How do nurses in England and Norway perceive that the organization of tasks between physicians and nurses in an Emergency Department influences the patients' waiting time?

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ABSTRACT

Aim: Patients often have long waiting time in the Emergency Departments to be seen, which in itself is considered a risk of less successful outcome. The aim of this study was to get the perception of how nurses in Norwegian Emergencies believe task shifts between physicians and nurses can influence the patients waiting time, and if the nurses are willing to take on more responsibilities. The study also aim to investigate how nurses in England, and who are practising task shifts, believe this has influenced the waiting time, and if they have managed to achieve their goal of improved access to care, higher treatment quality and lower costs.

Background: A long waiting time in the Emergency Departments are associated with a risk of patients leaving without being examined as well as increased mortality. It's estimated that 85% of all visits to the Emergencies are made for non-life-threatening illnesses, and many of these patients are more in need of care than medical treatment. Estimates show that 30% of all patients coming to an Emergency Department could have been handled by a specially trained nurse to free time for the physicians to work with the more complex cases in need of immediate treatment. Available literature show there is a huge body of evidence saying nurses can deliver the same quality of treatment as physicians for a range of services if they are provided proper training and exposure, and that transferring tasks from the physicians to the nurses have resulted in decreased waiting times in many countries. Based on that task shifts can be seen as one way of solving the problem with long waiting times in the Emergencies.

Nurses in England already have extended responsibilities, and tasks like requesting x-rays, ultrasound, stitching, cleaning wounds, relocation of limbs and plastering are some of the tasks they have taken over from the physicians. Their specially trained nurses see, examine, treat and discharge patients, and feedback from patient surveys show that patients are equally happy by being treated by a nurse instead of a doctor as long as they are experienced.

Theoretical framework: Task shifts are transferring tasks from one profession to another to maximise the use of limited resources. Task shifts between physicians and nurses have been used in England and other English-speaking countries for more than 50 years to solve some of the challenges in their health care systems like long waiting times. For patients with minor diseases or injuries it's been proven both safe and effective. Despite of this, there is still a lot of resistance against task shifts in the health care sector both from physicians, nurses, other health care workers and patients.

Methods: This study was conducted in 3 hospitals where 10 experienced nurses in Norway and 12 experienced nurses in England participated by answering 8 questions. Since the focus of the study was to collect information about what nurses knew, thought, felt and have experienced about task shifts a qualitative method with one-to-one interviews were chosen so the researcher could collect necessary information by talking directly to the sources. The study took place over a period of four months, and a post positive approach was used.

Results: The results showed that all the participants in Norway perceived that a task shifts from the physicians to them would lead to reduced waiting time for low-triage patients, while almost all the English participants told they have experienced decreased waiting time after they took over some of the tasks that were earlier performed by physicians. All the nurses in Norway and the majority of the nurses in England were willing to take on new responsibilities as long as it would benefit their patients and they received proper training. It was suggested new tasks should be carefully introduced to avoid conflict with their role as nurses.

The participants from Norway explained their waiting time for low-triage patients as caused by waiting for examinations or tests performed or requested by busy physicians. By taking over some of the physicians tasks they believed the waiting time would decrease as more examinations and tests would be ready by the time the physicians came to see their patient.

The nurses from England told they have taken over more and more of the physicians tasks, and some felt they now have become more like mini-doctors than nurses, and expressed concerns of losing their role as a nurse. Even if the nurses in England could tell of decreased waiting times as a result of tasks shifts, they also told that task shifts alone is not enough to solve the problem of long waiting times. They said the hospitals have to address the challenge of crowding to avoid the waiting time to start increasing again.

Conclusion: Based on the findings and the literature it would be recommended to start a project to look at tasks that can be transferred between the physicians and the nurses to reduce the waiting time for patients with minor diseases or injuries. It’s recommended to start discussing a transmission of the best documented task shifts from abroad like requesting x-rays, requesting ultrasound and to implement treatment lines for low-triage patients. It’s also recommended that both professions participate in this work to make sure the quality will be equally good for the patients seen by nurses, and to reduce the chance of medical resistance that have caused a lot of problems for the transmission process in other countries.

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CONTENT

1.0 INTRODUCTION

"How do nurses in England and Norway perceive that the organization of tasks between physicians and nurses in an Emergency Department influences the patients' waiting time?"

1.1 Background

The health care system in Europe is facing challenges with budgetary, regulatory and organizational pressures (Fawdon and Adams, 2013). Demographical changes, an aging population, pandemic, bio terrorism, climate changes and physical and biological accidents might become a treat to the populations in the future, and at the same time new technology might change the way we treat many diseases. In combination with lack of enough hands, enough competence, more political reforms and higher focus on economy is the health care system in Norway and Europe under a lot of pressure (Brusselkontoret, 2013).

Over the last 30 years the Norwegian Emergency Departments have taken a more central position in their hospitals, and after an audit in 2007 they have done several organizational changes to meet the new demands for more competence and treatment in front. Despite this patients still experience long waiting times, it's difficult to be seen by a specialist, and the Emergencies lack enough staff and competence to monitor their patients in an adequate way. The Emergency Departments are not built for long waiting times as they have limited space and seldom time to provide basal needs like rest and food. The insecurity patients and relatives feel while waiting to be seen cause a lot of stress (Helsedirektoratet, 2014).

Task shift is transferring tasks from one profession to another for better use of limited resources (Frich, 2012). The Norwegian government has had very little focus on task shifts as a way of solving some of the expected challenges even after a report by Brusselkontoret concluded that task shifts have been proven effective in countries like England. Reports like "Changing Workforce" (2001–2005) and "Modernising Nursing Careers" (2006) show England is way ahead of Norway when it comes to using task shifts as one way of solving some of the health care challenges (Brusselkontoret, 2013).

For almost 50 years the British health care system has used specially trained nurses for tasks that earlier were performed by physician's to improve access to care in a context of limited supply of doctors (Fotheringham, Dickie and Cooper, 2011, Delamarie and Lafortune, 2010).

These specially trained nurses are often referred to as Nurse Practitioners (NP's), Advanced Nurse Practitioners (ANP's) or Advanced Clinical Practitioners (ACP's), and by letting these specially trained nurses take over some of the less serious patient groups, the physicians' have been left with more time to deal with the more complex patients (Fawdon and Adamas, 2013, Garson, 2013).

In Norway there are no training programs educating NP's, ANP's or ACP's. Some of their tasks are performed by Emergency Nurses or other specially trained nurses, but the tasks they are allowed to perform are different from the tasks they perform in England.

An estimated 85 % of all visits to the Emergency Departments are made for non-life-threatening diseases. About half of these can further be categorized as non-serious, often more in need of care than medical treatment (Brusselkontoret, 2013, Delamarie and Lafortune, 2010, Wilsey et al, 2008). According to estimates up to 30% of the patients could have been handled by specially trained nurses instead of doctors (Jennings et al, 2008).

The OECD Health Working Papers No 54 – Nurses in Advanced Roles – conclude that there is a large body of evidence that specially trained nurses are able to deliver the same quality of care as doctors for a range of services transferred to them provided they have received proper training and education. The outcome has shown less crowding with lower waiting time and length of stay (LOS) for the emergency patients (Delamaire and Lafortune, 2010).

Waiting time and length of stay are quality indicators in Emergency Departments because a long waiting time is considered a risk of increased in-hospital mortality (Bernstein et al, 2008). A waiting time of 6 hours + have been associated with a high risk of patients leaving without being seen, while increased mortality have been seen with patients waiting for 8 hours + (Olshaker, 2009, Bernstein et al, 2008). A long waiting time also lead to crowding which make the Emergency staff feel they are being rushed in their work and both their work satisfaction and the patients' safety and satisfaction decreases (van der Linden et al, 2013).

The aim of this study was to talk to nurses working in Emergency Departments in Norway to get their perception of how they think a task shift from the physicians to the nurses can influence the patients waiting time and LOS, and if they are willing to extend their role.

Since English nurses already have been working with task shifts for many years this study also wanted to get their perceptions on how they believe task shifts influence the patients waiting time and the organization of an Emergency Department.

1.2 Practicing nurses

In Norway it's estimated that approximately 180 patients per 1.000 inhabitants will visit an Emergency Department in one year (30 per day per 100.000 inhabitants). For England the number is approximately 400 patients per 1.000 inhabitants (60 per day per 100.000 inhabitants). The difference is based on a tradition in Norway where the general practitioners play a more active role in the treatment process (Helsedirektoratet, 2014).

Numbers show that Norway have twice as many practicing nurses as England per 1000 inhabitants, but despite this nurses in England have more responsibilities and play a more active role in the treatment than the Norwegian nurses do.

2009	***Total number***	***Per 1000 inhabitants***
Doctors (GP's)		
Norway	3.909	0,81
UK	49.184	0,81
USA	92.322	0,3
Practicing nurses		
Norway	93.499	19,36
UK	589.592	9,68
USA	3.312.440	10,8
Personal care workers		
Norway	49.319	10,21
UK	-	-
USA	2.455.840	8,01

Table 1- Practicing nurses per inhabitant Norway, England and US - Brusselkontoret, 2009

1.3 Definitions

For this study several expressions used both in the research question and in the text are defined in this chapter.

1.3.1 Waiting time/Length of stay

Waiting time is the time it takes from the patient arrive the hospital to he or she are examined. Length of stay (LOS) is the time the patient spend in the Emergency Department before being admitted or discharged.

Norwegian waiting time and LOS increased 5–10% from 2012-2013, and is expected to increase from 2013–2014 due to an increasing number of patients being discharged from the Emergency (20% to 28%) as these patients have longer waiting time than admitted patients.

Waiting time and LOS were as follows for the Norwegian participating hospital 2013.

	Medical	**Surgical**
Time to assessment	10 min	10 min
Waiting time to be examined	45 min	1 hour
LOS admitted patients	3 h 10 min	3 h 35 min
LOS discharged patients	3 h 40 min	3 h 55 min

Table 2 – Waiting times Norway - numbers from participating hospitals

1.3.2 Nurse Practitioner/Advanced Nurse Practitioner

"Nurse Practitioner/Advanced Nurse Practitioner is a registered nurse who has acquired the expert knowledge base, complex decision-making skills and clinical competencies for expanded practice, the characteristics of which are shaped by the context and/or country in which s/he is credentialed to practice. A Master's degree is recommended for entry level" (Delamarie and Lafortune, 2010:14).

The concept is to empower nurses who have a sound clinical base and special skills to enable them to make autonomous judgments and decisions regarding patient care (Stura, 2014, Laurant, 2009, Savrin 2008, Chung, 2008). They should be able to carry out activities like diagnostics, screenings, prescriptions of pharmaceuticals or medical tests and prevention and

general health education that would otherwise be performed by physicians' (Delamarie and Lafortune, 2010). 70 countries are expected to provide this service by 2014 (Stura, 2014).

1.3.3 Specially trained nurses

A lot of different nursing titles are being used in the literature to describe nurses performing more or less the same tasks. The most common titles are Nurse Practitioners, Advanced Nurse Practitioners, Emergency Nurse Practitioners, Advanced Clinical Practitioners and Advanced Care Practitioners.

To avoid using five titles each time the author refers to a nurse with special training, this study will use the term "specially trained nurses" to cover the titles mentioned above.

The term will cover all nurses who have completed additional courses and specialized training to provide a broad range of healthcare services that may include autonomous and independent clinical decision making.

1.3.4 Task shift

Task shift is used when one profession takes over tasks previous performed by another profession, and will in this study be used for transmission of tasks between physicians and nurses (Frich, 2012). For full definition see 2.0.

1.3.5 4-hour target

The 4-hour target came as a consequence of the British government wanted to improve the waiting time in the Emergency Departments. The target was to see 95 % of all patients within 4 hours. Still many hospitals have problems reaching the target and usually due to lack of inpatient beds, delayed discharges, delay in accessing specialist, lack of nurses, lack of middle grade doctors, small departments or delayed access to diagnostic services (Weber et al, 2012).

A study of 772.525 Emergency visits showed that death in the department and return to the Emergency Department within one week was unchanged after implementing the 4-hour

target. Return visits resulting in hospital visits increased initially and then returned (Weber et al, 2012). Norwegian hospitals do not have a 4-hour target.

1.3.6 Triage

Triage is a priority system for patients coming to the Emergency Department used to make sure the most severe cases are seen first (Christ et al, 2010, Mackway-Jones, 2012).

Red - Immidiate assessment	Nurse: Immediate assessment Doctor: Immediate assessment
Orange - Very urgent	Nurse: Within 10 minutes Doctor: Within 10 minutes
Yellow – Urgent	Nurse: Within 30 minutes Doctor: Withhin 60 minutes
Green – Standard	Nurse: Within 60 minutres Doctor: Within 120 minutes
Blue - Non-urgent	Nurse: Within 120 minutes Doctor: Within 240 minutes

Table 3 – Manchester Triage codes (Akuttmedisinsk Traige, 2011)

Manchester Triage System (MTS) is an in-hospital triage system used by nurses all over Europe. All Oslo hospitals use MTS which considers five priority levels with estimated waiting time (Parenti et al, 2014).

For Norway patients in category green and blue cover 30 % of all Emergency patients, and these are the patients referred to in many studies as non-serious and often in more need of care than medical treatment (Wilsey et al, 2008). In England the participating hospital have stopped using MTS and replaced it with a rapid nurse assessment tool instead.

1.3.7 Crowding

Crowding occurs when patients can't be passed on in the system because of lack of space, lack of enough or experienced staff or huge variations in number of patients (Olshaker, 2009). Crowding is considered a worldwide problem. 90% of American hospitals have reported crowding as a problem leading to long waiting times with increased in-hospital mortality and patients leaving without consultation (Olshaker, 2009, Bernstein et al, 2008).

Studies have shown that crowding have been reported several times a week by 68% of the nurse managers in an European country (van der Linden et al, 2013), and that it's considered a stress-factor for the staff that can reduce the quality of treatment (Anneveld et al, 2013).

2.0 TASK SHIFT AND CHALLENGES

The expression task shift or job gliding is used when one profession takes over tasks from another profession. The tasks can both be formalized and non-formalized (Frich, 2012).

The reasons for doing tasks shifts from physicians to nurses in the health care sector is mainly based on three reasons: 1) Improve access to care for an increasing number of patients in a context of limited supply of doctors. The idea is to let nurses perform some of the doctors' tasks for non-acute patient groups so the doctors have more time to deal with acute patient groups (Fawdon and Adamas, 2013, Garson, 2013, Fotheringham, Dickie and Cooper, 2011, Delamarie and Lafortune, 2010). 2) Promote higher quality of care where the patients have less contact persons, and the ones they have are specially trained on counselling for patients with chronic illness and minor diseases (Brusselkontoret, 2012, Delamarie and Lafortune, 2010). 3) Save costs as transferring tasks from one profession to another have been considered cost effective in the health care sector, and the idea is to deliver the same (or better) quality at a lower price (McClellan et al, 2013, Delamarie and Lafortune, 2010).

In the health care sector task shifts can be divided into four categories: 1) Expanding their tasks (like when nurses request x-rays), 2) Specialization with formal training (like when specially trained nurses are trained to interpret x-rays), 3) Sharing tasks (like when junior doctors and NP's perform the same tasks), and 4) Sharing between professions with same level of education (like when psychologists and doctors are doing the same job (Frich, 2012). For this study task shift will only cover the first three categories.

Task shifts from physicians to nurses started in the 60's in English-spoken countries like the US, Canada, Australia and England. The concept was to empower nurses with special skills to enable them to make autonomous judgments and decisions regarding patient care (Chung, 2008). To assure the competence of the nurses taking over some of the physicians tasks they were provided extra education and training, something that resulted in new nursing titles like Nurse Practitioner, Advanced Nurse Practitioner or Advanced Clinical Practitioner (in this study referred to as specially trained nurses) to separate them from the more regular nurses (Brusselkontoret, 2012, Delamarie and Lafortune, 2010). Many of the new nursing roles developed in an ad hoc manner to meet local needs (Adams, 2013).

Originally these task shifts were introduced in the primary care sector, but more recently it's also become common in hospitals. Today 90% of all Emergency Departments in England offer this service to their patients (Fotheringham, Dickie and Cooper, 2011).

In English Emergency Departments these task shifts have either been transferred from the doctors (supplementation of tasks), or been divided between the two professions (substitution of tasks) to reduce the demands on doctors' time (Delamarie and Lafortune, 2010).

Two international studies on specially trained nurses' role concluded that nurses can generally deliver as high quality of care as general practitioners in the areas of preventive health care, routine follow-up of patients with long-term conditions and first contact for patients with minor diseases. It also concluded that nurses tended to provide more information and advices that resulted in higher patient satisfaction, and that efficiency gains can be achieved if doctors focus on health problems of more complex nature where there is a high degree of uncertainty regarding diagnosis and treatment (Brusselkontoret, 2012, Delamarie and Lafortune, 2010).

Today many reports conclude that specially trained nurses are academically advanced, professional and competent to provide emergency medical care (Iglehart, 2013, Bahena and Andreoni, 2013). Despite that the specially trained nurses in the Emergency Departments are poorly understood by emergency doctors (Weiland, Mackinlay and Jelinek, 2010).

For many physicians this can be explained by the fact that specially trained nurses are considered to overlap their tasks followed by loss of practice and loss of activities for their own profession, concerns about legal liability in case of malpractice and a general concern about the skills and expertise of the specially trained nurses (Delamarie and Lafortune, 2010). The numbers of titles are also causing confusion (Weiland, Mackinlay and Jelinek, 2010, Griffin, 2006), and the lack of clarity of the specially trained nurses role definition, their scope of practice and differentiation from the medical role is seen as one of the main problems for many doctors (Weiland, Mackinlay and Jelinek, 2010).

Despite the resistance among many doctors studies done on patients' satisfaction have concluded that significant differences were reported in questions comparing patient satisfaction with either specially trained nurses or emergency doctors with greater patient satisfaction demonstrated with the specially trained nurses (Lutze et al, 2014, Jennings et al, 2009, Jarvis, 2007). Several studies have also shown a decreased waiting time for patients being seen by a specially trained nurse instead of a doctor (Considine, Kropman and Stergiou,

2014, Colligan et al, 2011, Fry et al, 2011, Webster-Bain, 2011, Steiner et al, 2009, Jennings et al, 2008), which again lead to lower costs (Collins et al, 2014).

In organizational literature three reasons for change resistance are described: 1) Cognitive (negative or positive thoughts), 2) Affective (negative or positive emotional reactions), and 3) Behavioral (expressed negative or positive actions) (McKenna and Beech, 2014). Based on what's written about resistance against tasks shifts between physicians and nurses it seems to be a combination of these three where doctors and nurses see both threats and benefit of change.

