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Nursing interventions in adult psychiatric outpatient care. Making nursing visible using the Nursing Interventions Classification

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- **Author contributions**

Criteria	Author Initials
Made substantial contributions to conception and design, or acquisition of data, or analysis and interpretation of data;	MA, RK
Involved in drafting the manuscript or revising it critically for important intellectual content;	MA, RK, KJ
Given final approval of the version to be published. Each author should have participated sufficiently in the work to take public responsibility for appropriate portions of the content;	MA, RK, KJ
Agreed to be accountable for all aspects of the work in ensuring that questions related to the accuracy or integrity of any part of the work are appropriately investigated and resolved.	MA, RK, KJ

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The study received State Funding for University Level Health Research in Finland.

Aim: To describe and to clarify the work of nurses in psychiatric outpatient care using a standardized nursing terminology and to describe the potential benefits and challenges in the use of the terminology.

Design: A qualitative study of ethnographically grounded fieldwork in four adult outpatient units located in three major cities in Finland.

Methods: A two-phase ethnographically oriented study, consisting of observations and focus group interviews in four psychiatric outpatient care units (in January-March 2018). During

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this process, the identified nursing interventions were mapped into the Nursing Interventions Classification.

Results: We identified 93 different nursing interventions, of which 85 were found in the existing terminology, covering all seven domains. Categories describing potential benefits and challenges were: giving words to nurses' work and the challenge of overlapping interventions.

Conclusion: Our findings indicate that the Nursing Interventions Classification is a suitable means to describe nursing in the psychiatric outpatient care setting. Our findings support the theory that describing nurses' work using a nursing terminology can make nursing visible and further empower nurses and help them to structure their work. The lack of other professionals, especially physicians, has led to nurses taking over new tasks officially and unofficially and we suggest that the issue needs to be studied further.

Impact: Nurses' role in the psychiatric outpatient care has been described as invisible and difficult to describe. Our findings suggest that a nursing terminology can make nursing visible, not only from the perspective of patient health records but is also a way to conceptualize nurses' work.

Key words: Nursing Interventions, Outpatient Care, Ethnography, Focus Groups, Mental Health, Psychiatric Nursing, Nursing Interventions Classification

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INTRODUCTION

Psychiatric care services have recently gone through a major change in many countries, as the focus has shifted from hospital-based inpatient care towards community and outpatient settings (WHO 2015). In the outpatient setting, care is delivered by interdisciplinary teams, where nurses play an important part, but their role needs further clarification (Simpson 2005). Nurses' central but unclarified role in the interdisciplinary teams has been argued to have narrowed their work to case management for a large number of patients. It has been suggested that nurses often cover for other professionals, which has led to a lack of nursing and a lack of delivery of psychosocial and physical care by nurses. (Simpson 2005, Heslop et al. 2016). One of the ways to describe the role that nurses have is to study the interventions they use in their daily practice.

1. Background

Standardized nursing language (SNL) is a way to describe nursing processes systematically and to clarify nurses' work by making it visible (Flanagan 2018, Rutherford 2008). SNL has been organized into terminologies (SNTs) consisting of three components: nursing diagnosis, nursing interventions and nursing outcomes. Seven SNTs are currently acknowledged by the American Nurses Association. Three of these; the NANDA-I, describing nursing diagnosis, the Nursing Interventions Classification (NIC) and the Nursing Outcomes Classification (NOC) can be interlinked together, forming an NNN-taxonomy, which is currently the most widely used and studied nursing terminology (Tastan 2014).

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Recently the demand to use and study SNTs has become more central, with the emergence of the use of electronic patient records (EPR). EPR makes it possible to collect and evaluate a large amount of data, so called big data, but nursing needs systematic definitions in order to do this (Tastan et al. 2014, Flanagan 2018). When collected in a systematic way across different settings and linked to patient data, SNTs have the possibility to create linkages between nursing interventions and patient outcomes and contribute to the understanding of the role of nursing in patient care (Brennan-Bakken 2015). Furthermore, SNTs can be used for nursing education and managerial purposes. (Tastan 2014).

