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The scope of nursing practice in a psychiatric unit: A time and motion study

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Accessible Summary

What is known about the subject?: The evaluation of nurse care practices poses many challenges, including the identification of all the aspects of the care given. Few studies have looked at the scope of nursing practice in psychiatry. However, the evaluation of care practices in the mental health field poses many challenges, including the identification of all aspects of care.

What the document adds to existing knowledge?: Findings demonstrated that mental health nurses do not invest in all domains of their scope of practice in the same way and the time spent with patients is low. Several factors contributed to this, including the increasing complexity of care, stagnant staffing levels, and a culture of care that continues to be influenced by the medical model. Current models of care still retain the stigma of this past, prioritizing medically delegated tasks rather than promoting a holistic approach to care. Although the professional identity of nurses is evolving and asserting itself, the paradigm shift in practice is still incomplete.

What are the implications for practice?: It is essential to describe concretely what is actually expected of nurses, to help them allocate their time effectively and to identify opportunities for improvement. The field of practice of nurses is put under stress by a demanding work environment subject to many pressures and constraints. Changing practices so that nurses can use the full scope of nursing practice requires strong nursing leadership and action on education and the organization of care, particularly on clinical assessment.

Abstract

Introduction: The evaluation of nursing care practices poses many challenges, including identifying all the aspects of the care given. However, few studies have examined the scope of nursing practice in psychiatry.

Aim: The aim of this study was to describe the intensity of nursing activities on a psychiatric unit based on the adaptation of Déry and D'Amour's (2017, Perspect Infirm Rev Off Ordre Infirm Qué, 14, 51) Scope of Nursing Practice Model.

Method: This 56-day descriptive observational study used the time and motion method to follow eight nurses.

Results: 500 h of observations were carried out. The greatest lengths of time were allocated to communication and coordination of care activities and to "non-healthcare" domains. Less time was devoted to activities related to clinical evaluation and therapeutic education.

Discussion: Findings demonstrated that MHNs do not perform all the possible functions in the domains of their scope of practice in the same way, and time spent with patients was short. Several factors contributed to this, including the fact that nurses are working in increasingly demanding care settings that keep them under constant pressure.

KEYWORDS
nursing activity in psychiatry, psychiatry, scope of psychiatric nursing practice, time and motion study

1 | INTRODUCTION

The scope of nursing practice refers to "the range of functions and responsibilities legally assigned to registered nurses and for which they have the education, knowledge and skills" (Déry et al., 2017). When nurses perform the complete range of functions for which they have been trained and bear their responsibilities fully, this is referred to as optimal use of their scope of nursing practice. This factor has been strongly correlated with a good quality of care (Aiken et al., 2002; Hendrich et al. (2008). Studies to date have shown that the functions and responsibilities taught and theoretically entrusted to nurses are not used to their optimal level. This is referred to as sub-optimal use of their scope of nursing practice (Oelke et al., 2008). According to some studies, 73% of nurses feel that they are not working to their full potential (White et al., 2008). Nurses feel that they spend a lot of time on non-therapeutic or stewardship tasks, such as answering the telephone (Cleary, 2004). While performing non-clinical tasks, nurses are not fully engaged in activities appropriate to their highly educated roles and skills (Lavander et al., 2016). This can lead to the postponement or abandonment of some care activities (Schubert et al., 2005; Ball et al., 2014). Numerous studies have shown that the quality of care falls when conditions do not allow nurses to use their skills fully (Jones, 2005; Kane et al., 2007; Needleman et al., 2011; Smeds Alenius et al., 2014). For patients, this often means decreased satisfaction with their care (Duffield et al., 2011), as well as increased mortality, morbidity and risks of adverse events (Aiken et al., 2002). Sub-optimal use of nurses' full scope of practice has a negative effect on their job satisfaction in healthcare services (Déry, 2013), including seeing them leave the profession.