It's common for people to perceive that proposed changes are likely to threaten their expertise, undermine their influence, dilute their power base and reduce their resources (McKenna and Beech, 2014, Pilbeam and Corbridge, 2006). It's also common to see a lack of trust between management and employees as those likely to be affected by the changes often did not receive adequate information or were invited to participate in the process (McKenna and Beech, 2014, Price, 2007). People in general have a low tolerance for change, and for some people change lead to anxiety because it poses a challenge to established routines, and they might oppose the change even though they know it's for the benefit of the organization (McKenna and Beech, 2014, Pilbeam and Corbridge, 2006).

The source of resistance is often poor communication, and to overcome resistance for change action should be taken to communicate and keep people fully informed by disseminating all relevant information, listen to the employees and consult those with relevant experience. It's also important to target opinion leaders to assist in getting the message across (McKenna and Beech, 2014).

Kotter's model for change contains eight steps to be used to successfully implement change:

1) Establish a sense of urgency: The change must be seen necessary for the organization.
2) Establish a coalition: Put together a team strong enough to direct the process.
3) Create a vision and strategy for change: The coalition should develop a shared realistic vision.
4) Communicate the vision: Words, deeds and symbols must be used to communicate.
5) Remove obstacles: Empower people to move ahead.
6) Produce visible signs: Ensure people who make things happen receive recognition.
7) Stick to the change process: Refuse to give up when the conditions get tough.

8) Nature and shape a new culture: Support the improvements and innovations that are taking root (Kotter and Cohen, 2012).

Unfortunately not all of them have been used in the health care sector. As described a lot of the task shifts have so far been a result of ad hoc changes where decisions were made without consulting those involved. According to the literature this has caused a lot of resistance among many doctors for transferring some of their former tasks to nurses (Adams, 2013, Delamarie and Lafortune, 2010, Weiland, Mackinlay and Jelinek, 2010).

To manage a task shift one profession must be willing to give up a task while another profession must be willing to take it on. To achieve this it's important to have the two professions working together to find good solutions that both parts can approve without compromising on the quality of treatment or feel their status being threatened (Frich, 2012).

3.0 TASK SHIFT IN LITERATURE

The literature presented in this chapter is the one found about tasks the English nurses have, the Norwegian nurses possible could take over or general literature about positive and negative outcome of task shifts. Some of the literature is new while some dates back to 2005. Where older literature has been used no newer literature has been found.

3.1 Literature search

The literature chapter should demonstrate skills in library searching, to show command of the subject area and understanding of the problem, to justify the research topic, design and methodology (Silverman, 2013).

The most important literature search for this study was done in Medline, Embase, Cochrane and Cinahl, and a set of control words were used (MeSH, Emtree terms og Cinahl Headings) and text that was grouped within the concepts Emergency Department, Akuttmottak, NP and different quality indicators like waiting time, LOS, quality of health care services etc. The terms were combined with OR to cover as many articles as possible and with AND to limit the result to articles covering all the tree concepts:

- Emergency service OR emergency room OR acute care (...)

AND

- Nurse practitioners OR clinical practitioners (...)

AND

- Length of stay OR waiting time OR patient satisfaction OR quality of healthcare (...)

The result was 447 articles. All abstracts were read, and the number was limited down to 89 for downloading and reading.

It was also done minor searches (Medline/PubMed) for NP, Emergency Service and task shifting/job gliding. These searches gave 29 articles. 11 of these were downloaded after reading the abstracts.

It was also done searches on words like Emergency Unit and quality indicator in Medline, Embase, Cinahl and Cochrane. For these searches a large number of articles were found since general terms were used. The librarian limited the terms (MeSH and Cinahl headings etc.) to limit the number, but the result still ended at 408 articles. This result was treated the same way as described earlier and the final result was 76 articles that were downloaded.

After removing some articles the final result ended at 165 articles that were read. 82 of them have been used in this study.

Search history from Medline. Search 1 and 3 was also transferred to Embase, Cinahl and Cochrane.

Searc history Medline		
Medline search history from search 1 (Emergency Service, Nurse Practitioner and Quality of Healthcare)	**Medline search history from search 2** (Emergency Service and Task sharing)	**Medline search history from search 3** (Emergency Service and Quality of Healthcare)
1. exp Emergency Service, Hospital/ 2. (emergency service* or emergency room* or emergency department* or acute care or triage).tw. 3. 1 or 2 4. exp Nurse practitioners/ 5. nurse practitioner*.tw. 6. or/4-5 7. exp Quality of health care/ 8. exp Cost-Benefit Analysis/ 9. cost-effectiveness.tw. 10. Patient satisfaction.tw. 11. exp Patient Satisfaction/ 12. exp Length of Stay/	1. exp Emergency Service, Hospital/ 2. emergency department*.tw. 3. emergency service*.mp. 4. exp Triage/ 5. triage*.mp. 6. emergency room*.tw. 7. or/1-6 8. exp nurse practitioners/ 9. mid-level practi*.tw. 10. exp Nurse clinicians/ 11. nurse clinician*.tw. 12. exp nurses/sd 13. exp Nurse practice patterns/	1. *Emergency Service, Hospital/og [Organization & Administration] 2. *Quality of health care/og [Organization & Administration] 3. exp Patient Satisfaction/ 4. exp Length of Stay/ 5. exp Time Factors/ 6. exp Patient safety/ 7. workflow.tw. 8. exp Interprofessional Relations/ 9. or/2-8 10. 1 and 9 11. (editorial or comment or letter).pt.

13. length of stay.tw. 14. exp Efficiency, Organizational/ 15. patient discharge*.tw. 16. exp patient discharge/ 17. exp Waiting lists/ 18. wait* time*.tw. 19. or/7-18 20. 3 and 6 and 19 21. limit 20 to yr="2005 -Current" 22. limit 21 to (danish or english or norwegian or swedish) 23. (letter or comment or editorial).pt. 24. 22 not 23 25. exp Child/ or Pediatrics/ or exp Community Health Services/ or (child* or pediatric* or shelter or hospice).tw. 26. 24 not 25	14. exp Nurse's Role/ 15. 8 or 9 or 10 or 11 or 12 or 13 or 14 16. task shift*.tw. 17. (profession* adj3 boundar*).tw. 18. task substitut*.tw. 19. task switch*.tw. 20. task shar*.tw. 21. skill substitut*.tw. 22. (substitut* adj3 (doctor* or nurs* or physician*)).tw. 23. doctor-nurse substit*.tw. 24. exp physician-nurse relations/ 25. 16 or 17 or 18 or 20 or 21 or 22 or 23 26. 7 and 25 27. (emergency contraception* or child*).tw. 28. 26 not 27 29. (letter or comment or editorial).pt.	12. exp Child/ or Pediatrics/ or child*.tw. or pediatric*.tw. 13. 11 or 12 14. 10 not 13 15. limit 14 to "reviews (best balance of sensitivity and specificity)" 16. limit 15 to (yr="2005 - Current" and (danish or english or norwegian or swedish))

Table 4 – Search history

2.2 Nursing tasks in Norway

Norway does not have a national training program for Emergency nurses, but some hospitals have their own educational programs. Few nurses working in the Emergencies have this education, so those working as specially trained nurses in Norwegian Emergencies are usually

Intensive care nurses, anesthesiology nurses or nurses specialized in cardiology, pulmonary diseases or cancer (Almås, Stubberud and Grønseth, 2013).

An important nursing task in Norwegian Emergencies is triage. As the nurses are the first to see patients coming to the Emergency (except reds) they provide the triage (Mackway-Jones, 2012, Christ et al, 2010).

Other nursing tasks cover assessing the patient to measure vital signs, order blood tests, write reports, coordinate with the wards or external health care services, provide treatment prescribed by doctors and provide general care (Haugen, 2014, Almås, Stubberud and Grønseth, 2013).

In Norway the emergency staff is covering different positions based on their experience and internal training program, and they usually have 4–5 different positions they can cover when finishing the whole program. There are no differences between specially trained nurses and regular nurses when it comes to covering different positions as long as they have gone through the training programs (Haugen, 2014, Almås, Stubberud and Grønseth, 2013).

Few tasks in a Norwegian Emergency Departments have formally been transferred from the physicians to the nurses. The nurses do a lot of the physicians' tasks, but this is only after being prescribed, and what tasks being performed vary both from one diagnose to another or from one doctor to another.

3.3 Nursing tasks in England

The English Emergency nurses share the same tasks as the Norwegians, but they also have specialized roles with extended responsibilities for patients with minor injuries or diseases. These responsibilities cover requesting x-rays and ultrasound, dressing of wounds, stitching of soars, relocation of limbs and plastering. The specially trained nurses also examine, treat, prescribe, refer and discharge patients on the same level as junior doctors. Some are also trained to interpret x-rays and ECG's and can do ultrasound examinations.

As a result of extended responsibilities titles (see 1.3.2) have been introduced to separate specialized nurses from regular nurses. By giving these nurses the responsibility for a set of services that otherwise would have been performed by doctors, the main aim is to reduce the

demand of doctors', improve access to care and save costs (McClellan, Cramp, Powell and Benger, 2013, Delamarie and Lafortune, 2010).

Specially trained nurses in England are trained alongside junior doctors supervised by middle-grade doctors. After finishing their programs the nurses are supposed to be skilled to cover history taking, to do respiratory, cardiac, abdominal and basic neurological examinations, requesting and interpret blood tests, x-rays and scans (Fawdon and Adams, 2013).

On admission to the Emergency Department a specially trained nurse assesses the patients need for treatment either as minor illness, minor injury or rapid assessment and treatment stream (RATS) (Adams, 2013).

The English nurses use a rapid nurse assessment system instead of MTS. A review of 12 studies showed that MTS safety was low because of the high rate of undertriage and the low sensitivity in predicting higher urgency levels. The high rate of overtriage could also cause unnecessarily high use of resources (Parenti et al, 2014). It was also found that waiting time did not decrease after implementation of MTS but treatment time and LOS were significantly longer. No significant differences were found between triaged and non-triaged patients when it came to treatment (Storm-Versloot et al, 2014). Other studies have shown that the waiting time before being admitted has gone down by using triage (Stover-Baker, Stahlman and Pollack, 2012).

3.4 Tasks taken over by English nurses

Lack of national guidelines in England has made different hospitals give different content to their extended nursing roles. The more common tasks found in the literature for those with an extended role is to take history, do physical examinations, order investigations and provide first-line treatment such as analgesics, intravenous fluids and antibiotics. They also interpret x-rays and ultrasound and either refer the patient to a specialist or having them discharged (Fawdon and Adams, 2013).

In a survey the programs teaching the Acute Nurse Practitioners were asked what skills were needed for a nurse to work in an Emergency Department. The following 12 tasks were

mentioned as the most important and often the ones transferred to nurses (Kleinpell et al, 2006):

Number	Task	England	Norway
1	12 lead ECG interpretation	X	-
2	X-ray interpretation	X	-
3	Hemodynamic monitoring	X	X
4	Suprapubic bladder scanning	X	X
5	Local anesthesia application	X	-
6	Defibrillation/cardioversion	X	-
7	Spirometry and peak flow assessment	X	-
8	Endotracheal intubation	X	-
9	Discontination of chest tubes	X	-
10	Sedation for procedures	X	-
11	Intracranial pressure monitoring	X	-
12	Arterial puncture/cannulation	X	X

Table 5 – Nursing tasks in England and Norway

The tasks' listed under England is performed by their nurses, while the ones under Norway are performed by Norwegian nurses in the Emergency Department.

Other tasks mentioned as suitable for nurses to take over from the doctors were independent prescribing, treatment of soft issue injuries on upper and lower extremities and oral and written communication and documentation (Kleinpell et al, 2006).

3.4.1 X-rays and ultrasound

X-rays are considered time consuming because the patients very often have to wait for an available doctor to request the pictures. Studies and audits have shown that nurses can practice both requesting and interpretation of x-rays well within acceptable limits for producing false positive and false negative results, and their skills can benefit patients and lead to service improvements (Swaby-Larsen, 2009, Summers et al, 2005, Pedersen and Storm, 2009). Nurses are considered able to learn a skill to a high standard through experience, repeated exposure and training, and there is no indication for nurses requesting more x-rays that doctors do (Swaby-Larsen, 2009, Summers et al, 2005).

One study concluded that without the nurses being responsible for ordering and interpret x-rays many patients would not be able to receive proper treatment in the Emergency. The study

showed that of 2.225 patients coming to the Emergency Department, 88,7% could have been treated fully by a specially trained nurse (Heltoft and Laursen, 2009). A study from 2007 concluded that there is a trend toward greater accuracy with more experience, regardless of profession for x-rays and ultrasound. The exposure was considered more important than the title, and physicians and nurses were found equally competent (Carter and Chochinov, 2007).

Another study showed that the waiting time was reduced from 35 to 14 minutes for 75% of the patients if the x-ray was ordered by a nurse (Pedersen and Storm, 2009). The same study showed that the overall waiting time from the patient left the Emergency to they returned from the x-ray was 32 minutes for the patients who got their x-rays ordered by a nurse and 56 minutes for those who got their request from a doctor (Pedersen and Storm, 2009).

Studies done on nurses interpreting ultrasound showed that specially trained nurses achieved a sensitivity level of 93% and a specific level of 98%. They correctly identified the presence of disease pathology 93% of the time and the lack of 98% of the times (Henderson et al, 2009).

3.4.2 Non-medical prescribing

Since May 2006 non-medical prescribers in the UK have had prescribing powers comparable with doctors (Black, 2012). Many of the specially trained nurses in England, like NP's, ANP's or ENP's have undergone a course for prescribing within critical care.

An audit done in 2012 showed that the prescribing error rates were low, and that specially trained nurses were at least as effective as other groups in terms of errors (Carverry, Connelly and Murphy, 2012). A study showed that more than 50% of the prescribers' patients required medication, and that analgesia and antibiotics was the most common drugs. Safe prescribing practice was evident in 99,4% of the cases. The study found that independent non-medical prescribing makes better use of NP's clinical skills to facilitate independent practice witch may improve service delivery (Black, 2012).

3.4.3 Deep and superficial venous thrombosis (DVT)

DVT is a costly and time consuming diagnose and the estimated cost was 3,2 billion 2009-dollars, and it's expected to continue to grow (Tosone and Costanzo, 2012, Passman, 2010).

In Norway all DVT-patients are examined by a doctor, and because it's not considered an acute problem the patients had a LOS in 2014 up to 7,3 hours with an average waiting time of 4,2 hours (35% longer than other low-triage patients) (Norwegian participating hospitals).

In England they have developed guidelines for DVT that have shown to decrease the patient's LOS. The Wells score allow specially trained nurses to examine, give diagnose and start treatment (Dewar and Corretge, 2014). The average waiting time for DVT-patients was under 4 hours in England in 2014.

In a prospective cohort study with 100 cases of suspected DVT they compared the results from the Wells score reading from the specially trained nurses with the reading from the physician's. It showed that the two groups ended up with the same final Wells score in 81% of the cases (Dewar and Corretge, 2014). This has led to more Emergencies abroad shifting over this task to the nurses to save time without compromising on the quality.

3.4.4 Minor injuries

In many English Emergencies specially trained nurses are responsible for assessing and treating ankle and foot injuries, and usually with excellent diagnostic accuracy and patient satisfaction and reduction of waiting time. A study showed that nurses were even more sensitive, in detecting injuries requiring treatment with a cast or surgery (Derksen et al, 2007).

For tasks like dressing, ice compressing, sling, wound cleaning, bandage, elastic support, oral anti—inflammatory drugs and anti-tetanus serum the nurses scored very well and can provide an alternative model of service delivery in the management of patients with minor injuries (Wilson and Shifaza, 2008). A systematic review from 2007 showed that the average waiting time in the UK for Emergency Departments with specially trained nurses dropped from 56 to 30 minutes to see a practitioner, while the average LOS dropped from 1 hour 39 minutes to 1 hour and 17 minutes. All the time the number of patients' was lower in the department for those with specially trained nurses (Carter and Chochinov, 2007).

3.4.5 Soft tissue injuries

A study from UK looked at the clinical outcomes of soft tissue injury on upper and lower extremity treated by a specially trained nurse. The results showed that the nurses and the emergency doctors were equivalent to routine care provided by doctors (McClellan, Cramp, Powell and Benger, 2014). The study concluded that specially trained nurses can successfully manage patients with uncomplicated soft tissue injury.

3.4.6 Communication and documentation

A task taken over by English nurses is communicating with the patients both when it comes to information and parts of the documentation. They are now expected to communicate effectively with patients with complex needs (Burley, 2011, Berry, 2009).

The nurses were in a systematic review considered better at both documenting and following protocols than the physicians. They were also considered to give more and better health information and discharge instructions (Carter and Chochinov, 2007).

The same was found in an article saying specially trained nurses focused more on patient education and counselling about the medical condition or therapeutic regime than the doctors. Patients felt they took more part in the conversation, and they found patient satisfaction was related with how actively they participated in the conversation. Emotional support was also considered important, and here the patients felt more satisfied with the nursing group than the doctors (Sandhu et al, 2009).

Most of the evaluations done of nurses in advanced roles have shown high patient satisfaction, and in many cases higher than for doctors which are believed to be a result of the nurses spending more time with their patients, and provide them with more education and counselling (Delamarie and Lafortune, 2010).

3.5 Quality of care and patient satisfaction

According to the literature 65% responded they were willing to be treated by a specially trained nurse for their current condition, while 17% indicated they were not willing to receive

this kind of treatment. Of those treated by a specially trained nurse 93% indicated they were satisfied with the care they had received (Hart and Mirabella, 2009).

A literature review suggest that specially trained nurses in Emergency Departments can reduce the patients waiting time, lead to higher patient satisfaction and provide a quality of care equal to that of a mid-grade resident (Carter and Chochinov, 2007).

A study by Cochrane concluded that appropriately trained nurses can produce as high quality care as primary care doctors and achieve as good health outcomes for patients. The study also concluded that the nurses tend to provide more health advice and achieve higher levels of patient satisfaction compared with doctors, and that nurse-doctor substitution have the potential to reduce doctors' workload and costs of care (Reeves et al, 2009).

Another study from 2009 based on a patient satisfactory survey concluded that significant differences were reported in questions comparing patient satisfaction with either specially trained nurses or emergency doctors with greater patient satisfaction demonstrated with the specially trained nurses (Jennings, Lee, Chao and Keating, 2009).

Specially trained nurses are academically advanced, professional and competent to provide emergency medical care, and have shown positive outcomes comparable with physicians in the care they provide to their patients in the fast track areas in the Emergency Departments (Iglehart, 2013, Bahena and Andreoni, 2013).