Studies of the use of SNTs in psychiatric inpatient care has been increasing in recent years (Frauenfelder et al. 2013, 2018, Åling et al. 2018), but only a few studies have used the NIC to describe nursing interventions in psychiatric outpatient contexts (Wallace et al. 2005, Thomé et al., 2013, Boomsma et al. 1999). Thomé et al. (2013) used patient health records to identify nursing diagnoses and nursing interventions in community outpatient care in Brazil. They identified 23 nursing interventions, of which the most common were: Self-care Assistance, Socialization Enhancement, Exercise Promotion, Behavior Modification: social skills and Nutrition Management. Similarly, Boomsma et al. (1999) studied nursing records in two different types of psychiatric care settings in the Netherlands. They identified 52 nursing interventions in the long-term care and 31 nursing interventions in the acute care setting. In both settings, the emphasis was on behavioral interventions as well as on medication management. Wallace et al. (2005) used interviews and the critical incidents technique when studying the work of nurses in community link services. They identified 93 nursing interventions from the NIC, of which Case Management and Complex Relationship Building were the most common ones. They concluded that the NIC was descriptive of direct patient care, but that it did not cover the indirect interventions needed for interdisciplinary

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teamwork and for community support and which formed a large part of nurses' work. (Wallace et al. 2005.) The significant role of indirect patient interventions is similar to that observed in studies describing nurses' work roles in psychiatric outpatient care. Studies from different continents have all emphasized the large amount of time used for indirect care or administrative work in this setting (e.g. Heslop et al. 2016, McCardle et al .2007).

Much of the research has used patient documentation as data. However, as nurses do not document all tasks and activities, the use of patient documentation might lead to a too narrow description of nursing interventions (Boomsma et al. 1999). To describe nursing interventions in a psychiatric outpatient care setting, we designed an ethnographically oriented study, where we used the NIC 6th edition (Bulechek et al. 2013) as a terminology through which nursing interventions were organized.

We used the NIC (Bulechek et al., 2013) description of nursing intervention, which covers both direct and indirect interventions and describes nursing intervention as: "any treatment, based on clinical judgment and knowledge that a nurse performs to enhance patient/client outcomes".

2. THE STUDY

3.1 Aim/s

To describe and to clarify nurses' work in psychiatric outpatient care by using the NIC as a framework and to describe potential benefits and challenges in the use of the taxonomy. We chose the NIC for this study because out of the existing terminologies it can best be linked to nursing diagnoses (NANDA-I) and nursing outcomes (NOC) and because it has been most

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widely studied and used (Tastan 2014, Bulechek 2013). The NIC 2013 consists of 544 nursing interventions, covering all clinical areas of nursing. The interventions are classified under seven domains and 33 classes. An intervention is defined by its aim and consists of several actions, which can be modified according to patients' needs. (Bulechek et al. 2013).

3.2 Design

We designed an ethnographically oriented study of work (Szymanski and Whylen 2011), with two phases: first, a fieldwork period consisting of observations and unstructured interviews and then focus group interviews where the results from the first phase were further developed. Ethnographically oriented studies of work are grounded in ethnomethodology, describing everyday phenomena, in this case describing what people do when they are working, emphasizing the actors' (in our case the nurses') point of view. (Szymanski and Whylen 2011.)