Illustrating the scope of nursing practice requires a clear description of nurses' work and responsibilities and suggests the need to explore how they truly allocate their time. Studies oriented towards general care have sought to define the scope of nursing practice in relation to the concept of "added value," from which patients benefit directly (Antinaho et al., 2015), and then to describe nurses' various tasks (Cornell et al., 2010; Farquharson et al., 2013; Westbrook et al., 2011). Few studies to date have examined the scope of practice of mental health nurses (MHNs) in psychiatric units. Because of the many nursing categories investigated, the diversity of definitions of scope of practice, and the variety of measures used, comparison between research results is difficult. In their review of the literature, Sharac et al. (2010) noted that their 13 included studies focused on observing interactions between carers and patients, but the number of studies is decreasing over time. This shows the need for further exploration of how psychiatric hospital staff allocate their time on wards. Two studies analysed the distribution of nurses' working activities in psychiatric units in terms of their average daily duration (Seed et al., 2010; Torkelson & Seed, 2011). The activities allotted the most time during shifts were paperwork (120 min), nursing handovers (95 min) and assisting patients in their activities of daily living (ADL) (60 min). The activities allotted the shortest times were attending medical interviews with patients (7 min), psychoeducation (9 min) and relational care (25 min). Nurses and patients alike considered that their therapeutic relationships—the mainstay of care—were given inadequate attention (McAllister & McCrae, 2017). Studies have confirmed the short times spent on relational care (Whittington and McLaughlin, 2000; Goulter et al., 2015) and updating knowledge (Hodek et al., 2011). A few studies have looked at the proportion of time that mental health nurses spend on direct care, indirect care and service activities. These agreed that nurses spent the majority of their time on indirect care, without their patients (52% on average) (Goulter et al., 2015; Hodek et al., 2011; Sharac et al., 2010). Only one study, which used a time and motion (T&M) method to determine how psychiatric nurses used their time (Glantz et al., 2019), was able to show that medically delegated tasks and indirect care without the patient represented the longest time segments in nurses' shifts (161min/day). This study used 11 predetermined task categories guided by the Work Observation Method By Activity Timing (WOMBAT) protocol.

The evaluation of care practices raises many challenges, including that of identifying all the different aspects of care. The originality of the present study was adapting the observation grid to the nurses'

field of practice by using a validated care model (Déry et al., 2017). Thus armed, the study aimed to describe the nature and measure the duration of care activities in a psychiatric unit.

2 | METHOD

2.1 | Study design, setting and participants

We chose a T&M method for this study, which consisted of direct observation of psychiatric nurses in their workplace. This ensured a high level of precision in the working time estimates and enabled a precise survey of nursing activities. We used the Standard Time and Motion Procedures guidelines' list of methodological elements to consider when conducting a T&M study (Zheng et al., 2011). In order to test the prescribed model of care activity, the study was carried out in three different wards of a university hospital in Switzerland: (a) a medical ward (Michel et al., 2021); (b) a surgical ward (Müller et al., 2021); and (c) a 15-bed general psychiatry ward which is more specifically developed here. The ward is designed for patients aged 18–65 years old with psychoses and related disorders; some of the beds are devoted to young adults experiencing their first psychotic episode. To meet their health needs, the psychiatric department employs qualified, registered MHNs exclusively, on a 24-h rotation: two nurses work the day shift (7:00 a.m. to 4:00 p.m.), two work the evening shift (11:30 a.m. to 8:00 p.m.), and one works the night shift (7:30 p.m. to 7:00 a.m.). Observations took place on weekdays (Monday to Friday) over the entire shift, beginning when the nurse arrived and ending when they left.

2.2 | Data collection procedures

An observation grid was created based on various components (literature reviews, activities in electronic care plans and expert focus groups). The Scope of Nursing Practice Model developed by Déry and D'Amour was used to clarify the domains of nursing activities. It includes six main domains incorporating 26 activities: (a) assessment and care planning, (b) patient and family education, (c) communication and coordination of care, (d) staff integration and supervision, (e) optimization of the quality and safety of care, and (f) updating and using knowledge (Déry et al., 2017). However, this model had to be adapted to the specificities of a psychiatric department. To operationalize this model, a committee composed of clinical experts from the study environment and members of the research team met to define observable activities. They identified 42 activities and determined thirteen domains in which to classify them in the observation grid (Table 1). All the research team members validate the coding grid.