In one British survey 81% of the patients coming to an Emergency Department received their treatment from a specially trained nurse, and 97% of these patients answered "yes, definitely" when asked if they had confidence in the nurse treating them, and 76% answered "excellent" when asked about their satisfaction with the service provided. The survey showed the vast majority were satisfied by being treated by a nurse (Jarvis, 2007).

3.6 Task shifts shown on waiting time

A lot have been written about how implementing specially trained nurses in the Emergency Departments influence the patients waiting time. Most of these studies are from Australia, Canada and the US.

In general patients do not want to wait to long for treatment, and studies have shown that they are pleased with fast tracks irrespective of model of care (Lutze et al, 2014).

In Canada a study showed that the addition of a specially trained nurse in the Emergency Department was associated with 12% in patient volume per shift and a 7 minute reduction in mean waiting time for low-acuity patients (Steiner et al, 2009). They concluded that by adding specially trained nurses to take care of the less serious cases less people would leave without treatment. No reduction in LOS was found.

Australia did the same for women with symptoms suggestive of threatened or inevitable miscarriage. Their feedback was positive as this led to not only a reduction in waiting time and treatment time but also increased the patient's satisfaction (Webster-Bain, 2011).

An evaluation from the same country showed statistically significant differences between patients seen by an emergency doctor and a specially trained nurse. While the patients seen by a nurse had a waiting time on 5,5–28 minutes, the patients seen by doctors had a waiting time for 11,5–76 minutes. The LOS was also lower for the ones being seen by a nurse with 53,5–163,5 minutes compared to 100–274 minutes (Jennings et al, 2008).

An American study showed that a hospital decreased LOS and saved almost 9 million dollars in hospital charges by introducing specially trained nurses. In this study 100% agreed or strongly agreed that this group of nurses improved patients care overall (Collins et al, 2014).

Another study showed a median length of stay on 1,7 hours for patients managed by specially trained nurses compared to 2,7 hours for patients managed by junior doctors (Considine, Kropman and Stergiou, 2014). A similar result was found in a study from New Zealand where patients had to wait 40 minutes longer managed by an emergency doctor than if managed by a specially trained nurse (Colligan et al, 2011).

In a prospective study they looked at patients coming to an Emergency Department with minor illnesses and injuries. The majority of patients seen were triaged yellow, green or blue. For those managed by specially trained nurses the time to be seen was 38 minutes, while it was 53 minutes for those seen by other groups. The study concluded that advanced practice roles have reduced the waiting time, provided positive patient outcomes and increased the recognition of nursing expertise (Fry et al, 2011).

Despite being a general agreement that non-medical roles help to reduce waiting times in Emergency Departments and increase the level of patient satisfaction there still is a way to go when it comes to confidence and acceptance of these roles. Despite there has been reported a high level of patient satisfaction in the literature, a literature review from 2011 also noted that a small but significant percentage of the patients would not agree to be treated by a nurse (Hoskins, 2011).

3.7 Resistance and role confusion

The main reason for resistance among the physicians' are considered a potential overlap in the scope of practice and loss of activities, the degree of autonomy and independence of advanced practice nurses, concerns about legal liability in case of malpractice and a general concern about the skills and expertise of specially trained nurses (Delamarie and Lafortune, 2010).

Even if the specially trained nurses working in the Emergency Departments represent a highly skilled professional group their role is poorly understood by emergency doctors (Weiland, Mackinlay and Jelinek, 2010).

The fact that there are so many models for advanced practice nurses cause problems because it can be difficult to tell the different models apart. Only in England there are 4 models and two sub-models of advanced practice nurses:

1) Clinical Nurse Specialist
2) Nurse Practitioners, Emergency Nurse Practitioners and Advanced Nurse Practitioners
3) Nurse Consultants
4) Modern Matrons and Community Matrons

Since many of the titles do more or less the same job, the number of titles can be seen as confusing and make it difficult to explain what kind of responsibility the different titles have. The lack of clarity is by many considered the main problem (Delamarie and Lafortune, 2010, Weiland, Mackinlay and Jelinek, 2010, Griffin, 2006) (Also see chapter 2).

3.8 Other factors that influence the waiting time

Crowding is considered a world-wide problem. More than 90% of American hospitals have reported crowding in their Emergencies as a problem resulting in full occupancy of emergency beds and long waiting times with increased risk of poor outcome for the patients. The main challenges are space, staff and often huge variations in number of patients (Olshaker, 2009).

A waiting time for 6 hours or more have been associated with a higher risk of leaving without being seen. Studies also show an increased mortality for patients waiting for more than 8 hours for an inpatient bed (Bernstein et al, 2008). Preventable medical errors and patients returning to the Emergency Department are also results of crowding.

Tests have been done in England by modelling the Emergency Unit in a hospital not as it is, but as it could be as a “perfect world model”. To handle the high amounts of patients it was stipulated you needed a staff mix containing of 50% senior grade medical staff, 25% extended nurse practitioners and 25% middle and junior medical staff (Baboolal et al, 2012). Planning of Emergency service have so far focused on increasing trolley capacity and nursing staff, but the “perfect world model” suggest that the optimal solution would be to invest in further clinical decision makers to increase the flow of patients from the Emergency Department (Baboolal et al, 2012).

A study was done in the Netherlands where they compared the nurses’ perception of crowding with a measuring tool (NEDOCS). The result was that the tool showed crowding in 3% of the days, while the nurses perceived crowding and felt being rushed in 9% and the doctors’ in 11% of the days (Anneveld et al, 2013). This makes crowding a challenging problem because it’s hard to determine qualitatively, but still being perceived as a problem in 10% of the days. Another study from the same country showed that 68% of the nurse managers reported that crowding occurred several times a week or even daily (van der Linden et al, 2013).

For the literature found it’s important to mention that most of the studies have been performed by one profession, nurses, and that patient satisfaction does not necessarily say anything about the outcome of the treatment. No studies have been found that look at both patients satisfaction and treatment outcome.

4.0 RESEARCH METHODOLOGY

The aim of this study was to collect information about what measures nurses thought could be done to influence the waiting time for patients in their Emergency Departments.

The majority off the Emergency staff is nurses and they are the ones who see the patients first. Because of that the researcher wanted to talk to nurses working in Norwegian Emergency Departments and ask them how they thought a task shift would influence the patients' waiting time. At the same time the researcher wanted to talk to nurses who have been dealing with tasks shifts for a while, and representatives for this group of nurses was found in England.

After discussing the ide with the supervisor it was agreed that the best method for this study would be interviews. After looking at the options a qualitative method with one-to-one interviews were chosen to ask nurses in Norway and England how they perceived the organization of tasks between physicians and nurses influence the patients waiting time.

The use of method will in this chapter be described as transparent as possible without going on account of the participant's anonymity. The reader will be able to see the process of how the data were collected and analyzed which again will increase this studies credibility (Rubin and Rubin, 2005).

4.1 Qualitative method

A qualitative method is first and foremost a research method and a way of finding out what people do, know, think and feel by observing, interviewing or analyzing documents (Patton, 2011). The main strength of a qualitative study is its ability to study phenomena which are unavailable elsewhere (Silverman, 2006), and a qualitative health care study can identify health care problems not or poorly addressed (Denzin and Lincoln, 2011).

If you want to know what people think about a given subject, like for this study, qualitative method is the right approach, as a qualitative method gives the researcher information gathered by talking to people and see them behave within their contexts' (Rubin and Rubin, 2005, Patton, 2002). The researcher collects data in the field at the site where participants experience the issue or problem (Creswell, 2014, Malterud. 2013, Silverman, 2013, Denzin and Lincoln, 2011).

Qualitative researchers study participants' knowledge and practices, and it demonstrate a variety of perspectives. The researcher bring more or less open questions to the interview and hope that the interviewee will answer them freely (Flick, 2014) (appendix 13/14). The core characteristics that define qualitative research is that it's done in a natural setting, the researcher is a key instrument interviewing participants, the focus is the participants meanings, the process is emergent, the inquirer reflects about their role in the study and it has a holistic account (Creswell, 2014, Malterud, 2013).

Despite all the mentioned benefits of using a qualitative method it's also important to mention there is a widespread conviction that only quantitative data are ultimately valid and holding a high quality (Guba and Lincoln, 1994). Also for this study it can be asked if qualitative method was the right approach to collect data and get answers for the research questions.

The challenge by choosing a quantitative method for this study would be a possibility of context stripping, exclusion of meaning and purpose, inapplicability of general data to individual cases and exclusion of the discovery dimension in inquiry, all weaknesses in the qualitative method that have been subject for discussion over the last years (Guba and Lincoln, 1994). Since this study wanted the nurses' perception on given topics it was important to get as many considerations as possible, answers with meaning and purposes, not only listen to what the majority of the respondents had to say, and to open up for new topics during the interviews. Because of that a qualitative method was considered the best alternative for this study.

The term "qualitative" is an umbrella term superior to the term "paradigm" and ought to be reserved for a description of types of methods. Questions of method are by Guba and Lincoln seen as secondary to questions of paradigms, which are defined as the basic worldview that guides the researcher (1994).

4.2 Methodology

Methodology is the philosophy of methods (Jupp, 2006). It is described as the choices we make about cases to study, methods of data gathering and forms of data analysis in planning and executing a research study (Silverman, 2013). Methodology encompasses epistemology

and ontology where ontology is about what is true and epistemology is about methods to figuring out those truths (Jupp, 2006 Hirschheim et al, 1995, Lincoln and Guba, 1985).

"*Paradigms are Basic Belief Systems Based on Ontological, Epistemological and Methodological Assumptions.*" (Guba and Lincoln, 1994:107)

Ontological and epistemological questions concern what is referred to as a person's "worldview" defined as "*a comprehensive conception or apprehension of the world especially from a specific standpoint*" (Jupp, 2006:86). Inquiry paradigms are the basic worldview of the researcher and frame the course of both the research and its outcomes (Lincoln and Guba, 1985). The beliefs are basic in the sense they must be accepted simply on faith, and these basic beliefs can be summarized by the responses given by proponents of any given paradigm of three fundamental questions (Guba and Lincoln, 1994):

1) The ontological question:
   What's the form and nature of reality and what is there that can be known about it?
2) The epistemological question:
   What's the nature of the relationship between the knower or would-be knower and what can be known?
3) The methodological question:
   How can the inquirer go about finding out whatever he or she believes can be known? (Lincoln and Guba, 1994)

There are four paradigms to be used in qualitative inquiry: 1) Positivism, 2) Post positivism, 3) Critical theory, and 4) Constructivism (Guba and Lincoln, 1994):

Ontology is the study of being, and is important because whatever assumption you make affect how you approach science. If you are a realist you might think there is facts out there waiting to be discovered, and you might be comfortable with an experimental approach, while if you believe reality only exists through people's claims' you are a postmodernist and you might be comfortable with a discursive approach (Denzin and Lincoln, 2011, Jupp, 2006, Lincoln and Guba, 1985).

Epistemology is the study of knowledge, and is important because whatever assumption you make about what can be known, affects what you bother to try to find out scientifically. If you think you are helped by your senses to know the objective world you are considered an

empiricist, and might do experiments with sense date to gather knowledge. If your knowledge is constructed subjectively by people you might be a constructivist and might do discursive analysis (Hirschheim et al, 1995). Historically a central epistemological debate has been seen between empiricism and rationalism (Jupp, 2006).

For this study the researcher had a post positive approach which will be seen as: 1) Ontology: Critical realism, 2) Epistemology: Modified dualist/objectivist and, 3) Methodology: Modified experimental/manipulative (Guba and Lincoln, 1994).

Post positivism look at the aim of inquiry as explanation, it consider knowledge as non-falsified hypotheses that can be regarded as facts or laws, ethics is considered important and taken serious, the inquirer's voice is that of the disinterested scientist and knowledge seen as something that accumulates by a process where each fact serve as a building block (Guba and Lincoln, 1994).

This study's aim was to figure out what a group of individuals perceived of specific topics, and the topics were task shift and waiting time.

Methodologically the findings for this study are seen as a result of the interaction between the researcher and the participants. Even if the outcome should vary from similar studies it does not mean that the outcome of this study is incorrect (Lincoln and Guba, 1985).

Ontologically this means that the data in this study will be formed by the participants, and that the study will recognize the subjectivity of the data collected.

Epistemologically the researcher has chosen to believe that the findings in this study reflect the participants' opinion and should be regarded as subjective. The data found are dependent on their values and beliefs (Denzin and Lincoln, 2011, Guba and Lincoln, 1994).

4.3 Interviews

Qualitative researchers ask at least one central question and several sub questions and they pose broad to allow the participants to explain their ideas (Creswell, 2014, Malterud. 2013).

The interview guide is considered an important research instrument as a tool of data collection. There are five general considerations (Flick, 2014, Oppenheim, 2009):

1) The main type of data collection instrument: The type of data collection instrument was discussed. It was decided that interviews would give a higher response rate, a better chance of correcting misunderstandings, ask additional questions and collect more data.
2) The method of approach to respondents: The approaching was done by contacting the head of some Emergency Departments and asking them for help to distribute information about the study (see 4.4).
3) The build-up of questions: To get the participants to share their thought and ideas it was important to build the interview guide so it had some ice-breaking questions in the beginning. The pilot interviews showed this was a good way of getting the participant talking and it also made them reflect about their role which again made it easier to continue with the more specific questions.
4) The order of questions within each module: The thesis for this study could have been presented to the participants to answer, but instead it was decided to ask several questions to collect as much data as possible both about what the nurses thought about task shifts and their willingness to take on more responsibilities.
5) The type of questions to be used: There are three main types of research questions: Exploratory, Descriptive and Explanatory (Flick, 2014, Silverman, 2006). The questions used in this study are a combination. Open questions give freedom and spontaneity of the answers and are useful for testing hypotheses and where therefore used in this study (Oppenheim, 2009). No filter was used, and all the participants got the same main questions.

By using semi structured interviews the plan was not to tightly prescribed, and could be changed (Creswell, 2014, Silverman, 2013, Malterud, 2013). This was done under some interviews by asking additional questions.

4.4 Recruitment and data collection

A first contact letter (appendix 10) was sent to two hospitals in Norway and one in England. All three hospitals agreed to participate in the study, and written approvals were given in form of e-mails (Norway) and consent form (England).

The reason why two Norwegian hospitals were asked was because the average Norwegian Emergency Departments are smaller than the English both when it comes to number of patients and employees. Combined will the two Norwegian hospitals have approximately as many patients and employees as the one in England (N: Approximately 59.000 patients/year and 126 employees, and GB: Approximately 75.000 patients/year and 130 employees).

The researcher met the heads of the Emergency Departments and gave them information about the study (phone meeting for England). The heads informed their staff and handed out information to those interested. The information contained information sheet, consent form, interview guide and the approvals (appendixes 1, 4, 8, 10, 11, 12, 13, and 14).

The researcher was contacted by nurses from all three hospitals willing to participate. After the first 2–3 interviews the snowball effect was used, and the researcher accredited participants through recommendations from those already being interviewed. It was the participants who contacted their head of department or the researcher, and not vice versa.

The recruiting process in Norway took approximately two weeks, while it only took two days in England. Because of the access to experienced participants in England the researcher did two extra interviews there. By having data from as much as 22 interviews (10 Norwegian and 12 English) it was possible to reach saturation for several questions (Creswell, 2014).

All the participating hospitals offered their staff to do the interviews during their work hours, but prepared them they had to cancel the interviews if they were needed in the clinic. Four nurses' decided to have their interviews before or after work, while the rest was interviewed while at work.

Before each interview the researcher asked the participants if they had read the information and if they had any questions. The researcher went through the information sheet and the consent form and explained the possibility of withdrawing either during or after the interview without any given reason. They also received information about the recordings and for how long they would be saved, and they were informed about the studies approvals. Some of the participants had read the questions before the interview. Three brought notes.

Before the interview each participants received an interview number from 1 – 22 to keep them apart. With their number it was also noted what nursing education they had, sex and how long they had been working as a nurse. No other personal data was collected.

The notes from the interviews only contained the interview number. No personal information was recorded or noted. All recorded data was deleted immediately after the transcriptions were done, and all notes were maculated.

4.4.1 Inclusion criteria

Included were nurses working in the Emergency Department for at least three years and who covered all the different nursing positions in their department.

In Norway it was a goal to interview coordinating nurses since they are considered the most experienced nurses in Norwegian Emergency Departments. In England it was a goal to interview specially trained nurses since they are considered their most experienced nurses.

4.4.2 Exclusion criteria

Excluded were nurses working in other departments and nurses who had been working less than 3 years. Experienced nurses working only administrative were also excluded.

One interview was by mistake done with a nurse who only had been working in the Emergency for two years. This interview is not included in the study and the participant has received information about this.

4.5 Data analysis

The phenomenon for this study was to look at the subjective experiences of a specific group which is one of several aims to analyze qualitative data (Flick, 2014). This was done by one-to-one interviews with the participants.

When analyzing data it's important to avoid going native, avoid disclosing only positive results and respect the privacy of participants (Creswell, 2014, Malterud, 2013). These three rules were used by the researcher throughout the process. What's being presented is what was said, and all data are anonymized.

All interviews were recorded after approval from the participants (appendix 12). The researcher listened to the interviews and transcribed them. No data program or external help was used in the process. The Norwegian interviews were translated to English after being transcribed but before being analyzed.

By recording the participants were more exposed and subject to identification and misuse of the data by others (Flick, 2014). To avoid this no personal data were recorded and all the transcriptions were done the same day as the interview and deleted immediately after.

All the transcriptions were gone through several times without any pre-defined categories, and data was coded based on themes or key-words found in the transcriptions (Flick, 2014, Wallimann, 2011) (See table 11). The process was repeated several times to make sure all data were covered. Initially this process was done for one question at a time, but since the method is semi-structured it was also done as a whole to identify data covering more than one question.

After finishing the first step key-words were put into categories made for either topics or words that could answer the pre-defined questions (Flick, 2014, Malterud, 2013, Rubin and Rubin, 2005). The following questions were part of the interviews:

CODE	QUESTIONS
Q1 - A	How is the tasks organized between the nurses and the physicians in your Emergency Department?
Q1 -B	Are there any tasks being performed by the nurses that are not being formalized?
Q2	Are some of the physicians' and nurses' responsibilities overlapping?
Q3 - A	Is there any tasks being performed by the physicians today that after your opinion could as easily be taken over by an experienced nurse?
Q3 - B	Yes: Why?
Q4 - A	Would you be willing to take on more responsibilities than what you already have in your Emergency Department?
Q4 - B	Yes: Which responsibilities (and why)?
Q4 - C	Yes: Where would you set your limit in relation to take on new responsibilities (and why)?
Q4 - D	No: Why not?
Q4 - E	No: What factors should be present for you to consider taking on new responsibilities?
Q5	How do you believe the patients will look at the quality of treatment being performed by a nurse in an Emergency Department, and how do you think they would have looked at the quality of treatment if the same task was performed by a doctor?
Q6 - A	Do you believe that a task shift of tasks from doctors to nurses affects the patients waiting time?
Q6 - B	Yes: In what way?