3.3 Setting and participants

The four units are part of a larger university hospital system in an urban area in Finland. The amount of outpatient care in specialized health care psychiatric services has increased dramatically in Finland during the past 12 years, when the number of outpatient visits has increased from 1 385 619 in 2006 – 2 225 000 in 2017 (THL 2018). Patients with minor mental health issues, such as minor depression or mild anxiety problems, are primarily taken care of in general health care centers. The patients in the research units could be considered as suffering from more difficult mental health disorders. The four units were all specialized: one in the treatment of (early) psychosis, one in mood disorders and one in a combination of substance abuse and mental health disorders. One unit was an acute unit where patients' care

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needs were assessed and patients were referred to treatment in the more specialized units in the organization, or to receive further treatment in primary health care, occupational health care or private psychotherapy. All units worked mainly on an appointment basis, with some exceptions such as acute consultations, which were offered by three units, either by telephone and/or by visiting patients in hospital wards, at home or in the patients' natural living environment. All units had interdisciplinary teams, consisting of nurses, physicians, psychologists, social workers and occupational therapists. Registered nurses were the largest professional group in all four units.

Units for the study were chosen with the help of nurse directors, on the basis that they would cover as many different patient groups as possible. The primary researcher made the first contact with the study units' nurses during spring 2017, when she visited nurses' staff meetings in all units and described the purpose and background of the study. The primary interest and willingness to participate in the study was asked directly from nurses in these meetings and the voluntary nature of participation was emphasized. In addition to information given in staff meetings, all units were informed about the study by an email sent one month and again one week before the beginning of the fieldwork period.

3.4 Data collection

3.4.1 Fieldwork

The primary data collection method consisted of a fieldwork period in the four units during January - March 2018. The primary researcher, with a background in anthropology and several years of working experience as a nurse in a psychiatric outpatient care, conducted the data collection. Four full working days, approximately 30 hours, were spent in each unit. The

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method was piloted during one day in the first unit in December 2017. In each unit, the primary researcher followed one nurse during one to two working days, taking notes in patient meetings and the time in between, during which nurses often started to explain what they were doing. Additionally, unstructured interviews were used and these were sometimes spontaneous, when for example sitting in a car on the way to meet a patient together with a nurse working in a mobile team. Unstructured interviews were also used in cases where nurses or patients preferred to hold the meeting without the presence of the researcher. In these cases, the nurse would briefly describe what he/she had done after the meeting with the patient. Table 1 describes the different types of observation situations included in the study.

Interventions identified during the observations were mapped into NIC interventions by the primary researcher, using an analysis tree. These findings were validated and further developed in four focus group interviews. An example of the analyses table can be found in Table 2.

3.4.2 Focus groups

The focus groups convened after the fieldwork period in March – April 2018. A total of 17 nurses participated in the four focus groups, which were held during working time at the same units as the fieldwork. Focus groups were moderated the primary researcher. Nurses from one unit formed one focus group. The nurses knew each other and the primary researcher from the earlier fieldwork period. The primary researcher explained about confidentiality and the process of the focus group at the beginning of each session. The same nurses took part in the field work and in the focus groups, with the exception of one unit, where the researcher only worked with two nurses during the field work period. In this unit

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two more nurses were invited to join the focus group. One nurse canceled the participation, due to work-related issues.

At the beginning of each focus group meeting, nurses were given the analyses table from the fieldwork in their unit (an example in Table 2). The table was then discussed with the help of four questions: 1. Do the interventions describe your work? 2. Do you have any corrections or comments to the analyses tree? 3. Which interventions do you think are missing? 4. What are the core interventions?

The interview method and questions as well as the intervention translations were piloted in two focus groups with nurses in other outpatient units in the same organization. This led to some changes in the translations of the intervention terminology, as well as adding the NIC domains and classes to the analyses table, to make the interventions more accessible. The focus group meetings lasted from 54 to 96 minutes. They were audio recorded and transcribed into 56 pages of text by the primary researcher. The transcription was checked against audio for accuracy.