Two external observers—both nurses with experience in psychiatry but not working on the study ward—were commissioned to collect data. They received eight hours of theoretical training on how to conduct the study and code activities, first on paper and then on the study ward, where they were immersed for one day. Reproducibility between the two observers was assessed using a one-hour nurse observation in a real-life situation. Cohen's kappa coefficient was calculated to measure inter-rater reliability for the domains and activities selected, and the coefficient of variation was used to measure agreement between the durations noted. For the Cohen's kappa coefficient, we used the guidelines proposed by Landis and Koch (1977) and a minimum cut-off of.60 was necessary to indicate an acceptable degree of agreement. The coefficient of variation had to be under 5% to indicate a very good level of agreement, but a coefficient of up to 10% was tolerated. The Cohen's kappa coefficients for domains and activities were both.77. The coefficients of variation for the domains observed ranged from 0% to 6%. The data collected by the observers were considered similar.

2.3 | Sample and sampling

All the ward's MHNs were invited to volunteer to participate in the study, and a convenience sample of participants was used to meet the following inclusion criteria: holder of a nursing degree (Bachelor's degree or equivalent), working at least 0.5 of a full-time equivalent, and in the current position for at least six months at the time of the study. Temporary staff, interns, specialized clinical nurses and head nurses were excluded.

Observation began when the nurse arrived at their workstation and ended when they left. These individuals were followed wherever they went, shadowed by the observer without intervention or interaction, and each activity was timed in real-time using a Huawei MediaPad T1 7.0 tablet computer running the Android 4.4.2. operating system.

2.4 | Statistical analysis

Data recorded on the tablet computer were imported into an Excel database and examined using STATA 15.0 and R statistics software. The study variables were the 42 activities and their 13 associated domains, start and end times (day, month, year and hour: minute: second) and duration (in min), presence or absence of the patient or family, nurses' socio-demographic data (age, job position, qualification, years of experience and seniority in the position) and the type of shift. Analyses were based on descriptive statistics. Mean total time per day of observation was calculated for each domain and activity in hours, minutes and seconds. Results were then stratified by shift type in order to obtain the sum of times clocked per domain and per activity for each work shift observed.

3 | RESULTS

The participant sample (n = 8) included five women (62.5%) and three men (37.5%). One nurse refused to participate in the

TABLE 1 Observation coding grid of 13 nursing domains and their 42 observable activities

1. (Domain i): Patient assessment	Admission interview	7. (Domain ii): therapeutic education and families	Therapeutic education/coaching
	Consultation of the patient's file	8. (Domain iii): Communication and coordination of care	Interviews/communication
	Clinical physical examination		Interviews/telephone communication
	Clinical mental examination		Medical visit
	Patient rounds		Coordination conference
2. (Domain i): Care planning	Use of hospital software planning tool		Team conference
	Discharge planning		Nursing handovers
	Planning maintenance	9. (Domain iv): Integration and supervision of personnel	Supervision/supervision of a colleague
3. (Domain i): Technical procedures and delegated medical tasks	Technical care	10. (Domain v): Optimization of the quality and safety of care	Hygiene measures
	Emergency care		Reporting adverse events to the person in charge
	Mortuary care		Maintaining ward safety
	Constraint measures		Recording patient satisfaction/ complaints
4. (Domain i): Application of drug treatments	Preparation of drugs	11. (Domain vi): Updating and using knowledge	Professional training
	Administration of medication		Scientific consultation or documentation
5. (Domain i): Activities of daily living	Assisting in toilet hygiene		Supervision received
	Assisting personal hygiene	12. Miscellaneous/non-health care	Administrative tasks
	Assisting nutrition/ hydration–self-feeding		Patient and hospitality environment management
	Assisting functional mobility		Logistical tasks
6. (Domain i): Relational care and non-medication interventions	Psychological/relational support		Patient transport
	Psychotherapeutic interventions		Travel Time
	Sensory interventions		Waiting
	Environmental or occupational interventions, or structured activities		Other activities
	Opposition/aggression management	13. Personal time	Personal activities
			Planned meal breaks

Note: Domain numbers in italics refer to the six domains described by D'Amour and Déry, expanded to our 13 new domains and then broken down into activities to operationalize our model.

study, giving no specific reason. Six of the eight participants were between 20 and 40 years old (75%), and two were over 40 years old (25%). Five (62.5%) had fewer than 5 years of experience. Fifty-six days were required to gather a total of 500 h of observations, covering 22 day shifts, 22 evening shifts and 12 night shifts.