Q7 - A	Are you aware of any tasks that were historically the responsibility of doctors and which are now the responsibility of nurses?
Q7 - B	Yes: What do you think about this change?
Q8	Are there any tasks that you are performing but that you think would be better left to the doctors?

Table 6 – Questions

Equal or similar answers were counted, and questions where more than half of the participants gave the same answer will be described as the majority.

4.6 Comparing data

England has been working with tasks shifts and trained their nurses to take over some of the physicians' responsibilities for many years. This development is according to the literature also about to spread to the rest of the world as it's expected that 70 countries within a few years will try to implement similar systems with extended nursing roles (Brusselkontoret, 2012, Fotheringham, Dickie and Cooper, 2011, Delamarie and Lafortune, 2010).

Because England already has a lot of experience with task shifts the idea was to compare the English nurses' thoughts and experience in the field with the Norwegian nurses perception of how a task shift could influence the organization of their Emergency Department.

To compare data you need to compare similar groups (Silverman, 2006). This was not the case for this study as the focus was to compare the findings from those who are familiar with task shifts (the English nurses) with those who still have not started (the Norwegian nurses). By asking the two groups the same questions it was possible to look at and compare answers based on what nurses thought would be possible with answers from nurses who had experienced task shift to find out what might be possible and where the challenges might be.

4.7 Reliability, validity and trustworthiness

Qualitative reliability refers to the degree of consistency with witch instances are assigned to the same category by different observers or by the same observer at different times (Silverman 2013, Silverman 2006). Reliability can be divided into: Quixotic (how far a particular method can consistently lead to the same measurement), Diachronic (the stability of

measurements or observations in their temporal course), or Synchronic (the constancy or consistency of results obtained at the same moment but by using different instruments) (Flick, 2014).

Qualitative validity is another word for truth (Silverman, 2013) and means that the researcher checks for the accuracy of the findings by employing certain procedures. This is based on determining whether the findings are accurate from the standpoint of the researcher, the participant, or the researcher of an account. It's recommended the researcher incorporates validity strategies into the proposal (Cresswell, 2014, Silverman, 2006). The question of validity boils down to a question of whether the researchers in fact see what they think they see. Three errors may occur: 1) To see relationships where there are none, 2) to reject them when they are indeed correct, or 3) to ask the wrong questions (Flick, 2014, Silverman, 2006).

It's debated if validity and reliability can be used in qualitative methods (Creswell, 2014). Some researchers argue that a concern for the reliability and validity of observations arises only within the qualitative research tradition (Silverman, 2013). Because of that the researcher has instead chosen to use trustworthiness for this study.

Trustworthiness is important for a qualitative research study to evaluate its worth. According to literature trustworthiness involves establishing (Lincoln & Guba, 1985):

1) Credibility (the confidence in the truth of the finding). For this study it can be said the credibility is good. 22 interviews were done in two countries, and saturation was reached in both countries for several questions. The study is a primary research, and all the findings are presented with quotations without any filtering. Both positive and negative findings are presented. A negative case analysis was done to make sure findings that appeared to contradict patterns or explanations that emerged from the data analysis were covered (Lincold & Guba, 1985). The researcher know the Emergency field well, and are very familiar with culture, social setting and phenomenon of interest, so it's possible to say the prolonged engagement is good. The data collection took several weeks to finish and the researcher spent a lot of time in the participating organizations. The triangulation is not equally good. No observations were done for this study. The only source of information is the data from the participants and the literature found about the topic.

2) Transferability (showing that the findings have applicability in other contexts). It's possible to say the transferability is good. Despite Norway and England have organized their tasks differently between the nurses and the physicians, their health care system is very similar. Their patients groups, their treatment lines, their priority of patients, many of the physicians' tasks and the nursing education are also quite similar. According to literature it should therefore be possible to organize the Norwegian Emergencies the same way as the English ones (Brusselkontoret, 2013).
3) Dependability (showing that the findings are consistent and could be repeated). Some of the questions asked received very clear answers from the participants in both countries, and they had a very good and thought through reason for answering as they did (question 1-6). Because of that it can be expected they would answer more or less the same if presented to the same question again either by the same researcher or someone else. Some of the other questions (question 7-8) most of the participants had not given to much thought and it is possible the results would have been different if they were asked the same questions again after having time to think about them. For dependability an external audit is recommended (Creswell, 2014, Lincoln & Guba 1985), but no external audit was done for this study except having all steps of the analysis overlooked by the supervisor.
4) Confirmability (a degree of neutrality or the extent of which the findings of a study are shaped by the respondents and not researcher bias, motivation or interest). During the interviews the researcher tried to let the participants talk about both the positive and less positive sides of tasks shifts, and both are presented. Still there is a chance the researchers' presence during the interviews might have worked as a bias if participants felt they were expected to give certain answers. The researcher have not found anything in the data indicating this, but there still is a chance the confirmability is not that strong (Denzin and Lincoln, 2011, Lincold & Guba, 1985).

The researcher have tried to make the process as transparent as possible all the way from the start of the project to the development and reporting of findings. The recruitment, all applications, permissions and written correspondence are attached to this study as appendixes (chapter 8) (Creswell, 2014, Lincoln & Guba 1985).

4.8 Ethics

In any qualitative study it's important to describe steps taken to gain entry to the setting and to secure permissions to study the participants or situation (Creswell, 2014, Malterud, 2013, Silverman, 2013, Denzin and Lincoln 2011, Silverman, 2006). Since this study was done both in Norway and England the researcher had to do apply in both countries to get necessary access.

Committee	Applied	Appendix	Approved	Appendix
Norsk Samfunnsvitenskapelig Datatjeneste (N)	15.05.2014	Online	24.06.2014	1
Research Committee Norwegian Hospital One (N)	17.05.2014	Online	28.05.2014	Online
Research Committee Norwegian Hospital Two (N)	17.05.2014	Online	05.08.2014	Online
Faculty of Health and Life Sciences Research Ethics Committee (GB)	29.07.2014	3	15.08.2014	4 and 5
Integrated Research Application System (IRAS) (GB)	02.09.2014	6	22.09.2014	7
Research Passport for access to NHS (GB)	01.09.2014	Online	22.09.2014	8
Criminal Convictions Declaration (GB)	15.09.2014	Online	22.09.2014	Online

Table 7 – Approvals for the study

In qualitative research the inquirer reflects about how their role in the study and their personal background, culture and experience hold a potential for shaping the interpretations (Creswell, 2014, Denzin and Lincoln, 2011). Rather than pretend the interviewer come into the situation with no biases and can listen to answers without sifting them through their own experiences and cultural lenses, the researcher instead need to continually examine their own understandings and reactions (Rubin and Rubin, 2005).

The researcher works as head of an Emergency Department. Part of the job is to look for alternative use of the work force to ensure patients treatment within a reasonable time and cost. It's also in the interest of the researcher to ensure the staff has challenging tasks to make them continue in their jobs.

A part of the Norwegian study was done in the researchers own organization. In literature this is referred to as "backyard research" and raise questions about the information collected will be accurate because of the imbalance of power between the inquirer and the participants (Creswell, 2014).

According to the supervisor the questions asked in this study could not put the participants in a good or bad light depending on their answers, and none of the questions were considered personal. The participants were also recruited without the researcher knowing who said yes or no to participate.

Retrospective the researcher see very few differences in the answers given by participants from the researchers own hospital and the hospitals where the researcher were unknown

The researcher have been aware that the background and interests might be seen as biases, but have tried very hard to focus on finding literature covering both positive and less positive sides of task shifts, and have also used answers and quotations from nurses representing different views. The researcher has used his supervisor to avoid producing a study that could be taken as a blueprint of the researchers' view of task shifts. The main goal has been to have a holistic account and try to develop a complex picture of the issue under study.

The researcher also has the responsibility to ensure honesty, integrity and respect for the participants (Creswell, 2014, Malterud, 2013, Denzin and Lincoln, 2011, Wisker, 2007).

The ethical safeguards aim to voluntarily participation, making comments confidential, protecting from harm and ensure mutual trust between the researcher and the participants. Central is the idea of informed consent (Silverman, 2013, Denzin and Lincoln, 2011).

This study was design to assure confidentiality for all the participants, and they all received easy accessible information (appendixes 10 and 11) which made them free to decide if they wanted to participate or not. None of the participants were at any time in a situation where they could be harmed physically, and they gave written consents before the interviews (appendix 12).

None of the participants were asked what they thought of the study, but several of the Norwegian participants brought it up on their own initiative.

This is what was said:

NN2: “This is a very big and exciting project.”

NN4: “I liked the questions. It actually made me reflect about my role as a nurse.”

NN8: “It was very good questions. Very good they were. I actually think I needed this.”

NN10: “It was good and challenging questions. It was exciting for me to talk about it. It made me reflect a lot about what I do.”

The fact that almost all the interviews were done during the participants work hours might be seen as an ethical issue. The deal was that the interviews had to be rescheduled if the participants were needed in the clinic, something that happened four times. These four interviews were done at a later time. No participants’ cancelled or used their right to withdraw either during or after the interview, and all participants answered all questions.

An important principle of research ethics is that the researcher must be able to justify why research about their issue is necessary at all (Flick, 2014, Wisker, 2007).

The researcher hope that the literature presented and the data found have managed to justify the importance of collecting data on how nurses perceive a task shift can influence the patients waiting time to be able to improve todays’ situation. Since it was important for the study to actually talk to the nurses to get their perception, the researcher can’t imagine any other way of collecting the data needed for this study than through qualitative interviews.

5.0 RESULTS

10 Norwegian and 12 English nurses participated in this study (appendix 13 and 14).

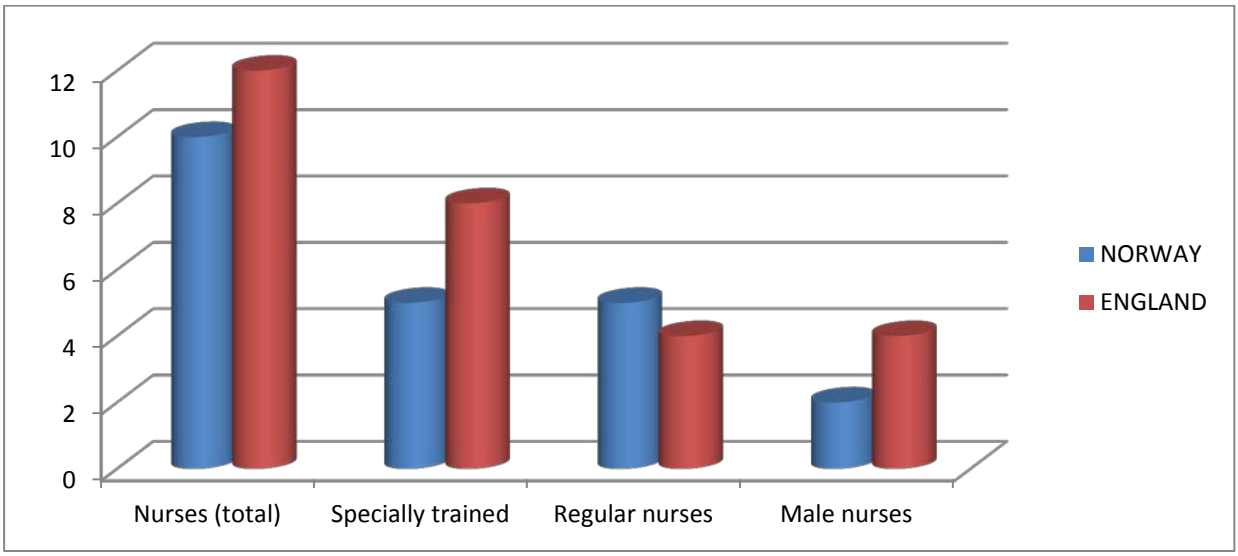

Table 8 – Participants

Norway: 4 of 10 nurses were specially trained nurses with minimum 1,5 years of additional nursing education. One of 10 was under specialization and 5 of 10 had a bachelor and minimum 3 years of experience from an Emergency. Two were males.

England: 7 of 12 nurses were Nurse Practitioners, one Advanced Nurse Practitioner and 4 of 12 had a basic nursing education with at least 3 years of experience from an Emergency Department. 4 were males.

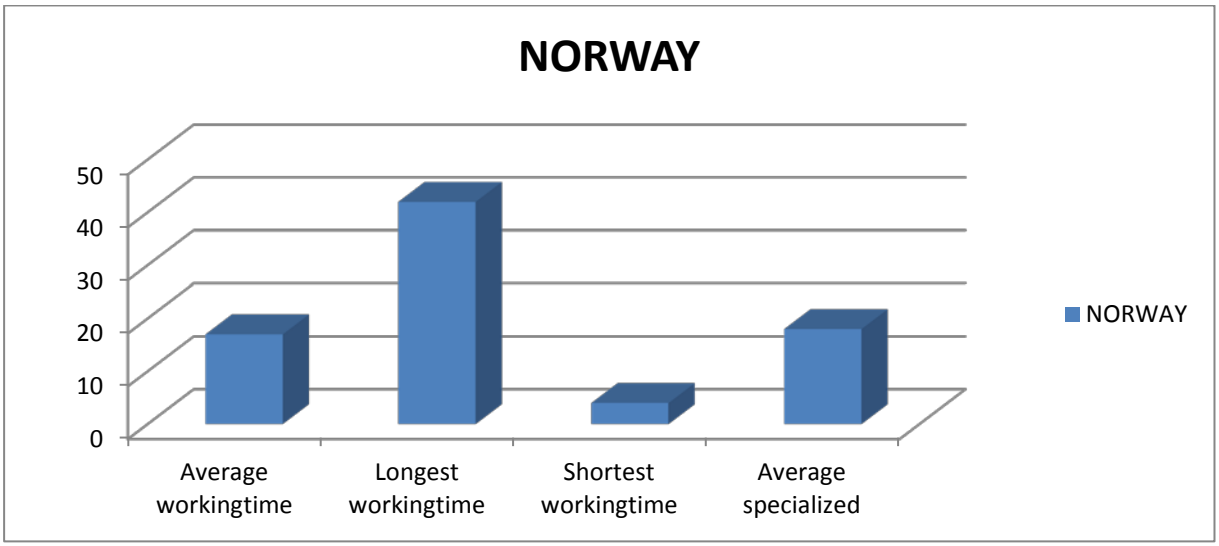

Table 9 - Number of year working.

In Norway the most experienced participant had been working for 42 years and the least for 4 years. The average number of year was 16 for non-specialized and 18 for specialized nurses.

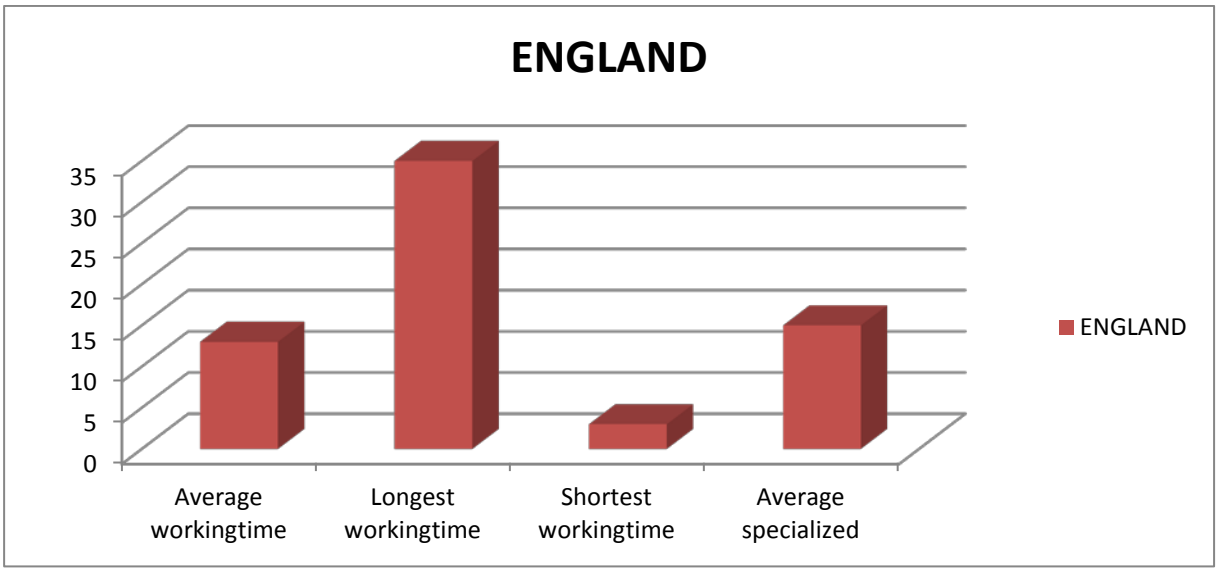

Table 10 - Number of year working.

In England the most experienced participant had been working for 35 years and the least experienced for 3 years. The average number of years was 13 for non-specialized and 15 for specialized nurses.

The findings from Norway and England are presented separately, starting with the Norwegian findings for each question. NN = Quotations from Norwegian nurses and GBN = quotations from English nurses.

Table 11 summons up the findings for all the questions asked. All questions in full version with reference to question number will be found in table number 6, chapter 4.5.