3.4 Ethical considerations

The university hospital's ethical approval was given for the research project and research permission was applied for and given by the hospital district. National legislation as well as national guidelines and the principles of the WMA Declaration of Helsinki were followed (WMA, 2013). A willingness to take part in the study was asked for in writing as well as orally from staff members and from patients present at the observations and/or interviews. The participants were informed about the voluntary nature of participation in the study, as

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well as about their right to leave the study at any time. The primary researcher came to meet each patient in the waiting room, before the beginning of the care meeting. This was done to give the patient enough time to think through their decision. The patients to whom nurses would phone during the observation were also informed by the nurse about the researcher's presence and were asked for an oral approval for the observation and given the possibility to refuse this. No notes were made concerning patient characteristics.

3.6 Data analysis

Data analysis took place during and after the fieldwork. During the fieldwork period, the primary researcher made notes about potential interventions in the field notebook. These observations were organized by mapping the interventions in the NIC 2013, using a data analysis table as described in Table 3. A textual example of the mapping can be found in the Appendix 1. This was done directly after each observation and further developed by returning to the field notes several times before the focus group interviews.

If observation could be mapped into two NIC interventions, it was placed under both and discussed with nurses in the second phase of data analysis. If an intervention did not correspond to any of the existing nursing intervention in the NIC, we suggested a new intervention. These were differentiated from the existing ones by using a different background color and font in the analysis tables used in the focus group interviews. The tables formed the primary findings, which were discussed in focus group interviews with nurses from each unit.

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To identify the possibilities and challenges in using the terminology as a means of describing nursing in this care setting, we analyzed the focus group interviews using thematic analysis, following the process described by Braun & Clarke (2006). In this process, the whole transcribed text was first read several times. After this we identified and coded text parts describing possibilities and challenges. These were summarized into themes, which were organized into categories and sub-categories. The sub-categories were organized and reorganized. We returned to the original text several times during this process. (Braun & Clarke 2006.) We used the qualitative data analysis software Nvivo12 pro in the process. The primary researcher conducted this first, after which the second author confirmed and commented on the findings. Interviews were conducted in Finnish and the authors made the translations of the original quotations

3.5 Rigour

The capability to reflect the researcher's own views and expectations as well as the effect which the researcher has on the situation is an obvious component of ethnographic methodology (Borbasi et al. 2005). The fact that the primary researcher had been working in a similar setting helped her to understand many of the institutional changes which were taking place in the units and thus affecting the nurses' work. Nurses also stated that this made them feel more at ease during the fieldwork period and focus group interviews. This phenomenon has been recognized in participant observation studies conducted by nurses and Borbasi et al. (2005) named it as "'fitting' in".

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The primary analysis was further developed and discussed in the focus groups. The reflections during the analysis process are an essential part of ethnographically oriented workplace studies (Szymanski & Whalen, 2011) and in this case emphasize the nurses' active role as study participants and experts in their own work, rather than merely as study objects. All focus groups suggested changes, new interventions and some changes to the analyses, which implies that nurses felt confident enough to share their own views.

3. FINDINGS

4.1 Characteristics of the nurses participating in this study

Of the 17 nurses taking part in the focus group interviews, 13 were female and four were male. Their age varied from 27-55 years. Average work experience was 15 years, 6.5 in the current unit. Of the nurses, 15 had post-graduation training in psychotherapeutic care. Most common was training in cognitive therapy (N=8), followed by dialectical behavioral therapy, interpersonal therapy and schema therapy (all N=1). Three nurses were licensed psychotherapists. This resembles the training level in this care setting in Finland in general.

4.2 Identified interventions

In all, 61 NIC interventions were identified during the fieldwork period and 32 were added during the active period of the focus groups. Thus a total of 93 different nursing interventions were identified, of which almost half (45%) were assigned to the NIC domain Behavioral, followed by the Health System domain covering 25% of the interventions. The class Coping Assistance was the most common, covering 20 % of all identified interventions.