3.1 | Caregiving activities

Most of the nurses' time was actually spent on activities performed in the patient's absence. The distributions of the average time spent on direct and indirect care were the same on day and night shifts, with three quarters of the time spent on indirect care and one quarter on direct care. Periods when nurses spent 100% of their time attending to patients were limited.

3.2 | Domains of activity

Table 2 presents the number of shifts on which activities from the 13 domains were observed and their average duration in min for each particular kind of shift. The analysis focuses on the day and evening shifts, with the night shifts showing, unsurprisingly, significant amounts of time spent not providing care (mean 408 min/night shift). The domains to which daytime nurses allocated the most time on a daily basis were communication and coordination of care (mean 220 min/shift), miscellaneous/non-healthcare activities (180 min/shift), care planning (34 min/shift), patient assessment (22 min/shift) and personal time (34 min/shift). The significant amount of time allocated to the latter activity corresponded mainly to planned meal breaks and will not be examined here. Activities in the other domains were not carried out daily and, when they occurred, they lasted less than 30 min/day on average.

TABLE 2 Average time allocated to different domains in the scope of nursing practice according to profession and shifts in the Department of Psychiatry

Domains of care activity	Day Shift 7:00 a.m.–4:00 p.m. (n = 21) Occurrences in shifts + Average time in min (95% CI)	Evening Shift 11:30am–8:00pm (n = 22) Occurrences in shifts + Average time in min (95% CI)	Night Shift 7:30–7:00 p.m. (n =12) Occurrences in shifts + Average time in min (95% CI)
Miscellaneous/ Non-health care	**21** **184.61 (159.98–214.12)**	**22** **150.06 (136.34–163.75)**	**12** **408.82 (380.61–437.47)**
Communication and coordination	**21** **181.49 (149.76–210.26)**	**22** **229.29 (212.06–246.36)**	**12** **82.22 (55.58–108.68)**
Care planning	**21** **34.94 (28.55–41.32)**	**22** **34.33 (25.8–42.7)**	12 43.14 (30.73–57.28)
Personal Time	21 58.48 (47.07–69.24)	22 9.86 (3.57–15.6)	11 13.46 (5.54–20.87)
Medication	21 19.11 (14.27–23.91)	22 16.49 (13.19–19.78)	**12** **76.41 (43.94–109.43)**
Technical procedures and delegated medical tasks	20 11.53 (4.1–18.95)	19 9.19 (5.58–12.71)	12 8.89 (3.76–13.82)
Activities of daily living	7 3.29 (−0.19–6.71)	6 1.33 (0.83–1.83)	4 1.14 (−0.10–2.36)
Patient assessment	21 19.11 (14.27–23.91)	22 22.91 (17.91–27.91)	12 39.23 (19.15–57.01)
Updating and using knowledge	1 0.95	3 24.64 (−74.09–123.36)	2 6.06 (−66.26–78.38)
Relational care	18 10.17 (5.38–14.88)	21 18.23 (9.04–27.42)	12 16.22 (5.83–26.62)
Patient and family education	6 5.23 (−1.84–12.15)	8 1.25 (0.68–1.8)	8 1.33 (0.64–1.87)
Staff integration and supervision	9 3.08 (0.37–5.79)	11 3.79 (1.40–6.18)	4 6.6 (−1.59–14.68)
Optimization of the quality and safety of care	20 1.14 (0.71–1.57)	18 1.59 (0.15–3)	11 6.93 (1.69–11.80)

3.2.1 | ● Communication and coordination of care

This domain contained six activities, including communication, medical interviews with patients, meetings and nursing handovers. At approximately 180 min of an 8.5-h day shift and a little less than 240 min of an evening shift, this was the domain that used up the most time during an MHN's working day. In it, nurses displayed their interdisciplinary and intradisciplinary roles through the activities of attending patients' medical interviews and other meetings, as well as communication with the care team (reporting). However, little time was allocated to communication with patients themselves (~21 min) or to discharge planning (2 min).