DATA ANALYZE		
Question	**Key subjects**	**Key words**
Q1 - A	Organization	Major side
	Triage	Minor side
	Assessment	Manchester Triage System
	Examination	Rapid Nurse Assessment
		High triage
		Low triage
		ECG

		Vital signs
		Taking history
		X-rays
		Blood samples
		Ultrasound
		Patients Group Directives
Q1 - B	Nurse Practitioner	All overlapping
	Independent descicion making	None overlapping
	Blurred boundaries	Arterial bloodgasses
	Misunderstandings	Historytaking
	Double work	Blood tests
		Diagnostics
		Male catheters
		Beta blockers
		Intravenous fluids
		Deep nasal tests
		Injuries
		Plastering
		Relocation of limbs
		Prescribing
		Confusion
Q2	Double documentation	Taking history
	Copying reports	Cannulations
	Nursing documentation	Arterial bloodgasses
	Increased responsibility	ECG
	Taking over doctors role	Deep nasal tests
		Prescribing
		X-rays
		Ultrasound
		Bloodsamples
		Discharging
		Information
		Social services
		Crowding
		Adequate documentation
Q3 - A + B	Potential task shifts	X-ray hips
	Experienced nurses in front	X-ray limbs
	Benefits of extended nursing role	X-ray chest
	Challenges by taking over tasks	Ultrasound
	Unclear nursing role	Medical treatment
		Plastering
		Wounds
		Relocate limbs
		Information

		Discharging
		Sick notes
		Experience
		Neubulizer
		Loss of skills
		Justify practice
		Referrals
Q4 - A	Wold like more responsibility	Yes
	Would not like more responsibility	No
Q4 - B	Creating a more interesting job	Challenges
		Patient Group Directives
		Traditional tasks
Q4 - C	Limit for new responsibilities	Increased preassure
	Removing existing tasks	Fast development
Q4 - D	Working outside the protocol	Safety net
Q4 - E	Legal limitations	Legal issues
		Contract
		Support
Q5	Equally good treatment	Proper treatment
	Difficult to tell the professions apart	Skills
	Closer to the patients	Quality
	Sceptical patients	Education
	Less contact people	Experience
		Holistic care
		Treatment
		Information
		Expectations
		Traditions
		Scepticism
Q6 - A	Positive influence	Yes
	Negative influence	No
Q6 - B	Physicians better prepeared	X-rays
	Faster acess to treatment	Blood tests
	Faster to give diagnoses	Cannulations
	Long waiting time	Arterial bloodgasses
	Role confusion	Ultrasound
	No place to send the patients	Deep nasal tests
		Cleaning wounds
		Stiching wounds
		Plastering
		Changing catheters
		Information
		Discharging

		Crowding
		Collaboration
		Wards
Q7 - A + B	All tasks originally doctors tasks	Arterial bloodgasses
	Becoming mini-doctors	ECG
	Fast development	Administrating medicines
	Increased responsibility	Intravenous treatment
	Nurse Practitioners responsibilities	Catheter for men
	Positive development	BIPAP
		Positive changes
		Challenges
		Patient Group Directives
Q8	Nothing the doctors can do better	Education
	Ambivalence	Skills
	Not willing to give back tasks	Faster treatment
	Practicing within our scope	Discharging
	Helping the doctors	Limits
		Scope of practice

Table 11 – Terms and words found for the data analyze

5.1 Organization and not formalised tasks

Question one served three purposes: 1) An ice breaking question, 2) to reveal differences between the three participating hospitals, and 3) to collect data of responsibilities not formalised.

The Norwegian and English nurses answered this question differently, while the Norwegian nurses had quite similar answers.

Nurses from both hospitals in Norway told they are organised more or less the same way where all patients come to the same Emergency Department independently of how severe their situation is. The most severe cases come straight by ambulance while other patients often are sent from general practitioners or other health care services like nursing homes. Very few patients come without any referrals.

The patients are first seen by a triage nurse who provides them with a triage-code based on MTS. The triage-code gives the patient a priority and an estimated waiting time for examination (see 1.3.6). Patients with triage red goes straight to the Resuscitation/Emergency room where they are received by a team of doctors and nurses, while patients with triage orange will usually be received by the most experienced nurses on duty.

A nurse will later access the patient and take a brief history, ECG, measure and observe vital sign, offer them a bed, do cannulation for patients in need of intravenous treatment and order blood tests. If they expect the patients to be admitted they will also change the patient and inform their relatives. After the patients' have been seen by a nurse the doctors will access the patients and ask for a full history, go through the nurses' observations of vital signs and request further blood tests, x-rays or ultrasound if needed. It was also mentioned that the nurses and the doctors seldom access the patients together except for triage red.

When it came to what tasks not being formalized, all Norwegian nurses mentioned taking arterial blood gasses. It's considered a doctors' task but usually performed by a nurse.

NN5: *"Instead of letting the doctors spend a lot of time taking blood gasses, something they seldom do, I rather have him listening to the lungs or do other kinds of examinations."*

Other tasks mentioned as not formalised was starting intravenous fluid therapy, ordering blood tests, managing beta blockers, male catheters and some diagnostics. Half of the nurses said they sometimes started treatment before the doctors saw the patient, either based on their own judgement or after calling a doctor to get their approval.

NN1: *"We are not supposed to diagnose the patient, but we do. The other day I had a patient who was reported as a pulmonary embolism and I asked for the symptoms. The doctor answered, and I said: "It can't be pulmonary embolism based on those signs. It must be pneumonia." And it was. We keep diagnosing the patients all the time."*

Three of the Norwegian nurses said they do deep nasal samples despite this is a doctors' task, and the majority start oxygen treatment without consulting the doctor. The more experienced the more they seemed to be doing on their own.

NN10: *"When I have the role as coordinator I make a lot of decisions about the patients, and I often think I should have consulted a doctor."*

The British nurses told that all the Emergencies in England are divided into a Minor and Major side. Minor side cover minor injuries and diseases and have a lot of walk-in-patients, while Major side have traumas and more serious cases usually delivered by an ambulance. The organizations of the nurses vary with more independent nursing tasks on Minor side.

Also in England the patients are first seen by a nurse who access the patients and decide if the problem is something they need to attend to immediately or if it can wait. They told they have stopped using MTS, but have instead a rapid nurse assessment where they take a history, measure vital signs, take blood samples and order blood tests, request x-rays, do cannulations and start medications after Patient Group Directives (PGD). The nurses can also request ultrasound for suspected DVT's and treat soars by cleaning and stitching wounds etc.

If the patients are seen by a specially trained nurse they have the same authority as a junior doctor and can both see, treat, prescribe and discharge patients on Minor side. These nurses also work as mentors for the regular nurses and the junior doctors.

GBN13: *"As a whole our job as Nurse Practitioners used to be the doctors, but we do it different than they do. Our service is more health care promotion oriented. We have more focus on avoiding further problems and complications."*

GBN15: *"A lot of our doctors have very little experience in handling injuries. Sometimes the Nurse Practitioners ask the doctors for advice but more often we see junior doctors ask the Nurse Practitioners for advice."*

The Major side is organized a bit different. They also have specially trained nurses, but their tasks are still limited compared to the ones on Minor side. The nurses on Major side can't discharge the patients, but they can refer them to a specialist.

When it comes to formalized tasks some English nurses believe all their tasks are formalized, while others believe a lot of the tasks are being done as an extra service to the doctors without being formalized. It was especially the tasks being performed by both specially trained nurses and doctors that were seen as blurred and not formalized by some nurses.

GBN14: *"We have been trained in everything we do, so in a sense it's all formalized."*

GBN22: *"It's an awful lot not being formalized"*.

According to the nurses it's a difference between Minor and Major side when it comes to what's considered formalized. While a lot of the tasks on Minor side have been formalized, less has so far been formalized on Major side.

5.2 Overlapping responsibilities

The aim of question two was to gather information about tasks being performed both by the nurses and the doctors, and to figure out if any double work was performed.

The majority of the Norwegian nurses mentioned taking history and asking about pain, weight, height, family relations, living conditions, allergies, and when they last ate as overlapping as the doctors' ask the same.

NN4: *"I would have gone mad if someone asked me for my weight and my height for the third time. It seems quite unprofessional."*

Hands-on tasks like measuring vital signs, cannulations and ECG is considered nursing tasks and done by nurses only, while examinations, prescribing, requesting x-rays, some documentation and discharging was mentioned as tasks done by the doctors.

NN1: *"It's very little the doctors do with the patients physically except shaking their hand."*

The only two overlapping hands-on tasks' mentioned was taking arterial blood gasses and deep nasal tests. In hospital one most of the blood gasses were done by the nurses while the deep nasal test was done by the doctors, while it was the other way around for hospital two.

It was also mentioned by the majority that the doctors and the nurses often document the same things and both are giving information to the patients and their relatives. Some nurses told

that the doctors and the nurses borrow from each other reports by copying the other professions documentation into their own. When asked if they thought only one profession should be responsible for the documentation, and if so, who they thought it should be the answers varied. Some thought it should be done by the doctors, some thought it should be done by the nurses, some thought it should be done by both (as today), and some thought more information in general should be documented at the wards and less in the Emergency.

The importance of good nursing documentation came up in three interviews, and one nurse explained why she thought this so important.

NN9: *"We had a case were a nurse was kicked down by a patient before he tried to strangle her. He was not convicted because someone wrote in his journal that they thought he was psychotic. You can't convict someone who is psychotic. You must know what you are documenting, and you must be responsible for your own documentation. You can't leave it to others."*

The British nurses answered this question different than the Norwegian nurses and the answers depended on the nurses' position in the Emergency department.

Those who worked as specially trained nurses could tell that all their tasks were overlapping as both they and the doctors do examinations, treatment and discharging.

GBN20: *"Non-medical prescribing is a very good example of that where the responsibility is overlapping and nurses are taking on more and more responsibility."*

Some doctors in the British Emergency Departments are still requesting x-rays, but the nurses are taking over more and more of this task.

GBN17: *"We are taking over the doctors' role of requesting x-rays, but we have not taken over their knowledge to interpret them."*

Social services' was also mentioned as overlapping. Generally the nurses' sort this out, but sometimes the doctors do it as well.

Arterial blood gasses, cannulations and taking blood samples were mentioned by the majority of the British nurses as overlapping. It's considered a doctors' task, but mostly performed by a nurse. Only nurses with long experience take arterial blood gasses, while doctors only do cannulations and take blood samples if it's busy in the department. The fact that some tasks are performed prior to availability and the individuals perception of how hectic it is in the ER sometimes made it a bit blurred who did what and at what times.

GBN15: *"There are some blurred boundaries in Minor. In Major it's a bit clearer. There are still some doctors who find it hard that some nurses are seeing patients in Major. It's like it's their territory. We experienced the same in Minor 20 years ago. It's all about being secure about the others professions skills."*

For both countries it seemed like the nurses thought some of the double work happened when it was crowded in the department, and very often it happened because the nurses and doctors tried to help each other by doing the other professions tasks but failed to communicate this to the right people. Especially the British nurses mentioned this as one reason why they often felt they got less done when it was hectic, often despite being more people at work.

5.3 Tasks that could have been transferred

Question three was asked to see if the nurses could think of any tasks they could take over from the doctors without compromising the quality.

The Norwegian nurses suggestions for potential tasks to be taken over from the doctors were requesting x-rays, requesting ultrasound, starting standard medical treatment for some minor diseases, plastering stable fractures, cleaning and stitching wounds, relocate shoulders, deep nasal tests and give more information before discharging patients. Extended responsibilities as pain relief with intravenous opioids were also mentioned by several of the more experienced participants.

NN3: *"When I worked in Australia we had a good number of tasks we don't have here. We plastered and dressed, and we did it just as well as the doctors."*

NN10: *"The doctors look in their method book and follow some indications about the need for ultrasound. The patients often wait for 3 – 4 hours for something we could have done much faster. It's not exactly rocket science we are talking about here."*

One task that stood out by being mentioned by almost every nurse was requesting x-ray of limbs, hips and chest as tasks they could take over from the doctors to save time.

NN4: *"If the patient is coming with a suspected pneumonia they always do an x-ray. It can take the doctor an hour to see the patient and request an x-ray we all know will be requested. If we did it we would have saved time."*

Two nurses suggested writing sick notes for some patients and prescriptions for some painkillers as tasks that could be handed over to the nurses. They could see it as tasks that potentially would save time but at the same time they were a bit sceptical about taking on the responsibility as they were afraid of too much secretary work.

NN7: *"I want to spend time with my patients, and not with my papers."*

Two nurses made it clear they thought some of the tasks should remain a doctors'. They considered some of the tasks performed in an Emergency Department as so important that they should be left to someone who were trained to do examinations through their education.

All the Norwegian nurses mentioned the importance of having experienced staff, and half of them said that nurses who's only been working for a year or two should not be allowed to work in an Emergency Department.

The British nurses answered this question differently. The main reason was according to themselves' that they already have taken over many of the doctors' tasks. Especially the specially trained nurses are now doing more or less the same as the junior doctors.

GBN16: *"The next step for us is to give diagnoses, and I believe you need more than just experience to do that."*

Of the very few tasks mentioned as possible to take over were arterial blood gasses. This is mainly being done by the doctors in England. Two nurses also mentioned prescribing and starting treatment with nebulizer.

GBN19: *"It would be good if we could prescribe nebulizer. It's a bit strange that you can start non-invasive treatment for COPD-patients with CPAP and BIPAP, but we can't give nebulizer."*

Unlike the Norwegians the English nurses saw many challenges by taking over to much responsibility from the doctors. Some of them were afraid it would take focus away from the nursing part of their role. They were afraid that skills would get lost on the way, and mentioned typical nursing skills like undressing the patients and observe their skin, help them to get something to drink, find a good position for them in bed and do prophylactic bed soars procedures as skills they were afraid would not be prioritized if the nurses were busy with other tasks.

GBN22: *As long as you can justify your practice it's ok. Nurses are often more careful because it's an extended role and they will be careful not to do something wrong."*

Some also thought the nurses are doing too much of the doctors' tasks already. Two of them mentioned the fact that in some places the nurses now do very advanced tasks like chest drain, and they were afraid the nurses would forget their role and turn into mini-doctors.

At the same time the majority of the nurses saw the positive effects of transferring some of the tasks from the doctors to the nurses, and especially requesting x-rays was mentioned by almost every English nurse as a task that have saved the patients unnecessary waiting time.

GBN18: *"If a patient is coming with breathing problems and a history of COPD or infections 99,9 % of the doctors will request an x-ray, so why wait for the doctor to decide that? All you do is getting the pictures sooner so the doctor can diagnose the patient. It speeds up everything."*

Referrals were also mentioned by one British nurse as a task that could be taken over by the nurses, and probably be done equally well by a nurse as by a doctor.

GBN20: *"There is no reason why a nurse could not give a proper referral. As long as you are aware of the red lights and the nurses have proper training its safe."*

5.4 Willingness for extended responsibility

This question was one of very few closed question. Depending on the answer it was followed up by asking the yes-group where they would set their limit, while the no-group was asked what were needed to be done for them to change their minds. For this question it was also interesting to see the different responses from the Norwegian and English nurses since the English nurses already have taken over many tasks.

For Norway 8 of 10 nurses agreed without hesitation they would be willing to take on more responsibilities. Two were a bit hesitant, but no one said no.

NN3: *"Yes, I would for sure. It's boring to go to work without challenging yourself."*

Two of the nurses who said yes were a bit afraid of what the amount of extra work would lead to. It was mentioned by one of them that they do a lot of work other professions could have taken over like making beds and cleaning and refilling equipment. If that was removed as their responsibility it would free time to take on new and more exciting tasks.

NN5: *"It's interesting to expand the role, but we have a limit for how much we can take on."*

When asked where they would set the limit for new responsibilities the nurses had different approaches, but the majority mentioned more education, training and management as key factors. No one had any limits for what kind of tasks they could take on as long as these areas were covered, but some of them had concrete suggestions.

NN8: *"I would like some treatment packets with pre-approved treatment methods and medicines to choose from. Then I could be responsible for starting the treatment."*

The British nurses were more sceptical about taking on new responsibilities, not because they did not want to, but because they felt they already have taken on a lot. The lack of time combined with increased pressure on their nursing role was their main issue.

One of the most experienced nurses mentioned that it is difficult to see any places where the nurses can expand their role further as they already have taken over quite a lot of the physicians' responsibilities.

GBN13: *"The development has gone so fast. Today I treated a dislocated elbow. A few years ago we were not allowed to give intravenous medication."*

When asked what had to be changed for them to consider taking on new responsibilities they mentioned more staff, better training and to give up some of the tasks they have today.

Three of the British nurses thought it would be interesting to take on new responsibilities despite being quite busy in their roles, but they thought it was important that this was done only for those who want to.

GBN14: *"I would love to. The limit will be the level of my knowledge and my skills. I would not do something I could not handle and fix if I failed."*

Where the British nurses would set their limit was closely connected to the support they had in their contract and from the management. As long as they felt they were supported by their contract and had a safety net they would consider taking on more responsibility. No one would take on more responsibility if they were not supported.

Some of the nurses mentioned it was a challenge to try to build safety nets. Earlier they had tried by making protocols, but this was never a success.

GBN21: *"It's very difficult to set limits. When we started we wrote a lot of protocols for what to do and not to do, but it did not work. Many nurses already worked outside the protocol. As long as you have the competence I see no reason not to extend your tasks and responsibilities."*

5.5 Quality of nurses treatment

This question was asked to get the nurses perception on the quality of treatment they provide. It's essential for the patients that a decreased waiting time not also lead to a decreased quality of treatment.

In general the Norwegians answered they did not think it would make any difference in quality of treatment if a nurse or a doctor performed a task as long as they were properly trained. According to the nurses very few patients care if a nurse or a doctor take a blood gas or do a cannulation as long as they know what they are doing. They all believe their patients should receive optimal treatment regardless of who provides it.

NN2: *"I believe it would not matter if it was a nurse or a doctor who requested the radiology as long as it went faster. For example: Today we already do all the measures and examinations for the DVT-patients except ordering ultrasound. I don't think the patients would look at the quality as any less if we did that too."*

Some Norwegian nurses thought the idea of being treated by a nurse might be new to many patients but that this probably would change over time.

NN7: *"Some say we are at least as good as the doctors, but some patients only want to talk to the physicians'. If we told the patients it is our responsibility they would probably change their mind."*

Skill-wise communication was mentioned by several nurses as a skill they believe they handle better than the doctors. They said the doctors never can manage to get the same contact with the patients because they have too many patients to see. The nurses stay with the patients as long as they are in the Emergency and will be able to provide them with the information needed. The nurses mentioned the importance of taking some extra minutes to make the patients feel safe, something the doctors seldom have time for.

Almost all the English nurses said it would not matter if the patient were treated by a nurse or a doctor, and only one of them had a negative personal experience where a patient had said no to receive treatment from a nurse, but all of them had heard of examples.

Three of them said they did not know if the patients realised who they were looked after by since the doctors and nurses often perform the same tasks. 9 of them meant nurses in general have a more holistic approach as they offer both treatment and care and have focus on accessible information to the patients. Two of them also referred to articles they had read where the conclusion was better outcome for the nurses because of their focus on holistic approach.

GBN21: *"Most of the patients don't want to wait too long to be seen and they are eager to get in and out as fast as possible. Most of them are quite happy to be seen by a nurse. We often have better time and a more holistic approach."*

GBN22: *"Nurses in advanced roles are quite specialized so they most probably do a better job than the doctors in their areas. An advanced practitioner in any field will know a lot more than the doctor. I also believe that if a nurse got it wrong it would probably cause more problems than if a doctor got it wrong."*

Two of the English nurses said they thought the quality of treatment would be equally good, but that it could be a problem for the older patients.