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The findings of the focus groups suggested adding the following interventions: Skills Group Training, Diagnostic Data Collection, Home Visits, Acupuncture, Care Need Assessment, Support Network Mobilization, Drug Screening, Care Plan and also Collaboration Enhancement, which is already included in the seventh edition of the NIC (Butcher et al. 2018). Interventions that needed modification based on our findings were: Anticipatory Guidance, Normalization Enhancement and Anxiety reduction. These were used by nurses but the context or content was different from that described in the NIC 2013.

In the thematic data analysis of the focus group interviews, we identified two main categories describing possibilities and problems in using the terminology. The first category was "giving words to nurses' work", under which we placed four sub-categories: feeling empowered, making work visible to others, structuring one's work and expanding work role. The second category was "challenges of overlapping interventions".

4.3 Giving words to nurses' work

We identified four sub-categories under this heading, the first being a feeling of empowerment. These were nurses' positive reactions as the result of seeing their work analyzed and described, making them feel good or proud. These feelings were connected to the large number of interventions identified or to a particular intervention:

> RN 41: "*I notice thinking in a healthy selfish way that we have so much here, what we do* […] *we have actually produced all this*".

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The second sub-category was making work visible to others. The common theme in this category was seeing the terminology as a way to make nursing visible for other members of the interdisciplinary team. This was often in connection to a sense that other professionals did not understand the scope of nursing interventions, how autonomous the role of nurses was and how much responsibility their work included:

> RN 11: *"That there is so much we do and that it becomes visible to others. And that they see it as well, which is good*"

The third sub-category was systematic use of interventions. Nurses stated that the systematic analysis of their work made it possible for them to identify and outline their own work and to describe how they could analyze and evaluate their work by using the terminology in the future:

> RN 33: *"It's really interesting to go through that list and to notice everything you actually do. And then maybe already let your thoughts go to what I ought to be doing more and what are those* [interventions] *I emphasize in my work"*

The fourth sub-category describes nurses' expanded work role, which the terminology made visible. Nurses were the most permanent staff members in most units and ended up supporting and at times even doing the work originally done by other members of the interdisciplinary team. This happened in two ways: first, there was official task reallocation, such as Diagnostic Data Collection and Care Needs Assessment. Secondly, this also

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happened unofficially, which raised concern and criticism among nurses. In the dialogue below, nurses discussed whether the intervention Laboratory Data Interpretation is part of their work:

RN 23: *Sometimes. It's a physician's task.*

RN 21: *And I even give* [laboratory] *results*

RN 23: *That's wrong.*

RN 21: *Yes it is, but yesterday I did.*

RN 23: *So did I, but it is still not our task to interpret the results.*

Furthermore, the nurses voiced their concern that in cases when task reallocation occurred unofficially, it was without compensation:

RN 11: [T]*hat if the physician is away, the nurse meets new patients alone and takes over the whole responsibility, which didn't happen earlier.*

RN 15: *It should be indicated here.*

RN 11: *That we do this without getting anything.*

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4.4 The challenge of overlapping interventions

We identified one category describing problems in using the terminology, the challenge of overlapping interventions. This came up in the second round of discussion, when nurses were asked to make corrections to the analyses tree. Nurses made similar comments in all focus groups. As one nurse put it:

> RN35: "[F]*for example this Smoking Cessation Assistance* [quotes an observation] *'think now, that you could afford a nice holiday if you could quit'. It is also Socialization Enhancement. And for the patient it is also supporting her to set her own goals*"

In another case, where nurses were discussing an observation, which was mapped into the NIC intervention Surveillance, they described that it covered both Surveillance and Complex Relationship Building.

> RN 43: "*And on the other hand it is Surveillance, that we reach the patient and know how they are doing, but perhaps I also tend to think that most of all, why I'm doing all the work in trying to reach the patient is the Complex Relationship Building. And that the patient would come in the future and not feel like I didn't come and that no one cared."*

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5. DISCUSSION

The need for outpatient care in psychiatric services is increasing. The findings of this study provide unique insight into nurses' work roles as well as into the possibilities of using a systematic nursing terminology to describe nursing interventions in this care setting. Our findings suggest that adult psychiatric outpatient nursing could be systematically described by using the NIC. Moreover, the description made task reallocation visible, which the nurses found to be important.