The longest times in this domain were allocated to the activities of nursing reports and communication. Communication consisted of exchanges of information enabling management of the ADL and the coordination of care; it did not include purely relational discussions, which were counted in another domain (~10 min on average). Accompanying patients to medical consultations occurred in 18 day shifts and 19 evening shifts, suggesting that medical visits occurred several times a day, usually lasting from 30–50 min.

Nursing reports took up 30–50 min, depending on the shift. Coordination meetings were mainly observed on day shifts (13 observations) and lasted about 30 min. A few team seminars also took place, lasting 25–40 min.

3.2.2 | ● Care planning

We noted that this domain's activities were allocated time unevenly. Care planning was mainly done through the psychiatric department's computerized system and lasted 30–45 min on average, across all shifts. Discharge planning was observed in 6 of the 56 shifts but

lasted no more than 10 min. No planning interview activities were observed at all.

3.2.3 | ● Miscellaneous/non-health care

This domain included all actions that are not directly related to care, such as administrative and logistical tasks and time spent waiting (e.g. for doctors) or travelling from one building to another. A significant part of nurses' time was dedicated to various non-healthcare tasks, with mean durations ranging from 150 min to 180 min for day and evening shifts. Travel time averaged 25–35 min, and administrative tasks took 20–40 min. The activity which took up the most time in our study was waiting, and this was true on every day of observation. There was approximately 90 min of waiting during both day and evening shifts.

3.2.4 | ● Patient assessment

Little time was devoted to this domain. Nurses regularly carried out evaluations but the time spend doing them remained brief (~20 min/shift). The present study showed an average time devoted to relational care of 10–20 min/shift. The activities that took up the most time in this domain were patient rounds, with an average duration of 18–35 min/shift, depending on the shift. Physical assessments were observed on 20 shifts, lasting 5 min on average. Mental assessments were observed on 7 shifts and averaged 3 min.

The other domains of the scope of nursing practice were rather marginal and were not observed daily: relational care and interventions not involving medication (14.2 min/shift), helping with the ADLs (2.31 min/shift), administering drug treatments (17.8 min/shift), and technical procedures and delegated medical tasks (10.36 min/shift).

4 | DISCUSSION

This T&M study's objective was to describe the time devoted to different nursing activities on a university hospital psychiatric ward in Switzerland. In the absence of any standard for determining what constitutes an effective, optimal scope of nursing practice in psychiatric settings, these findings should be interpreted with caution. More thought should be given to the overall distribution of the time allocated to different activities rather than to the actual time allocated to each individual activity type. We attempt to understand these findings by following several avenues of discussion.

4.1 | Comparison with international literature

Our results express the averages of the time allocated to the various activities over all the observations rather than an hour-by-hour description of a workstation. Although the previous studies used different research methodologies and theoretical frameworks, they established some general trends which hold true in our study as well. To begin, the results showed that nurses' time was almost fully utilized, but it is noteworthy that the actual time spent with patients was relatively low, representing only one quarter of their total working hours. This result was below the values reported in previous research, which estimated that direct care took up 25%–43% of nurses' time (Higgins et al., 1999; Sharac et al., 2010; Hodek et al., 2011). MHNs allocated lots of time to the domain of assessment and care planning, but although this domain's component activities were practised every day, significant differences between them were noted. The time allocated to patient assessment (mean 20 min/day shift) was consistent with the literature (Salerno et al., 2012; Antinaho et al., 2015; McAllister and McCrae, 2017). Patient rounds were the most time-consuming assessment activity, with an average duration of 23,6 min per shift. Conducted only seven times, with a mean duration of less than 3 min, the clinical mental examination activity was allocated the least amount of time in this domain. The time devoted to the ADL and giving patients their medication was lower than in a previous study (Seed et al., 2010). The mean time of 14,87 min per shift devoted to relational care was consistent with some studies (Whittington and McLaughlin, 2000; Goulter et al., 2015) but significantly lower than another (Torkelson & Seed, 2011). MHNs rarely devoted time to the activity of patient and family education, and, on average, this lasted no more than 5 min. This finding was consistent with the only two studies to have looked at this activity (Goulter et al., 2015; Seed et al., 2010).