GBN20: *"The older they are the more traditional they often are. They are not used to the nurses' new roles. Since they come to a hospital they perceive they are more ill, so they want to see a doctor. I always present myself and tell the patient that I will see them today instead of a doctor. Then I ask if that's ok. No one said no so far."*

5.6 Task shifts and waiting time

This is the main question in the study. The question is closed, so all the respondents had to explain why they either answered it by yes or no.

All the Norwegian nurses believed the waiting time would decrease by transferring tasks from the physicians to the nurses. Half of the nurses said that some of the tasks they have today must be transferred to other professions to free time for them to take on these tasks.

NN3: *"If we do something the patients now are waiting for it will of course have something to say for the waiting time."*

This question lead to a lot of discussion about waiting time in general, and several nurses pointed out how a long waiting time affects the whole department. The nurses' described shifts where patients' turn negative because of waiting and affected other patients. This often creates a situation where the patients start complaining and the nurses ended up spending more time answering questions about waiting time than to actually see patients. Shifts like these were described as the worst shifts thinkable for both the patients and themselves.

The Norwegian nurses mentioned many specific tasks the patients often had to wait for, and very often it was minor things that could have been handled faster.

NN8: *"I had a patient who waited for 7 hours to change a catheter. She was in a wheelchair running back and forth asking about when she would be seen. She became a disturbing element for both the staff and the other patients. The best thing would have been to just change it and send her home."*

Many of the Norwegian nurses had suggestions for what tasks could be transferred to the nurses to decrease the waiting time. Requesting x-rays was number one followed by tasks like requesting ultrasound, deep nasal tests, cleaning and closing wounds, plastering, changing catheters, pain relief and to give information before discharging patients.

One nurse described plastering as a task that nurses can take over to save time.

NN7: *"We have a situation today where the orthopedic surgeons are busy most of the day. If we could have plastered the patients and sent them to a control x-ray we would have saved time. Some days we have up to 70 of these patients. Can you imagine the amount of time we could have saved?"*

Another challenge brought up was that many nurses know very little about the doctors' work, and this was considered creating misunderstanding between the professions.

NN10: *"If I receive a patient it might only take me 15 minutes extra to figure out if the patient might have a DVT and need an ultrasound. I see patients like that waiting for hours for the doctors to do the same without finding a good reason why it takes so long. Most of the patients are only waiting for the doctors to do their investigation or discharge them."*

All the British nurses also perceived that a task shift had lead to a faster way for the patients through their department, but some of them also mentioned other factors they saw as essential for the waiting time. Crowding have become an increasing problem in England, and the reason for this was by the participating nurses described as lack of space and staff.

GBN15: *"You can't speed the flow if it's no place for them to go."*

The 4-hour target was also mentioned by several nurses as a target that had contributed to a positive development when it came to waiting time. It was said that before this target was introduced it was not uncommon that some patients had to wait for as much as 12 hours.

Many of the British nurses' pointed out the importance of having the test results and pictures ready before the patients were seen by a doctor so they could give diagnoses, start treatment and discharge the patients earlier. It was said by some that they had experienced that by waiting for a doctor to do a task it could delay the waiting time with up to two and a half hour.

GBN13: *"Yes, it minimize the waiting time. Requesting x-rays and blood tests have done the patients way through the Emergency Department much quicker."*

Other factors' mentioned was the importance of a good collaboration with the wards and enough beds or chairs for the patients.

GBN21: *"These days we are trying to use more chairs than beds. As soon as the patients have been dressed in hospital clothes and put in a bed they become a patient and they can hardly have a glass of water without help. That takes a lot of resources."*

It was mentioned by several of the participants that if the nurses are not properly trained in requesting x-rays and blood tests, wrong requests can lead to an increased stay and have the opposite effect.

5.7 Historically changes

This question was asked to make the nurses think about tasks they perform today that was not originally their responsibility and to make them reflect over their professions development.

Almost all the Norwegian nurses mentioned tasks like starting intravenous treatment with fluids, arterial blood gasses, ECG, catheter for men and administrating medicines as tasks that were previously done by doctors. Several answered that more or less every task they do was originally the physicians' tasks except changing bed linen.

NN10: *"I doubt the nurses were previously running the BIPAP-machine."*

Despite all the nurses said it had to be a lot of tasks they were performing today that originally were the tasks of the doctors' only the five mentioned above came up as examples.

NN4: *"It is more profitable to give the nurses more tasks than to hire more doctors. Eventually you stop thinking about what was originally a nursing task. The older doctors talk about the nurses as someone who have become more like mini-doctors. They have witnessed the development."*

All the Norwegians thought the change was positive because by increasing the number of advanced tasks they also thought the nursing profession gained more respect.

As concrete examples the English nurses mentioned taking blood tests, cannulations, requesting x-rays, administrate intravenous medication and start treatment for some patients.

GBN11: *"Today, by the time the doctors' see the patients we have already started the treatment."*

The majority of the British nurses said they can't imagine going back to a time when nurses did not do cannulations or gave intravenous medication. Several also mentioned the importance of implementing Patient Group Directives (PGD) that allows some specially trained nurses to start medical treatment.

GBN16: *"I once had an old lady as my patient. She used to be a nurse. I was assisting the doctor while he dressed her wounds. When he was finished I left him to clean up so I could attend to other tasks. The old lady called me back. She told me she was shocked that I did not clean up after the doctor. It was my responsibility as a nurse. Well, it's not like that anymore. She could not believe I left a doctor to clean up. I could not believe she suggested I should."*

Half of the British nurses said that even if they perform tasks that historically were the responsibility of the doctors they do not consider them their responsibility. They think of it as an extra service to the doctors to help reducing the patients waiting time.

GBN20: *"You must remember that only a few years back the doctors would give all the intravenous medicines. If you asked a doctor to do that today they would just look at you. If the tasks' does not excite them anymore they are more than willing to pass them on to someone else."*

None of the British nurses mentioned any specific tasks they wanted removed.

5.8 Returning tasks to the doctors

All questions have been about tasks nurses can take over from the doctors, while question eight ask if the nurses believe any of the tasks they do could be done better by a doctor.

The Norwegian nurses answered this question with a clear no, but 3 of them were a little hesitant. Again it was a question of having tasks removed to free time to work on other tasks.

NN5: *"I feel a little ambivalent to this. I will not lose any of my tasks. It would be inefficient. It is already part of my working routine. As a male nurse it gives more pride to know that I can do more than holding hands or washing the patients' asses."*

None of the participants being hesitant wanted to give back any of their tasks to the physicians', but they were interested in transferring some of their tasks to other professions.

All the English nurses also answered no to this question and several of them explained why.

GBN13: *"No, we all practice within our own scope. The patients want someone who knows what they are doing, and I don't think it matters if it's a doctor or a nurse. We don't take on anything we don't master. I am already a nurse-doctor. If we go 50 years back and told people what nurses do today they would probably have laughed in your face."*

Among the British nurses it was mentioned that some of the tasks they perform today are tasks they take on to help the doctors. They have not been formalized, and it varies from person to person and situation to situation if they are being done or not. One example mentioned was that nurses sometimes do the discharge summary for the doctors' to get the patients discharged faster. This is a doctors' task. If nurses take on tasks like this they can end up working outside their scope of practice, and that can end up causing problems both for them and the patients they treat told one nurse.

In general all the English nurses had a very strong belief in their skills, and they all mentioned the importance of knowing your limits and work within your scope of practice.

GBN21: *"If I need a doctor I will go and seek that help. There is nothing I do that I think I should not do or a doctor would do better."*

6.0 DISCUSSION

In this chapter the findings have been divided into 7 categories and discusses by comparing them to the available literature presented in chapter 3.0.

6.1 Tasks not formalized

The Norwegian nurses gave clear answers on what tasks they perform today not being formalized. All mentioned arterial blood gasses, and many mentioned starting intravenous fluid therapy, ordering blood tests, managing beta blockers, male catheters and some diagnostics. Most of the participants thought of some of these tasks as semi-formalized, while other tasks were performed despite knowing they were not supposed to. Tasks like starting different kinds of medical treatment, diagnose patients and take deep nasal tests were mentioned as examples for the last category. It was mostly the nurses' with long experience that sometimes performed tasks or made decisions they knew they were not authorized for.

Half the English nurses answered they thought all their tasks were formalized, while the other half told that almost none of their tasks were formalized. Blurred boundaries between the specially trained nurses and the junior doctor were mentioned as one reason why it was difficult to tell what profession is responsible for some of the tasks the nurses perform today. The problem was brought up by the specially trained nurses in the participating hospital.

According to literature some physicians are worried about the legal liability for task shifts in case of malpractice (Delamarie and Lafortune, 2010). Many physicians are also skeptical about the skills and experience among some of the nurses who have taken over their former tasks (Weiland, Mackinlay and Jelinek, 2010, Griffin, 2006). Blurred boundaries between what's formalized and not formalized can create problems for the physicians if the treatment goes wrong, and it can be hard to know where to place the responsibility.

Some Norwegian nurses admitted they knew they sometimes went outside their authority by performing certain tasks, while the English nurses answered they tried not to do anything that were not supported by their contract. Despite this it was mentioned by a English nurse that some tasks are being performed outside their contracts as many nurses work outside the protocol. This statement might indicate a gap between what tasks actually being performed by the nurses and what tasks have been formalized for them to perform.

What was seen by comparing the two participating groups was that both some Norwegian and English nurses thought some of their tasks were not formalized and that they sometimes performed extra tasks or tasks they knew they were not authorized for.

Many nurses told they contributed a little extra if they felt they could handle the task and that their contribution would lead to the patient being seen or treated faster. Since the two groups have a different set of responsibilities in the first place, this might indicate that even after task shifts some nurses will continue to take on extra responsibilities if they feel it will benefit their patients.

It's important to mention that performing not formalized tasks is not the same as working outside their scope of practice. Almost every participant said they would never perform a task they did not feel comfortable with, and they all knew what they could handle themselves and when they needed assistance from a doctor. The problem is that blurred boundaries have shown to create conflicts between the two professions (Weiland, Mackinlay and Jelinek, 2010, Delamarie and Lafortune, 2010, Griffin, 2006).

6.2 Overlapping tasks and role confusion

The Norwegian nurses told that taking history, documentation and information to the patients' were tasks both professions did and therefore were considered overlapping, while hands-on tasks seldom were overlapping. Especially when it comes to documentation there is a lot of double work going on. Today part of the documentation is done by both professions, and doctors and nurses sometimes copy parts of each other documentation.

Nurses receive good feedback for their communication skills, and they are expected to communicate effectively with patients with complex needs (Burley, 2011 and Berry, 2010). Nurses have been considered better than the physicians at documenting, follow protocols and provide health care or discharge information (Sandhu et al, 2009 and Carter and Chochinow, 2007). Despite this giving information and documentation are still performed by both professions. If it's possible to transfer this responsibility to only one profession is debatable as the two professions have different focuses, but it should be possible for them to work on a common documentation to increase the quality and save time.

It must be mentioned that the interviewed nurses were skeptical about this task shift as it will give them less time in the clinic. If nurses are to take on this responsibility the systems must be made easier with more standardized documentation and access to documentation tools.

In England the specially trained nurses answered that all their tasks were considered overlapping as they and the junior doctors perform the same tasks. They also said double work often takes place when it's hectic in the department as an attempt to help each other. This can be seen as a challenge for those being responsible for the department because it can be hard to know if the tasks are performed by a nurse or a doctor or neither of them. If the tasks are being performed by both professions it can easily lead to delays for the patients and create misunderstandings between the two professions as they both are documenting.

England has had task shifts for almost 50 years, but despite this there is still resistance against this change. Some of the resistance is from nurses, some from patients, but most of it is coming from the doctors (Fotheringham, Dickie and Cooper, 2011, Delamarie and Lafortune, 2010).

Some of this resistance was explained by the English nurses as lack of knowledge about the other professions expertise and skills. It was mentioned that none of the basic education is shared between nurses and doctors, so nurses and doctors know very little about each other competence when they finish their education. One nurse told she had her education from a country where the two professions did their first year together before they split, and meant this had helped to create respect and understanding between the two professions.

Some Norwegian nurses had similar thought when they told they sometimes find it hard to understand what the doctors are doing, and why some of their examinations take as much time as they do. They mentioned they did not understand why doctors could not finish the work they had started on one patient to have them discharged or admitted.

Lack of knowledge about the other profession is one of the main problems in the relationship between nurses and doctors when it comes to tasks shifts (Weiland, Macinlay and Jelinek, 2010). Task shifts started as an attempt to improve access to care in a context of limited supply of doctors (Fotheringham, Dickie and Cooper, 2011, Delamarie and Lafortune, 2010), and it was estimated that up to 30% of the ER patients could be handled by specially trained nurses instead of a doctor (Jennings et al, 2008). The problem is that new nursing roles started developing in ad hoc manners to meet local needs (Adams, 2013), and many doctors were

concerned if the nurses had the right qualifications to perform their former tasks (Weiland, Mackinlay and Jelinek, 2010). A lack of trust and knowledge about the other professions skills can be one reason why some tasks still are performed by both professions.

Several mentioned this challenge when they told that the nursing role has changed a lot, and that some doctors might have missed this development. Some told that especially the older doctors might not be familiar with the increased autonomy of the nursing role while they thought the younger doctors will take it for granted that nurses work as independent as they do. Some of the participants could tell it was less double work when they worked with younger doctors than with older ones.

The Norwegian nurses don't have the same experience with tasks shifts, but thought it could be challenging to make the doctors give up some of their tasks. They thought they would feel insecure about the nurses' competence, and that some doctors would be resistant to lose tasks and afraid what the patients would think if they left them to be treated by a nurse.

A lot have been written about this challenge in the literature. The nurses are considered academically advanced, professional and competent to provide emergency medical care, (Bahena and Andreoni, 2013), but they still have problems being accepted and are poorly understood by many emergency doctors (Weiland, Macinlay and Jelinek, 2010). This is despite the positive outcome shown for patients being treated by nurses (Iglehart, 2013, Bahena and Andreoni, 2013). This can once again be seen as a sign of lack of knowledge about the other professions competence.

There are now so many nursing titles in some countries (like England) for specially trained nurses that this also can cause a lot of confusions. The lack of national guidelines and clarity between the different roles is by many doctors considered a huge problem (Delamarie and Lafortune, 2010, Weiland, Mackinlay and Jelinek, 2010).

According to one nurse this problem is about to be solved as a new national guideline are on its way where the title Advanced Care Practitioners will be used in the future. To get this title the nurses will need to undergo advanced education in relation to anatomy, physiology, diagnostics, and a non-medical prescription. With the new national standard all the nurses will be working towards the same competence, and this might be a step on the way to make better understanding among both patients and health care workers what specially trained nurses can do. By time it will hopefully eliminate todays' confusions.

The importance of marketing tasks shifts as something more than just another attempt to save money was also mentioned. To train the healthcare workforce to undertake extensions of their role is considered cost effective (McClellan et al, 2013), but this must not be the main focus. According to the nurses the focus should instead be on the positive outcome for the patients where they receive the same quality of treatment and care within a shorter period of time.

Despite the literature describe a very positive outcome for nurses versus doctors when it comes to patients' satisfaction (Jennings et al, 2009 and Reeves et al 2009), several nurses from both countries told that they have either experienced themselves or heard about colleagues who had patients who refused to be treated by a nurse. This challenge will be discussed further in chapter 6.5.

By listening to the English nurses and reading available literature it looks like some of the task shifts in countries like England have been made from central authorities without paying too much attention to those performing the tasks (Bahena and Andreoni, 2013). It also looks like titles have been used to justify some of the task shifts, something that again have created to a lot of confusions among both health care workers and patients (Weiland, Macinlay and Jelinek, 2010). If task shifts are to develop in Norway the process would probably go smoother by listening to the experience from the English nurses and focus on cooperation between the nurses and the physicians, more training and education, and more treatment lines.

6.3 Task suggested taken over by the nurses

A potential task to take over mentioned by every Norwegian participant was requesting x-rays. Patients' waiting for doctors to request x-ray was mentioned as an important reason why many patients often have to wait for a long time. Several nurses said that it often was obvious an x-ray would be requested, so it would save a lot of time if they were authorized to request.

The English nurses are already requesting x-rays for some injuries and diseases, and according to them this have led to a decreased waiting time for their patients compared to earlier when this was done by doctors.

Many studies have been done on the quality of tasks being transferred from physicians' to nurses, and they all have more or less the same conclusion. OECD Health Working Papers No 54 conclude that there is a large body of evidence that specially trained nurses are able to

deliver the same quality of care as doctors for a range of services transferred to them provided they have received proper training and education (Delamarie and Lafortune, 2010).

Many studies and audits have shown that nurses can practice both requesting and interpretation of x-rays well within acceptable limits for producing false positive and false negative results, and that their skills can benefit patients and lead to service improvement such as decreased waiting time (Pedersen and Storm, 2009, Swaby-Larsen, 2009, Summers et al, 2005). Nurses are able to learn new skills to a high standard through experience, repeated exposure and training, and there are no indications for nurses requesting more x-rays than doctors (Swaby-Larsen, 2009, Summers et al, 2005). One study even concluded that without nurses being responsible for requesting and interpret x-rays many patients would not be able to receive proper treatment (Heltoft and Laursen, 2009, Pedersen and Storm, 2009).

To transfer the requesting of x-rays to trained nurses is something many doctors have been skeptical about because nurses don't have the same focus on anatomy in their education (Weiland, Mackinlay and Jelinek, 2010). To take on this task they need education and training. The importance of proper training was also mentioned by several participating nurses. It's was also said that some countries have the same training program for nurses and doctors who are requesting and interpreting x-rays, and this might be one way of building trust and make the two professions work together.

Other tasks suggested taken over by the Norwegian nurses were requesting ultrasound and starting treatment of DVT. According to the Norwegian nurses they already do more or less the whole procedure when it comes to diagnose DVT except requesting ultrasound and start warfarin treatment. The specially trained nurses in England already do both, and studies have concluded that nurses and doctors end up with the same Wells score for their patients, and that nurses are capable of requesting ultrasound and start treatment (Dewar and Corretge, 2014).

Safe prescribing by nurses have also been found in studies where safe prescribing were evident in 99,4 % of the cases (Black, 2012). An audit showed that the error-rate for nurses were low (Carverry, Connelly and Murphy, 2012). The problem is that some patients still are skeptical about accepting medical treatment from nurses, even if they have proper training and skills (Hoskins, 2011).