We identified a similar number of different interventions to that reported by Wallace et al. 2005. This is four times more than in the study by Thomé et al (2013), who identified only 23 different categories and significantly more than in the study by Boomsma et al. (1999). The differences might be explained by the wide variety of different types of units in our study, as well as by the various different data collection types, including both observations and focus group interviews. Thomé et al. (2013) and Boomsma et al. (1999) retrieved data from patient documentation. A further examination of this difference would be interesting and needed, with the increasing possibilities to use big data from EPRs in nursing research (Brennan-Bakken 2015). Ethnographically oriented studies can provide important insights from the clinical level and contribute to the understanding of how well documentation represents the practice level.

Previous research has reported a lack of use of family interventions by nurses in this care setting (McCardle et al. 2007, Wallace 2005). Our results differ from these. A total of 13 interventions in the domain Family were identified. The number of family interventions was higher in the two units where a nurse with family therapy training worked, but family

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interventions were identified in all units. Another somewhat contradictory finding was that nurses in three units (all except the acute unit) both asked patients about their physical health, measured blood pressure and BMI and also emphasized the importance of physical health checks for their patients. Besides checking blood sample results, nurses would book times and guide patients to take laboratory tests and used interventions such as Exercise Promotion and Nutritional Counseling. Earlier research has found that psychiatric nurses do not pay sufficient attention to the physical health care needs of their patients (Heslop et al. 2016, Bressington 2017).

The large amount of time needed for indirect nursing interventions in this care setting has been addressed in earlier research (McCardle 2007, Simpson 2005, Wallace 2005). Although we did not include a time use audit, the amount of indirect nursing interventions was evident in our findings as well and the fact that nurses named interventions in the domain Health System as core interventions suggests that they were aware of the important role that these interventions play in their work. However, in contrast to Wallace et al. (2005), we found that the NIC covered these interventions rather well.

Our findings suggest that eight interventions would need to be added. Frauenfelder et al. (2013, 2018) suggested adding two of the proposed eight interventions, namely: Acupuncture and Care Plan, in their earlier studies of nursing interventions in inpatient psychiatric care. Two interventions would need revising. Nurses used the intervention Normalization Enhancement, which is currently placed under the class Childrearing Care, as a way to reduce stigma around mental disorders and to help patients conceptualize their behavior as a health-related issue. This is important, since self-stigmatization is common among psychiatric

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patients and is related to negative consequences (Corrigan & Rao 2012). Another intervention which nurses used in a different way was Anxiety Reduction. Nurses recognized that they used Anxiety Reduction as described in the NIC in patient meetings, to make patients more at ease. However, there was also another type of Anxiety Reduction, which consisted of teaching relaxation techniques and the use of exposure therapy. These actions are partly in contradiction to those described in the NIC. One option could be adding an Anxiety Reduction: Long term–intervention in the class Coping Assistance, differencing it from short term Anxiety Reduction. A similar division was made in the newest edition of the NIC (Butcher et al. 2018) between the interventions Pain Management Short Term and Pain Management Chronic.

The problem of overlapping interventions has been mentioned in earlier research (Wallace et al. 2005). This was also evident in our findings and will need to be studied and described in more detail. The complexity of nursing work made it difficult to map some of the observations to a specific intervention during the fieldwork period. For example, the intervention Active Listening and Presence are an evident part of Complex Relationship Building. On the other hand, Presence was identified as an individual intervention in the interdisciplinary care meetings, where nurses, who were often most familiar with the patient, supported the patient to actively take part in the care planning process.