The domain of communication and the coordination of care was also one of the most important ones for MHNs. The activities that make it up were carried out on almost all the shifts observed, for an average total duration of almost 60 min. Average times devoted to this domain were consistent with the literature (Whittington & McLaughlin, 2000). Among its component activities, intradisciplinary and interdisciplinary communication took up the most time, followed by nursing handovers and medical visits with patients attended by MHNs. The domain of staff integration and supervision was one of those allocated little time. This may be explained by the fact that the observations took place during a nursing school vacation period, and there was an absence of students to supervise. MHNs devoted only rare, short periods to the domain of the optimization of the quality and safety of care. However, this was probably underestimated due to the methodological limitations and categorizations used. Indeed, a large proportion of the activities carried out in relation to quality and safety were integrated into the practice of other activities and were therefore included in the time devoted to other domains. MHNs allocated only rare, short periods to the last domain of updating and using knowledge, which was consistent with the studies that have examined this previously (Hodek et al., 2011; Goulter et al., 2015). Finally, the miscellaneous/non-healthcare domain of activities was among those to which MHNs devoted the most time, with means of 180 min and 150 min on day and evening shifts, respectively. Among the activities included in this category,

simply waiting took up the most time, followed by administrative tasks, with significantly longer durations than observed in previous studies (Antinaho et al., 2015; Whittington & McLaughlin, 2000).

4.2 | What the study adds to existing research

There is a great deal of variability among studies that have analysed the distribution of psychiatric nurses' activities (Hodek et al., 2011; Antinaho et al., 2015, 2017; Goulter et al., 2015; McAllister & McCrae, 2017). Only one study used a time and motion method (Glantz et al, 2019). The originality of our study lies in the adaptation of a theoretical nursing model that describes specific nursing tasks and allows comparisons based on reliable data.

4.3 | Organization of care and workforce planning

The organization of care is recognized as a factor influencing the optimal use of the full potential scope of nursing practice (Dubois et al., 2013; Fealy et al., 2015). The distribution of staff on our study ward highlighted less nursing presence in the mornings and evenings, when just two nurses were on duty. The permanent presence of at least one nurse is required to ensure the safety of care on the ward. This leaves just one nurse available to carry out clinical activities, like patient interviews, or activities related to ward organization. This two-nurse ward configuration has limitations, particularly in the evenings when semi-outpatients, who are out during the day, return to the hospital and time is needed for listening to them and making clinical evaluations. The greatest number of patients are present in the mornings and evenings. The day and evening shifts overlap between 11:30 p.m. and 4:00 p.m., bringing the number of nurses to four. Yet, there are fewer patients present at this time. Indeed, some of them will be in therapeutic discharge—an indispensable step in preparing them for hospital discharge. The need for fewer clinical activities can lead to sub-optimal use of the time spent with patients and to spending time on administrative tasks instead. The organization of care observed was supported by neither theoretical nursing models nor a common therapeutic model. MHNs operate by referral (they are allocated particular patients for the shift). Given the rotation in the nursing team over the entire three-shift day and patients' short lengths of stay, the continuity of care expected of this system is not always efficient.

4.4 | Increasingly specialized clinical expertise

In psychiatry, the increasing development of outpatient services has raised the threshold for which inpatient treatment is indicated, such that hospitals are receiving patients with increasingly complex care needs. A recent study of inpatients in this study's hospital indicated that one third of hospital psychiatric beds were occupied by patients who are hospitalized for long periods or repeatedly (Gloay et al., 2019). These patients characteristically present with multiple problems that require increasingly sophisticated psychopathological knowledge and clinical expertise. In addition, half of the patients admitted to this study's participating ward were admitted against their will and presented with difficulties in accepting care because of the denial mechanisms related to their disease. These reactions are also well-known and common after a first episode of psychosis (Baumann et al., 2013). The creation of a therapeutic alliance capable of enabling a clinical assessment is, therefore, a necessary treatment step, and this requires strong relational skills. The staff in the ward observed were relatively young, with five of the eight participating nurses having fewer than five years of professional experience. For these five younger MHNs, given the increasingly demanding context of care, the transferability of the clinical assessment skills they had acquired during their basic nursing training is an important issue. Teaching on psychiatry remains marginal compared to other specialties.