As the English nurses already have taken over a lot of the physicians tasks this question brought up little new information. A task mentioned to be taken over was arterial blood gasses. The Norwegian nurses had on the other side many ideas, and besides the ones mentioned above, some of them thought the waiting time would decrease it nurses treated minor injuries and soft tissue injuries. Hospital two had a lot of these patients and saw a huge benefit for the patients if this was handled by nurses in the future.

The nurses suggesting this are probably correct in their assumption. According to studies the waiting time dropped for patients within these diagnoses when they were treated by nurses instead of doctors. Studies also showed that the treatment offered by nurses was at least as accurate as the one offered by the doctors (Wilson and Shifaza, 2008, Derksen et al, 2007 and Carter and Chochinov, 2007).

The Norwegian nurses also brought up the importance of focusing on the development of the nursing role, and how a future extended role might help increase the status of the profession and help recruit nurses in the future. Despite some Norwegian nurses were afraid a development would lead to less focus on the nursing part of their role, the majority thought it important to show that nurses are trained for more than cleaning, feeding and holding hands.

Nurses in both countries have a very similar bachelor education (Brusselkontoret, 2012), but the English nurses have more focus on tasks that in Norway are considered a junior doctors tasks when they specialize to become a specially trained nurse. The Norwegian nurses want to learn more and handle more tasks. They also have a focus on how to improve the reputation and status of their profession, and believe more advanced tasks can help them achieving this. It would be possible to think that the English nurses' experience and parts of their training programs for specially trained nurses could be modifies and used in Norway to improve and increase the competence of specially trained nurses there.

6.4 Willingness for increased responsibility

The majority of the participants told they already have a lot to do, but that they would be willing to take on more responsibilities if some of their existing ones were removed

All the Norwegian nurses said they were willing to take on new tasks and more responsibility, but most of them had problems seeing how they could do so without also having some

removed. The Norwegian nurses have a lot of tasks that could easily be passed on to other professions like making up bed, cleaning, filling equipment, transporting patients for tests etc.

The English nurses have been working with tasks shifts for many years as part of a long term program to free time for the physicians to concentrate on the patients who need them the most (Stura, 2014, Laurant, 2009, Savrin 2008, Chung, 2008). Since they already have taken on a lot of the physicians' responsibilities, the English nurses thought it would be hard to expand their nursing role even further, and especially for those working as specially trained nurses on Minor side. They already see, examine, treat and discharge patients, and there are very few tasks left that the physicians are doing that they are not also doing.

Many of the English nurses thought the development of their profession had gone too fast over the last years, and several of them mentioned that they were afraid that if the development continued the essence of the nursing profession would be lost on the way. They were afraid that what they were trained during their education would end up being a very small part of their job and they instead would end up working as mini-doctors (Fotheringham, Dickie and Cooper, 2011, Delamarie and Lafortune, 2010).

Almost half of the English nurses said they were willing to take on new tasks and expand their scope of practice, but they also thought this should be done on an individual level, and not something they all should be forced to do.

The Norwegian nurses have not experienced the same amount of tasks shifts, but even some of them mentioned the development they have witnessed and were afraid that the standard of their profession would suffer if they took on to many new tasks. At the same time they were all excited about the idea of expanding their role and increase their professions reputation.

It's important to notice that the majority of the participants from both countries mentioned the importance of proper training, exposure and education if the nurses should expand their role further. Some of the experienced nurses had many examples of tasks given them without being followed by proper training or education. Most of them had failed.

By comparing the two nursing groups it seems like the development of the nursing role in England might have gone a little too fast for some of the participants, especially over the last five to ten years, and that the process has made some of the English nurses afraid of losing their professional identity. Even if the Norwegian nurses are eager to extend their roles, some

of them also expressed the same fear of losing identity if the changes were done too quickly. It would probably be wise not to move as fast as the English nurses have to avoid the same fear and frustration, and focus on developing the nursing role instead of reducing it.

6.5 Quality of care and patients satisfaction

None of the participating nurses from the two countries thought it would matter to the patients if they were treated by a doctor or nurses as long as those treating them were properly trained, experienced and worked within their scope of practice. In both countries the nurses already have quite independent roles, and many patients have problems understanding if they are seen by a nurse or a doctor in the first place. One nurse said she did not think it would matter for the patient as long as they felt better after being seen.

All participating nurses wanted the best possible treatment for their patients and the most experienced person to provide it independent of profession.

England have used specially trained nurses in their Emergency Department for many years and the patients are used to having either a specially trained nurse or a junior doctor to see them for minor diseases or injuries. Very seldom the nurses experience any problems with patients not willing to be treated by a nurse, but it still happens from time to time.

Some Norwegian nurses said they could see this as a potential challenge since their patients are used to be seen by a doctor even for minor problems. At the same time they thought this problem would be short lived as patients got used to the idea. They thought that positive nursing skills like communication, practical procedures and holistic approach would be seen as something positive by the patients. Several nurses also mentioned that the patients would benefit from faster treatment and lesser waiting time in the Emergency Department.

A lot of studies have been done on how the patients perceive the quality of care and treatment provided by nurses versus doctors. Most of these studies conclude that the patients are more or equally satisfied with the treatment they receive from nurses, and that specially trained nurses in the Emergency Department contribute to reduce the patients waiting time and free time for the doctors to work with patients in need of immediate care (Reeves et al, 2009, Carter and Chochinov, 2007).

The OECD Health Working Papers concluded that specially trained nurses are able to deliver the same quality of care as doctors for a range of services as long as they have received proper training and education (Delamarie and Lafortune, 2010), and a big study from 2009 found that nurses tend to provide more health advice and achieve higher level of patients satisfaction than doctors (Jennings et al, 2009, Reeves et al, 2009). One study showed that nurses are not only perceived as equally good as the doctors but have shown positive outcomes comparable with physicians in the care they provide to their patients (Bahena and Andreoni, 2013).

Studies in England have shown that as many as 97% said "yes, definitely" when asked if they had confidence in the nurse treating them, while 76% describes the treatment received as "excellent" (Jarvis, 2007).

Studies also show that waiting time is important for patients as patients tend to be less satisfied with their stay in the ER the longer waiting time and LOS (Parker and Marco, 2014).

Nurses in both countries told they have focus on patient safety and patient satisfaction, something that is also confirmed in some of the available literature (Bahena and Andreoni, 2013). It was interesting to see that the English nurses, like the Norwegians, believed they could offer their patients a safe and adequate treatment despite already having an extended role. As described in the findings, this might indicate that some nurses don't have any limits for what responsibilities they can take on as long as they receive proper training and education, and that they have support in their contracts and management for the tasks they are performing.

Even if both the participants and the literature believe that patients satisfaction will be better or equally good for those treated by nurses, it's important to notice that none of the studies that were found looked at any connection between the patient satisfaction and the outcome of the treatment given. Because of that it's not possible to conclude that nurses are equally good or better at treating patients than doctors, but it does indicate that the patients sometimes are more satisfied with the treatment offered by nurses.

6.6 Tasks shifts and waiting time

When asked if they thought a task shift from the physicians to the nurses would influence the patients waiting time all participants from both countries said they thought it would lead to a

decreased waiting time. While the Norwegian nurses perceived this the English nurses answered based on their experience with tasks shifts, especially over the last years.

They all said they thought the waiting time would be decreased by letting nurses do some of the requests, examinations, documentation and treatment so the doctors would have as much as possible ready before seeing the patients. According to the nurses this is good use of resources since a lot of the patients waiting time is caused by waiting for test results and examinations. As long as the investigations are out of the way, the doctors can start their diagnostics and treatment faster.

Not many British studies have been published focusing on task shift and waiting time, but in Australia, Canada and the US they have done plenty of studies covering this subject, and they all seem to draw the same conclusion: By letting nurses take over some of the physicians tasks the waiting time will decrease (Lutze et al, 2014, Collins et al, 2014, Considine, Kropman and Stergiou, 2014, Colligan et al, 2011, Webster-Bain, 2011, Fry et al, 2011, Steiner et al, 2009, Jennings et al, 2008, Carter and Chochinov, 2007).

For this question the participants and the literature agreed. If well educated, skilled and trained nurses take over tasks from the physicians it will lead to a decreased waiting time for the patients to be seen, admitted or discharged. Some studies showed how much time could be saved, ranging from minutes (Steiner et al, 2009) to hours depending on the task and the nurses experience (Colligan et al 2011, Fry et al, 2011 and Jennings et al, 2008).

To transfer some tasks from the physicians to the nurses can be seen as an easy way to reduce the patients waiting time in the Emergency Departments, but neither all the literature nor all the nurses agreed this was the only solution.

First of all the literature has found that a small but significant group of patients would not agree to be treated by a nurse instead of a doctor, even for a minor disease (Hoskins, 2011). Very few nurses asked had been exposed to this problem themselves, but most of them had heard of colleagues who had experienced it. Second nurses' can't take on other professions' responsibilities unless it's agreed to give it to them. Some of the literature indicates there is resistance among the doctors for giving up tasks, so this can be a challenge (Weiland, Mackinlay and Jelinek, 2010, Griffin, 2006). Third there are some studies that have shown that despite decreased waiting time to be seen, the LOS was not necessarily reduced since it's

not always a question of staff only, but also about other resources like physical space in the Emergency Department and available beds at the wards (Steiner et al, 2009).

This problem was mentioned by several of the participants as they said it's hard to speed up the process unless you have a place to send the patients. They referred to crowding as the main challenge.

Crowding is already associated with long waiting times and an increased risk of in-hospital mortality and patients leaving without being seen (Murrell, Offerman and Kauffman, 2011, Bernstein et al, 2008), and it's expected to increase in the upcoming years. Efforts to reduce waiting time and LOS are crucial, because this has the potential to influence the patients' outcomes, efficiency of the Emergency, which may affect costs to the health care system (Nippak et al, 2014). Many hospitals see crowding as a huge challenge and in the US 90% of the hospitals report this as one of their main challenges (Olshaker, 2009).

Literature found about the topic conclude that a good mix of staff where at least 50% is senior grade medical staff, 25% specially trained nurses and 25% middle and junior medical staff will lead to less crowding in the Emergency Department (Baboolal et al, 2012), but also more physical space is needed.

Nurses from both countries mentioned lack of experienced staff as one of their main challenges. Both in England and Norway most of the doctors in the Emergency Department are at junior level, and in Norway they sometimes have no presence of doctors with surgical competence in the Emergency. In England they use more and more specially trained nurses to compensate, but the training process takes time, and they have problems covering all shifts with enough competent staff. In Norway very few of the nurses working in an Emergency have any formal education other than their bachelor in nursing, but some of them have informal education and experience by working for many years in the department.

Some of the English nurses told they saw crowding as a result of lack of space, and not only lack of competence. Very often they felt they had problems receiving the patients properly because of lack of space. Problems moving patients to the wards because they had no available beds were also mentioned by several participants from both countries.

The Care Quality Commission have done local audits for the participating English hospital showing that they provide both an effective and good service after doing a task shift from

their physicians to their nurses. In their 2014 report they write *"The A&E Department provided safe care to patients"* (Hospital Quality Report, 2014). They mention that the Emergency use clinical guidelines to deliver care and treatment to meet people's needs and give good outcomes. They also mention their strong leadership and that they had been proactive in looking for more ways to be efficient as a success factor.

Despite the English Emergency Department have spent a lot of time finding a good way to organize their work the report showed that they still have problems meeting the national target for waiting time and did not have capacity to meet the patient's need all the time. A lot of the problem was explained to be caused by crowding where the Emergency had problems delivering patients to the wards due to a huge pressure on the whole hospital. According to the same report patients said the nursing care had been fantastic, but they were really unhappy about the waiting time (Hospital Quality Report, 2014).

While the Norwegian nurses had a very clear understanding that task shifts were equal to decreased waiting time, the English nurses made this question a bit more nuanced by bringing in other factors like crowding. Several of the English nurses made it clear that crowding is a challenge that must be addressed to manage to keep the waiting time and LOS down. Based on their experience task shifts alone could not solve all the problems.

6.7 Historically changes and returning tasks

The Norwegian nurses who had been working for many years mentioned changes they knew of either before or during their time as nurses. Several participants told they could remember the days where nurses mostly made beds, fed, washed, or simply hold the patients hands. As one said, all tasks we do have once been the doctors tasks except changing bed linen.

The Norwegian nurses also mentioned tasks as taking arterial blood gasses, order blood tests, do cannulations, give intravenous fluids and male catheters as tasks they over time more or less have taken over from the physicians.

Many of the English nurses talked about the development their profession have been through since the 60's and the 70', and especially the nurses who had been working for a long time could tell of totally different responsibilities today. It was told that no nurses would ever be allowed to request x-rays, do cannulations or prescribe medicines only a few years back.

The literature also describes a massive task shift from the physicians to the nurses since the 60's and 70's. The concept was to empower nurses with special skills to enable them to make autonomous judgments and decisions regarding patient care (Chung, 2008). The lack of enough hands led to a task shift between doctors and nurses to clear patients faster and free time for the doctors to work with patients in need of acute medical treatment (Brusselkontoret, 2013, Fawdon and Adams, 2013, Garson, 2013, Fotheringham, Dickie and Cooper, 2011).

Especially the English nurses told they feel they now have taken over so many tasks they almost feel like mini-doctors instead of nurses. It was also said they are afraid the development might lead to less focus on the nursing part of their role because they instead have to cover tasks from other professions. Several mentioned they became nurses because they wanted to work close to the patients, but especially some of the specially trained nurses now feel they spend less time with the patients and more time in front of the computer.

The feeling of being less involved in clinical work was mentioned as a negative development both by Norwegian and English nurses. In both countries the increased pressure on documentation was used as an explanation for this development.

Despite many nurses having an extended nursing role with a lot of responsibilities none of them would like to go back to the days where nurses were not even allowed to give intravenous medicines. At the same time many of the English nurses thought the development had reached a limit, and it was said that they had problems seeing how their nursing role could extend even further in the future. It was on the other hand pointed out it would have been hard to foresee the development they have been through the last 15 years.

Absolutely none of the participants thought that any of the tasks they were responsible for today would be done any better if they were returned to the doctors.

The majority answered this because they believed nurses always operated within their scope of practice, that nurses always make sure they know what they were doing, that nurses in general are careful when performing new tasks and that nurses working in the Emergencies usually are very experienced and qualified with far more knowledge than many of the junior doctors (Bahena and Andreoni, 2013, Weiland, Macinlay and Jelinek, 2010).

As described in chapter 6.5 the impression from available literature agree that nurses are able to do an equally good or better job than the physicians in areas where they have proper training and exposure (Bahena and Andreoni, 2013, Delamarie and Lafortune, 2010, Jennings et al, 2009, Reeves et al, 2009). This was also something all the participating nurses pointed out: They did not think they were better than the physicians, but they thought they either did or could do a better job for some patients with minor injuries or minor diseases because they had a lot of exposure of these patients, knew the treatment well, and had lots of knowledge about them. The Norwegian nurses were mostly talking about patients in triage-category blue, green and some yellow, while the English nurses mostly referred to patients on Minor side.

Despite going through a different development over the last 50 years, both the English and the Norwegian nurses felt their roles had changed a lot. Especially the ones working ten years or more could tell about a massive change in their responsibilities.

It's important to mention that task shifts, especially in some English-spoken countries, came as a result of lack of doctors, and the idea was that nurses could take over some of the doctors' tasks to free time for them to work on the patients who needed them the most (Fawdon and Adamas, 2013, Garson, 2013). Today the situation has changed. It's no longer only lack of doctors, but also lack of nurses, and according to statistics nurses are needed both in England and Norway to face both present and future challenges (Delamarie and Lafortune, 2010). It's not possible to tell if a task shift will increase the pressure and create an even higher demand for nurses, or if task shifts will change the professions status and lead to more people taking a nursing education to work as a specially trained nurse.

7.0 CONCLUSION

A long waiting time in the Emergency is associated with a higher risk of patients leaving without being seen and increased in hospital mortality (Bernstein et al, 2008). It also leads to crowding which can create pressure on the staff with reduced quality of care as doctors and nurses feel they are rushed in their work (van der Linden et al, 2013, Olshaker, 2009).

An estimated 85% of all visits to Emergency Departments are made for non-life-threatening illnesses, and 50% of these are considered non-serious (Brusselkontoret, 2013, Delamarie and Lafortune, 2010, Wilsey et al, 2008). Estimates conclude that up to 30% of the Emergency patients could have been handled by specially trained nurses instead of physicians, leaving the physicians with more time to deal with more complex patients in need of immediate treatment (Fawdon and Adamas, 2013, Garson 2013, Fotheringham, Dickie and Cooper, 2011, Delamarie and Lafortune, 2010, Jennings et al, 2008).

In England specially trained nurses have taken over tasks that earlier were performed by physician's to improve access to care in a context of limited supply of doctors (Fotheringham, Dickie and Cooper, 2011, Delamarie and Lafortune, 2010). A lot of the studies done have shown that this transmission of tasks have led to a decreased waiting time.

The aim of this study was to interview Norwegian nurses to see how they thought task shifts would influence the patients waiting time, and if they would be willing to take on more responsibilities than they already have. At the same time English nurses were interviewed to get their view on and experience with task shifts from physicians to nurses.

All the Norwegian participants perceived that a task shift from the physicians to the nurses would lead to reduced waiting time for their patients, and they were all willing to extend their scope of practice and take on new responsibilities as long as it would benefit their patients.

The Norwegian participants explained the long waiting time for patients with minor injuries or minor diseases as caused by waiting time for examinations or test results performed or requested by busy doctors who have to prioritize patients in need of more immediate treatment. By taking over some of their tasks they believed the waiting time would decrease, as more examinations and test results would be ready by the time the doctors came to see their patients. Their assumption was largely based on the experience they have with low triage

patients groups, knowing that many of the tasks the physicians perform today could be handled by them if they got proper training and exposure.

The Norwegian nurses said they needed to lose some of their existing responsibilities to take on new ones, and suggested several tasks that could be transferred to other health care professions. They also said that they would be selective about what tasks to take on, as they feared the extended responsibilities would increase the amount of paperwork, decrease their time in the clinic and potentially reduce the nursing part of their professional role.

The Norwegian nurses also mentioned the benefit of increasing the status of their profession if they were to expand their scope of practice and take on more advanced tasks.

The English participants believed the reduced waiting time they have seen over the last years was partly a result of the extended nursing role, and especially the specially trained nurses in the Emergency Department got a lot of the honor. For patients with minor diseases and minor injuries some of the nurses had earlier experienced waiting times up to 12 hours for something that is now being treated within 4 hours. They all told that examinations, requests or treatments their patients earlier was waiting for the doctors to perform they now performed themselves, something that according to them saved a lot of time. The English nurses also mentioned the 4-hour target as a contributor to the reduced waiting time, so the decrease could not only be explained by their increased responsibility for the treatment.

