delays in care, absence of care, non-evidence-based practices, etc.; Banja, 2010).

6 | LIMITATIONS

This study has a number of limitations. First, the findings are based on the perception of 21 nurses working in one large tertiary hospital. Second, the study over-represented experienced nurses (the average number of years of experience was 14 years). Third, the study did not include intraoperative (operating room and recovery room)

nurses who could have provided a valuable, albeit different, perspective given the nature of their roles.

7 | RECOMMENDATIONS

The current findings have implications for academic training programmes. For example, a focus should be on the ability of nurses to describe and articulate their different roles in relation to safe and ethical care, decision-making and critical thinking. Moreover, leadership courses should also be part of nurses' initial training (Poorchangizi et al., 2019).

Similarly, in clinical practice, mechanisms, such as making continuing education more readily available, should be put in place to allow nurses the opportunity to enhance their individual skills and develop their competence to recognize and respond to surgical patient needs and prevent adverse patient outcomes (Iddrisu et al., 2018).

At the management level, unit managers are in a strategic position to implement reforms to improve the work environment of nurses. This can be done by: (i) allocating sufficient resources at the unit level to have the right professional perform the right tasks (e.g. adequate staffing ratios and appropriate staff mix); (ii) developing and implementing evidence-based policies, care pathways and guidelines that clearly outline nurses' roles, responsibilities and boundaries; (iii) ensuring continuing quality improvement measures and initiatives and (iv) facilitating regular reviews of nursing roles so that nurses can work to their full potential (College of Nurses of Ontario, 2018).

While they are frequently told to engage in politics, nurses' political roles have mostly been discussed in the context of administrative roles in healthcare organizations (McMillan & Perron, 2020). However, political action is imperative to further develop the nursing profession. As a result, medical-surgical nurses must not only focus their practice on clinical tasks and patient care, but should also be involved in the political process and decision-making to ensure that policies do not impede their roles (Wilson et al., 2022).

8 | CONCLUSION

Medical-surgical nurses play a pivotal role in the perioperative continuum ensuring that patients are well cared for before, during and after their surgery. Findings from the current study suggest that nurses struggle to articulate their roles and to work to their full scope of practice. Results also highlight that siloed clinical practice due to hierarchical organizational culture and poorly organized work environment can have a negative impact on nurses' clinical practice and potential patient outcomes. A team approach is a strategy that would better respond to patients' clinical needs across the surgical journey, thus reducing the incidence of adverse events. Further research is warranted to better understand the magnitude and the impact the lack of understanding of the nurses' roles has on nurses, healthcare teams and patients, and to identify concrete and sustainable strategies to support medical-surgical nurses in working to their full roles and scope of practice.

9 | RELEVANCE TO CLINICAL PRACTICE

Since nurses in medical-surgical units play a critical role in ensuring clinical monitoring and continuity of care and reducing the risk of adverse events and complications, it is important that they understand and articulate their roles and work to their full scope of practice. Allowing medical-surgical nurses to be fully contributing members of the interprofessional team by allowing them to have greater involvement in decision-making about patient care and discharge is essential. Improving the work environment of medical-surgical nurses is also required if they are to work to their full potential. This can be done, for example, by having a flexible work environment with better working conditions and manageable workloads.

Impact statement

What does this paper contribute to the wider global clinical community?

- The relevance of the work performed by pre-admission nurses is not well understood by postoperative nurses resulting in the information collected in the context of pre-admission being underutilized.
- Nurses working in postoperative units currently do not fully understand their roles and scope of practice, raising concerns about their ability to recognize and manage patients whose conditions may be deteriorating.
- Continuity of care, an essential care principle that is particularly meaningful in the context of perioperative care, is lacking, thus potentially having a negative impact on the quality of care delivered and patient safety.

AUTHOR CONTRIBUTIONS

All authors, Evy Nazon, Isabelle St-Pierre and Denise Pangop, have approved the final text. Denise Pangop was involved in the design and data collection. All authors Evy Nazon, Isabelle St-Pierre and Denise Pangop analysed and prepared the manuscript.

ET: conceptualization and data acquisition. ET and LA: methodology. ET, DW, GD and LA: analysis of data, resources and writing (drafting, reviewing editing). LA and SR: funding acquisition.

All authors have agreed on the final version and meet at least one of the following criteria [recommended by the ICMJE (http://www.icmje.org/recommendations/)]:

- substantial contributions to conception and design, acquisition of data or analysis and interpretation of data;
- drafting the article or revising it critically for important intellectual content.

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CONFLICT OF INTEREST

The authors declare that there is no conflict of interest.

DATA AVAILABILITY STATEMENT

Data available on request due to privacy/ethical restrictions

ETHICAL STATEMENTS

The study received ethics approval from the Research Ethics Boards of the Université du Québec en Ouatouais and a large tertiary care hospital located in Quebec, Canada. The 21 participants signed the consent form before participating in the study. Data anonymity and confidentiality were maintained throughout the study. There were no risks associated with the research and study purpose.

PATIENT OR PUBLIC CONTRIBUTION

The public involvement included one nurse working on a medical-surgical unit who accepted to review and comment on the interview guide.

ORCID

Evy Nazon https://orcid.org/0000-0002-0638-1241

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