4.5 | Switzerland's legal and health context

Switzerland's legal and health insurance frameworks do not recognize the nurse's role as being an autonomous one, and they consider the nursing profession to be ancillary to the medical profession (in March 2018, the Federal Council decided to reject a public referendum initiative for stronger nursing care). This limits nurses' ability to carry out their role autonomously and contributes to maintaining the classic biomedical model that can negatively affect nursing activities. The delegation of medical tasks centred on a disease sometimes takes priority over a more holistic approach to nursing (Dallaire, 2008). In terms of legislation, health policies led to a drastic 44% reduction in psychiatric hospital beds between 1992 and 2011, whereas psychiatric hospitalizations increased by 151%, with a median length of stay of 18 days (Gloay et al., 2019). Relative staffing levels have not changed, however, requiring nurses to work in increasingly demanding contexts of care that keep them under constant pressure. Delegated medical tasks are often given priority over nursing tasks when organizational constraints of time and staff resources are imposed (Dallaire, 2008). The almost systematic participation of nurses in medical interviews, even though this is not necessary at every stage of hospitalization, may be a manifestation of this. It may also explain the time nurses spend "waiting" for doctors to carry out activities that they are entirely capable of carrying out autonomously. For example, nurses rarely take the initiative to meet families without the doctor present, even though this is an integral part of their role. This is paradoxical in view of the nursing profession's continuing development. Moreover, these constraints lead to a task-oriented organization of care, to the detriment of the holistic vision of care that characterizes nursing. Prioritize the task can be accentuated if what is expected of nurses is not clearly defined. Despite these resource issues and problems of healthcare system organization in general, pragmatic action at the ward level can optimize the scope of nursing practice.

5 | RECOMMENDATIONS

5.1 | Clinical

The ward observed in the present study has no support staff, meaning that the nurses have to take on the tasks of housekeeping and hospitality. Hospital managers should question the composition of ward teams; greater diversity of skills seems essential, particularly the presence of support staff. With regard to staff distribution throughout the day, changes ensuring a greater nursing presence at the end of the day should be evaluated; more specific responses are needed for patients' needs and rhythms and for ensuring a better distribution of workloads. Finally, to improve the efficiency of care, it would be useful to clarify how nurses and physicians can collaborate better based on their respective fields of competence (Besner et al., 2006). Fresh thinking is required to reorganize and free up nurses' time so that they can use the full scope of nursing practice. Moreover, determining psychiatric inpatients' specific needs will help to organize the care required to meet them. This study showed that nurses need to refocus their activities around patients to strengthen their essential therapeutic relationships.

5.2 | Training

Levels of nurse education and professional experience also influence the optimal use of the scope of nursing practice (Davies & Fox-Young, 2002). Adopting a clinical assessment model helps to develop professional attitudes and improve the use of nursing practice. Kim (2012) emphasized that theoretical conceptualizations of nursing and its philosophical perspectives had an important influence on nurses' clinical deliberations. Clinical assessment is essential for accurately identifying patient needs and ensuring the quality and safety of care. It is therefore recommended that institutions adopt a model of care and that all their nurses be trained in it, including local management teams. Management teams play crucial roles in introducing and supporting clinical activities. Structuring those clinical activities by using specific tools may prove challenging. Carrying out a rigorous clinical evaluation requires establishing a therapeutic relationship, and that requires good interpersonal skills—all the more so with patients who present difficulties in accepting that they need care. Organizing clinical tutoring or coaching sessions for less experienced nurses should be considered, especially when they start working on a psychiatric ward. Group analysis sessions for reflecting on nursing practices can also help to support nurses' professional development.