One way of addressing the problem of overlapping interventions would be to study the correlations between nursing diagnoses, interventions and outcomes and to describe the entire nursing process. In our study, nurses were all new to the NIC and even if they were positive about the possibilities of using the terminology in describing their work, more

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systematization and training would be needed before its implementation in clinical practice. The importance of adequate training to support the systematic use of the descriptive terminology has been emphasized in earlier studies (von Krogh et al. 2008, Muller- Staub et al. 2007). The number of interventions has increased in every edition of the NIC (Butcher et al. 2018). This can partly be explained by the increase of interest in the taxonomy as well as by new roles which nurses have. Even so, perhaps it would be time to take a critical look and to ask whether there is a need to reorganize some of the interventions.

Nurses ended up naming 20 interventions as core interventions, most of them belonging to the class Coping Support or to the domain Health System. Since nurses in three groups stated that they would include all the listed interventions as core interventions, we suggest that this aspect needs to be studied in more detail. Understanding the core interventions is essential in understanding nursing in a specific care setting (De Vlieger et al. 2005).

SNTs have been said to be a way of making nursing more visible (Rutherford 2008, Bulecheck et al. 2013). Our findings support this conclusion from the nurses' perspective in two ways. First, describing the work of nurses using SNT was a way to make nursing visible both for the nurses themselves and for the interdisciplinary team. This seems vital, since earlier studies have found the role of nursing in psychiatric outpatient services to be invisible or difficult to describe (Crawford et al. 2008, Hercelinskyj 2014, Santangelo 2018). Furthermore, these findings support the use of SNTs as a structural basis for understanding nurses' work.

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Second, the use of SNT made it clear how nurses had expanded their work role through task reallocation. This finding and the challenges arising from it, are similar to those described earlier studies by Simpson (2005) and Elsom et al. (2007) describing the role of community mental health nurses. In our study, nurses had partly taken over tasks which are officially the duties of physicians, as well as from other specialties such as social workers. This trend might be explained by the lack of physicians in psychiatric care (Rellman 2016), which is known to have led to task reallocations in many care settings (Niezen & Mathijssen 2014, Laurant 2018). The fact that this reallocation of tasks was partly unofficial is concerning and suggests that there is a need to revise the role of nurses and other staff members in the current psychiatric outpatient care setting.

5.1 Limitations

Generalization of the findings of this work is limited due to the small sample size and we suggest that the results should be validated using a larger sample size in the future. In addition, the fact that the study took place in a secondary specialized setting might affect the transferability of the results to other psychiatric outpatient care settings.

The staff and patient meetings were not recorded, only field notes were made. This decision was based on two considerations. First, prior to the data collection period, nurses themselves suggested that some patients might be more suspicious towards the study if the meetings would be recorded. Second, ethnographic fieldwork has traditionally been recorded in field notes and we assumed that the amount of data recorded this way would be sufficient for this study. However, this might have led to some misinterpretations in the direct quotes of the nurses. We approached this by asking nurses their views on the coding tree in the focus group

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interviews. Furthermore, the NIC has not been officially translated into Finnish. The translations were made by the primary researcher and they were commented and further developed in the two pilot interviews, but there may be some inaccuracies in the translations.

6. CONCLUSION

Psychiatric care is restructuring itself and so is nursing, especially in the outpatient care setting. The growing demand for outpatient services challenges nurses to understand and to describe their role in care delivery. Based on the findings of this study, we suggest that the conceptualization of nursing in psychiatric outpatient care through SNT is both possible and necessary. The NIC was found to be useful in giving words to the wide variety of direct and indirect nursing interventions which nurses use in this care setting use. Furthermore, it demonstrated how nurses have expanded their role, both officially and unofficially, covering tasks traditionally belonging to other professionals of the interdisciplinary team.

Conflict of interest:

No conflict of interest has been declared by the authors.