5.3 | Research

The present study focused on specific nursing tasks and could be adapted to other specialties and healthcare systems worldwide to validate these results and make them more generalizable. Further research is also needed to deepen our knowledge of the scope of psychiatric nursing practice in the Swiss context. Using a methodology that can measure activities carried out simultaneously, as well as activities carried out in informal spaces, should be considered.

6 | LIMITATIONS

Several limitations must be mentioned. The theoretical nurse model used (Déry et al., 2017) is a generalist model adapted for psychiatry by experts. This adaptation took into account the specificities of the service, and the study was carried out in this unit alone. The results are therefore not generalizable as they stand. In this service, half of the patients are admitted against their will and present difficulties in accepting care, so therapeutic activities often take place in the informal spaces of the service (e.g. at the meal table, at a sink) and by managing their ADLs (Lanquetin & Tchukriel, 2013). These activities can represent up to half of the time (Prescott et al., 1991) spent on unidentified care activities because they are often brief, unscheduled and constitute an "invisible" part of care. Lanquetin and Tchukriel (2013) discussed the informal aspects of care and specified that they were unavoidable elements of psychiatric nursing practice. It is likely that part of the time devoted to clinical assessment—when it is carried out in informal spaces—escaped our T&M methodology because it was not directly observable. Making this therapeutic work visible and measurable is also important from a financial perspective so that it can be considered and its true value recognized. Another limitation was the lack of observations on weekends, when the organization of care is significantly different. Finally, because the scope of MHN practice is not yet clearly defined, it is difficult to assess whether or not it is optimal. This research does, however, shed light on the domains on which nurses spend the least amount of time.

7 | CONCLUSION

MHNs' skills, knowledge and abilities—their scope of practice—and particularly the activities related to their own particular roles, are put under stress by the heavy burdens of their working environment and are subject to multiple constraints, particularly cost and time constraints. Creating favourable conditions for optimizing the use of the full scope of nursing practices requires strong nursing leadership and action at many other levels: at the hospital management and political level, by challenging decision-makers; at the structural level, by participating in new thinking about healthcare organization; and at the clinical level, by developing models of care adapted to different environments. This work must be carried out in concert between the different professions involved in psychiatric care in order to define areas of mutual expertise and methods of collaboration.

8 | RELEVANCE FOR CLINICAL PRACTICE

In order to use the full scope of psychiatric nursing practice, there is a need to clarify what is expected of MHNs at each stage of a patient's treatment, especially if there is high staff turnover due to the demanding context of care and the intense pace of work. There is a need for precise care benchmarks. In addition, clear descriptions of each patient's needs would make it possible to adapt nursing interventions. This is about supporting a holistic approach to care, an approach that values relational care over a task-based approach. It is essential to describe concretely what is expected of nurses, to help them allocate their time effectively and to identify opportunities for improvement.

9 | RELEVANCE OF THIS PAPER

The originality of this study lies in the adaptation of a theoretical nursing model that describes specific nursing tasks. The results show that psychiatric nurses do not perform all the possible functions within their scope of practice, particularly those involving working autonomously. Several factors contributed to this, including the increasing complexity of care, stagnant staffing levels, and a culture of care that remains influenced by the medical model. Current models of care retain the stigma of this past, prioritizing tasks delegated by physicians rather than promoting a holistic approach to care. Although nurses' professional identities are evolving and they are asserting themselves, the necessary paradigm shift in practice is still underway.

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CONFLICT OF INTEREST

The authors have no conflict of interest to declare.

AUTHOR CONTRIBUTIONS

COB-JP studied the design. PL, MLB and TVCP collected the data. MA, PL, MLB, TVCP, JP and COB analysed and interpreted the data. COB involved in study supervision. MA, PL and COB wrote the manuscript.

ETHICAL STATEMENT

The research protocol was approved on 4 May 2018, by the hospital's Research Application Review Board (no. 2018–03). A procedure was in place in case poor care was observed, but fortunately, this did not have to be applied.

DATA AVAILABILITY STATEMENT

Data are available on request from the authors.

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