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Table 1. Description of the ethnographic fieldwork periods and types of data collection used

Unit	Hours spent at the clinic	Number of nurses observed during one shift	Number of observed nurse-led patient meetings	Number of nurse-led patient meetings described afterwards by nurses in semi-structured interviews	Number of interdisciplinary care meetings observed	Number of team meetings, work delegation observed	Number of telephone interventions observed
1	35	2	3	1	5	5	1
2	28	3	4	2	1	5	1
3	28	3	2	1	3	3	5
4	32	2	4	1	0	1	2
Total	**123**	**10**	**13**	**5**	**9**	**14**	**9**

Table 2. Example of the analysis table used in focus group interviews.

Domain	**Class**	**NIC intervention name**	**How**	**An example of the observation**
Behavioral	**Behavior therapy**	**Mutual goal setting**	Together with the patient, setting goals for an appointment or treatment period.	”It was our goal to assess your level of satisfaction and to help you create the goals which might help you further”

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Table 3. Interventions identified organized according to the NIC

Domain	Class	Intervention
Physiological Basic	Activity and exercise management	Exercise Promotion
	Nutrition support	Nutritional Counseling
		Weight Management
		Weight reduction Assistance
	Physical comfort promotion	**Acupuncture†**
		Progressive muscle relaxation
	Self-Care facilitation	Self-care Assistance
Physiological Complex	Drug Management	Medication Management
		Medication Administration i.m.
	Tissue perfusion management	Hemodynamic Regulation
Behavioral	Behavior therapy	Activity Therapy
		Assertiveness training
		Behavior management. Self-harm
		Behavior modification; Social Skills
		Commendation
		Impulse Control Training
		Limit Setting
		Mutual goal setting
		Patient Contracting
		Smoking Cessation Assistance
		Substance Use Treatment
		Substance Use Treatment: Drug Withdrawal
	Cognitive Therapy	Cognitive Restructuring
	Communication Enhancement	Active Listening
		Complex relationship building
		Socialization Enhancement
		Conflict Mediation
	Coping Assistance	Anticipatory Guidance
		Anxiety Reduction Long Term
		Coping Enhancement
		Counseling
		Crisis intervention
		Emotional Support
		Guilt work facilitation
		Home Visit†
		Hope Inspiration
		Life-Skills Enhancement
		Mood Management
		Presence

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		Self-awareness Enhancement
		Self-efficacy Enhancement
		Self-esteem enhancement
		Role Enhancement
		Skills Training Group†
		Support System Enhancement
		Support system Mobilization†
	Patient Education	Health Education
		Teaching: Disease process
		Normalization Enhancement‡
		Teaching: Group
	Physiological Comfort Promotion	Anxiety Reduction
		Meditation Facilitation
		Calming Technique
Safety	Crisis Management	Risk Identification
		Suicide Prevention
		Environmental Management: Safety
	Risk Management	Environmental Management: Violence Prevention
		Surveillance
Family	Childrearing care	Parent Education: Adolescent
		Parent Education: Childrearing Family
		Parent Education: Infant
		Parenting promotion
	Life span care	Family support
		Family Involvement Promotion
		Family Mobilization
		Family support
		Family Therapy
		Care Giver Support
		Family integrity promotion
Health system	Health System Mediation	Admission Care
		Case Management
		Health System Guidance
		Patient Rights Protection
		Sustenance Support
	Health System Management	**Care Need Assessment†**
		Collaboration Enhancement **§**
		Laboratory Data Interpretation
		Drug screening†
		Controlled Substance Checking
		Staff Development
		Physician support
		Preceptor Employee

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		Preceptor Student
	Information Management	Consultation
		Care plan†
		Documentation
		Health Care Information Exchange
		Multidisciplinary Care Conference
		Referral
		Diagnostic Data Collection†
		Telephone Consultation
		Telephone Follow-up
Community	Community	Community Health Development

† Suggestion for a new intervention

‡ Intervention found in the NIC, but in a different class

§ Intervention suggested by nurses to be added, found in the 7th edition of NIC (Butcher et al. 2018)

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