The specially trained nurses at the participating hospital perform the same tasks as the junior doctors, and several of them told they now believe they have reached a point where it won't be possible to take on more responsibilities without compromising on their role as nurses, and advised the Norwegian Emergencies to transfer the responsibilities slower than what have been done in England to avoid losing the nursing focus. They also told that to manage keeping todays relatively low waiting time the hospitals have to address the problem of crowding so they will have a place to send the patients after being examined and diagnosed in the Emergency Department. If this problem is not addressed, the waiting time will, according to them, start increasing again.

7.1 Research limitations

Even though an interview is considered a good way of collecting data from individuals based on the researchers questions it has limitations. The method will normally provide indirect information filtered through the views of interviewees, provides information in a designated place rather than the natural field setting, researcher's presence may bias responses and not all people are equally articulate and perceptive (Creswell, 2014, Patton, 2002).

For this study the interviewer has tried to keep personal interest in mind, the interviews took place in their natural setting and all the participants were found experienced, articulate and perceptive. Despite that it can still be questioned if the researchers' present was a bias resulting in other answers than if someone else did the interviews.

The participants spent 1-2 hours to answer eight questions with sub questions. Most of the data were collected from question 1-5. Retrospective it can be questioned if 8 questions were too much, and this might have influenced the amount of data collected for the last 3 questions.

With 10 Norwegian interviews and 12 English interviews the researcher reached saturation for several questions. Despite that it can be questioned if 22 interviews are enough to draw any conclusion. It's also possible that those willing to participate was more interested in task shifts' that those not participating.

Task shift is when one profession takes over tasks previous performed by another profession (Frich, 2012). To organize a task shift one profession must be willing to give up some of their tasks, while another profession must be willing to take them on. For this study the researcher has only been talking to those willing to take on new tasks. This is also a limitation.

Finally it's important to mention that most of the studies done on task shifts and waiting time, comes from countries like Australia, Canada and the US. Their results are not necessarily transferrable to a Norwegian organization.

7.2 Recommendations for practice

A lot of available literature and experience from England concludes that by letting specially trained nurses take over some of the physicians' tasks for some patient groups the patients waiting time will decrease without compromising on the quality (Lutze et al, 2014, Collins et

al, 2014, Considine, Kropman and Stergiou, 2014, Colligan et al, 2011, Webster-Bain, 2011, Fry et al, 2011, Steiner et al, 2009, Jennings et al, 2008, Carter and Chochinov, 2007).

Based on the literature and the findings it would be recommended to start a project to look at tasks that can be transferred between the two professions, starting with the best documented task shifts from other countries like requesting x-rays, ultrasound and treatment lines for minor injuries and diseases (Dewar and Corretge, 2014, McClellan, Cramp, Powell and Benger, 2014, Tosone and Costanzo, 2012, Burley, 2011, Passman, 2010, Berry, 2009, Heltoft and Laursen, 2009, Henderson et al, 2009, Pedersen and Storm, 2009, Swaby-Larsen, 2009, Carter and Chochinov, 2007, Derksen et al, 2007, Summers et al, 2005)

Parallel with this work a program must be developed to make sure the nurses will receive proper exposure, education and training to take on their new tasks. It's also important to look at nursing tasks that can be transferred to other professions (Carter and Chochinov, 2007).

It's important that the work is done by representatives from both professions to avoid resistance or role confusion in the future (Adams, 2013, Delamarie and Lafortune, 2010, Weiland, Mackinlay and Jelinek, 2010, Griffin, 2006).

7.3 Recommendations for further research

Many studies have been done on the patients' satisfaction for treatment provided by nurses instead of doctors, and the positive outcome have been used to conclude that nurses can provide the same level of treatment and care as doctors for some patient groups.

Unfortunately no studies have been found that look at both the patients' satisfaction and the outcome of the treatment. It's possible to assume that a satisfied patient is satisfied because he or she has received the best possible treatment, but this is only an assumption. Because of this it would be recommended that future studies also look at the combination of patients' satisfaction and treatment outcome before concluding that nurses give equally good or better treatment than doctors (Iglehart, 2013, Bahena and Andreoni, 2013, Hart and Mirabella, 2009, Jennings et al, 2009, Reeves et al, 2009, Carter and Chochinov, 2007, Jarvis, 2007).

7.4 Personal reflection

This study has been challenging, enjoyable, educating and rewarding in equal measures.

Since my study was done in two countries I needed a lot of approvals. Especially in England it was extremely challenging to get the necessary approvals, and I was close to give up the whole project several times.

The meetings with the heads of the Emergency Departments and the interviews with the nurses in the two countries were nothing but enjoyable from day one. It was a pleasure for me to talk to every single one of the nurses about something I consider a very important topic.

Before starting this study I thought I knew a lot about managing and working in an Emergency Department. All the interviews gave me a lot of new knowledge and ideas, and I feel I have learned a lot by listening to the participants' stories and views on the topic.

Before starting this project many people questioned if it would be possible to complete it in such limited time. It's very rewarding to see they were wrong. It's also extremely rewarding to see how much responsibility nurses take on in their organizations and how much more responsibility they are willing to take on to be able to offer their patients the best treatment possible. Their attitude makes me proud.

8.0 LITERATURE AND APPENDIXES

8.1 Literature

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8.2 Appendixes

** Please note that appendix 8.2.01, 8.2.05, 8.2.02, 8.2.09, and 8.2.12 only are available in the printed version of the dissertation due to technical problems of implementing PDF-files into the document. They will be found from page 109.

Sykehus X
Ved kontaktperson X

Adresse

Postnummer og sted

Oslo, 17.05.14

Søknad om tillatelse til å intervjue sykepleiere ansatt ved akuttmottaket på XXXX sykehus til et masterprosjekt.

Undertegnede tillater seg herved å søke XXX sykehus forskningsutvalg ved administrerende direktør XXX om tillatelse til å gjennomføre intervjuer med sykepleiere ansatt på akuttmottaket ved XXX sykehus i forbindelse med gjennomføring av et masteroppgaveprosjekt. Masteroppgavens foreløpige arbeidstittel er «Kan en innføring av "Nurse Practitioners" i norske akuttmottak bidra til å redusere vente- og liggetiden for pasienter med lav triage?»

Bakgrunn for masterprosjektet:

Etter innføringen av triage i norske akuttmottak opplever man at vente- og liggetiden for pasienter med lav triage øker. De pasientene som får tildelt en lav triage venter ofte lenge på avklaring da de stadig blir nedprioritert til fordel for dårligere pasienter. Siden det i Norge er legetjenesten som avklarer alle pasientene er det ofte først og fremst deres tilgjengelighet som er en utfordring i forhold til disse pasientenes vente- og liggetider.

I blant annet England får det økonomiske konsekvenser for akuttmottakene om ikke minst 95 % av pasientene avklares innen 4 timer. For å få til dette benytter akuttmottakene Nurse Practitioners som er spesialutdannede sykepleiere med delegerte oppgaver. Denne sykepleiergruppen både undersøker, behandler og utskriver enklere og lavtriagerte pasientgrupper, og er dermed med på å frigjøre tid hos legetjenesten til å jobbe med de mer alvorlige diagnosene med høyere triage. Ordningen har ført til en reduksjon i avklaringstiden for deres pasienter.

Undertegnede søkte i forbindelse med sin utdanning «Master i erfaringsbasert ledelse» ved Universitetet i Oslo om utveksling til Oxford Bookes University i England for å se nærmere på hvordan det britiske helsevesenet håndterer utfordringen med vente- og liggetider i akuttmottakene. Undertegnede har fått tildelt stipend og har blitt tatt opp ved Oxford Brookes University for høstsemesteret 2014 for å skrive sin masteroppgave der.

Undertegnedes prosjekt er en masteroppgave som dermed skal utføres både ved Universitetet i Oslo og ved Oxford Brookes University i England. Formålet er å se om en innføring av Nurse Practitioners (i

dette tilfellet oppgaveglidning mellom legetjenesten og sykepleietjenesten) i Norge vil føre til reduserte vente- og liggetider for pasienter med lav triage.

Prosjektet skal gjennomføres gjennom intervjuer med erfarne mottakssykepleiere ansatt i norske akuttmottak og Nurse Practitioners ansatt i engelske akuttmottak. Dette skal bli en kvalitativ komparativ studie hvor man både ser på hva sykepleierne i Norge mener de kan utføre av oppgaver i et akuttmottak som i dag ivaretas av legetjenesten, uten at dette går utover pasientenes sikkerhet, samt hvilke oppgaver de britiske Nurse Practitioners faktisk håndterer og hvordan de mener dette er med på å avlaste legetjenesten og redusere vente- og liggetidene. Det vil i tillegg bli innhentet statistiske data for vente- og liggetider fra både norske og britiske sykehus, både på triagenivå og på diagnosenivå.

Hvordan skal prosjektet gjennomføres?

Både norske og engelske sykehus vil bli kontaktet med spørsmål om de vil tillate undertegnede å intervjue noen av deres ansatte. De ansatte vil deretter få tilsendt informasjon om studien og forslag til tider for gjennomføring av et intervju. Intervjuene vil bli en-til-en intervju mellom sykepleieren og masterstudenten. Intervjuet vil bestå av noen enkle spørsmål rundt deres rolle og deres oppgaver i akuttmottaket, samt deres tanker om hvilke oppgaver som er mest utfordrende og tidkrevende for lavtriagerte pasienter, og hvordan disse oppgavene eventuelt kunne vært ivaretatt på en annen måte og/eller av andre yrkesgrupper. Det vil bli spesielt fokus på oppgavefordelingen mellom lege og sykepleier. Det er antatt at intervjuene vil ta ca en time per stk.

Planen er å intervjue 20 erfarne sykepleiere og Nurse Practitioners ved 4 ulike sykehus. To norske og to britiske.

Tanken bak studien er å se om det er en forskjell i vente- og liggetider for enklere diagnoser i akuttmottak som benytter Nurse Practiotioners til diagnostisering og behandling kontra akuttmottak som benytter sykepleiere og leger til de samme oppgavene, samt om en potensiell oppgaveglidning i norske akuttmottak vil kunne føre til antatt kortere vente- og liggetider.

Hvordan ivaretas intervjuobjektenes anonymitet?

Alle personopplysninger vil bli behandlet konfidensielt, og det er kun masterstudenten og masterstudentens veiledere som vil ha tilgang til dataene.
Hver respondent vil før intervjuet få tildelt et referansenummer. Dette referansenummeret vil bli notert på dataene innsamlet under intervjuet. Det vil bli laget en egen oversikt over hvem referansenummeret viser til, samt respondentens telefonnummer i tilfelle det skulle oppstå spørsmål som må avklares. Ingen øvrige personopplysninger vil bli innhentet.

Skjemaet og dataene vil bli oppbevart hver for seg. Straks dataene er analysert vil skjemaet som viser til dataene bli makulert. Straks prosjektet er gjennomført vil også dataene bli makulert. Gjennom å skille respondentenes referansenummer og dataene vil publiseringen av dataene ikke kunne tilkjennegi respondenten. Hvor respondentene jobber vil ikke bli trukket inn i prosjektet.

Prosjektet skal etter planen avsluttes 15. desember 2014.

Alle innsamlede data vil bli makulert etter at prosjektet er avsluttet, og ingen data vil bli lagret.

Frivillig deltakelse

Det er frivillig å delta i studien, og respondentene kan når som helst trekke sitt samtykke uten å oppgi noen grunn. Dersom respondenten trekker deg, vil alle opplysninger om vedkommende bli anonymisert og slettet.

Ved ytterligere spørsmål om masterprosjektet kan undertegnede kontaktes på telefon + 47 40061503.

Undertegnedes veiledere kan også kontaktes. Deres kontaktinformasjon befinner seg nederst i brevet.

Jeg håper på en rask og positiv tilbakemelding på min søknad.

Med vennlig hilsen

Lasse Andreassen

I tillegg til XXX etiske forskningskomite har undertegnede søkt følgende instanser om tillatelse til gjennomføring av sitt forskningsprosjekt:

Søknader:

I Norge:	Norsk Samfunnsvitenskapelige Datatjeneste – Personvernombudet for forskning
I England:	University Research Ethics Committee - Oxford Brookes University – UREC Form E2U - Application for Approval of a Project Involving Human Participants, Data or Material

Undertegnede har fått tildelt to veiledere til sitt forskningsprosjekt. Hovedveilederen vil være fra Oxford Brookes University, mens biveilederen vil være fra Universitetet i Oslo:

Veiledere:

England:	Jan Davison-Fischer, Oxford Bookes University, telefon + 44 7810 170195
Norge:	Eli Feiring, Universitetet i Oslo, Medisinsk fakultet, telefon + 47 984 13 965

Lasse Andreassen
C/o Jan Davison Fischer
Faculty of Health and Life Sciences
Marston Road Campus

15th August 2014

Dear Lasse,

Re. How do nurses in England and Norway perceive that the organisation of tasks between physicians and nurses in the emergency department influences the patient's waiting time?

Thank you for your recent correspondence, detailing your response to my letter dated 24th July 2014.

I can confirm that all the points raised in my letter have been satisfactorily addressed. I am therefore pleased to approve the research on behalf of the Faculty of Health and Life Sciences Research Ethics Committee and enclose an E3 ethics approval form to this effect.

Good luck with the data collection.

Yours sincerely,

Hazel Abbott
Faculty of Health and Life Sciences Research Ethics Committee

Cc. Dr Jan Davison Fischer, MSc Supervisor

Jack Straw's Lane Marston Road
Oxford OX3 0FL UK

T +44 (0) 1865 482639
F +44 (0) 1865 482775
heabbott@brookes.ac.uk

Oxford Brookes University

Faculty of Health and Life Sciences

Decision on application for ethics approval

The Faculty Research Ethics Committee (FREC) has considered the application for ethics approval for the following project:

Project Title: How do nurses in England and Norway perceive that the organisation of tasks between physicians and nurses in the emergency department influences the patient's waiting time?

FREC Study Number: 2013/44

Name of Applicant: Lasse Andreassen

Name of Supervisor: Dr Jan Davison-Fischer

Please tick one box

1. The Departmental Research Ethics Officer / Faculty Research Ethics Committee gives ethical approval for the research project. ☐

   Please note that the research protocol as laid down in the application and hereby approved must not be changed without the approval of the DREO / FREC

2. The Departmental Research Ethics Officer / Faculty Research Ethics Committee gives ethical approval for the research project, subject to the following: ☐

3. The Departmental Research Officer / Faculty Research Ethics Committee cannot give ethical approval for the research project. The reasons for this and the action required are as follows: ☐

Signed: …Hazel Abbott … …… Approval Date: 15th August 2014…..……...…

Designation: Departmental Research Ethics Officer

(Signed on behalf of the Faculty Research Ethics Committee)

Date when application reviewed (*office use only*): 22nd July 2014 ……..……

OXFORD BROOKES UNIVERSITY

FREC 2013/44
5 September 2014

To: Research and Development

To whom it may concern

Re: How do nurses in England and Norway perceive that the organisation of tasks between physicians and nurses in the emergency department influences the patients' waiting time?

I am writing to confirm that Oxford Brookes University is accepting the role of Research Sponsor for the above project. This is in accordance with the role and responsibilities of the Sponsor, as laid out in the Research Governance Framework for Health and Social Care (2005).

Lasse Andreassen is a student in the Faculty of Health and Life Sciences at Oxford Brookes University. He is undertaking an ERASMUS Master's Programme. The research will be supervised by Dr Jan Davison-Fischer, Senior Lecturer in Professional Education and Leadership.

Oxford Brookes University has public liability, professional indemnity and clinical trials insurance.

Yours faithfully

Linda King

Prof. Linda A King, BSc, DPhil, FSB
Associate Dean Research and Knowledge Exchange

cc Dr Jan Davison-Fischer
Dr Hazel Abbott, Chair FREC

<name of hospital>
<address 1>
<address 2>
<address 3>
<address 4>
<post code>

FREC 2013/44
<type date here>

Dear <type recipient's name here>

Searching participants for a master project

We are seeking your assistance to recruit participants for a study investigating "How do nurses in England and Norway perceive that the organisation of tasks between physicians and nurses in the emergency department influences the patients' waiting time?"

This study is a Master's Dissertation project and a collaboration between the University of Oslo, Norway and Oxford Brookes University, England.

The aim of this study is to interview nurses in both countries to understand how they believe a task reorganisation between physicians and nurses can influence patients' waiting time in the Emergency Department. This will be done through interviews with a total of 10 experienced nurses (minimum of 3 years full-time or 5 years part-time experience, including working as a triage nurse) in each country. Each interview will take approximately one hour.

You will find an information sheet and a consent form attached. We would be grateful if you would please take time to read them to see whether you and your hospital are interested in participating or not. If you are, we would be grateful if you would pass the details of this study on to nurses in your department.

We will contact you within four days for further discussion.

If you have any questions about this study, please do not hesitate to contact us by emailing j.fischer@brookes.ac.uk or telephoning 07810170195.

Thank you very much for your help!

Kind regards,

Lasse Andreassen
MSc student

Dr. Jan Davison-Fischer
Senior Lecturer

FACULTY OF HEALTH AND LIFE SCIENCES
Jack Straw's Lane Marston Road
Oxford OX3 0FL UK
T +44 (0) 1865 482740
M +44 (0) 78101 70195

OXFORD BROOKES UNIVERSITY

Oslo, July, 2014

Invitation to participate in a research study.

You are being invited to take part in a research study. Before you decide whether or not to take part, it is important for you to understand why the research is being done and what it will involve. Please take time to read the following information carefully.

The study title.
The study title is *"How do nurses perceive that a task shift from the physicians to the nurses in an emergency department will influence the patients' waiting time?"*

What is the purpose of the study?
This is a research project is being done by a Norwegian intensive care nurse to compare the potential efficiency in dealing with patients with minor medical or surgical problems in Norwegian Emergency Departments by using task shifts from the physicians to the nurses.

England has for many years used Nurse Practitioners or Advanced Clinical Practitioners to reduce the waiting time in their Emergency Departments, and the investigator would like to interview experienced nurses working in Emergency Departments in England to get their perceptive in how this might have influenced the patients waiting time, and for what kind of patients or diagnoses it is appropriate.

The purpose of this research project is to get both Norwegian and British nurses' perceptions of how a task shift from the physicians to the nurses can influence the patients' waiting time in an Emergency Department. This will be done true interviews with experienced nurses from the two countries and combined with statistical data and former research and literature.

Why have I been invited to participate?
We have contacted the head of your Emergency Department asking for suggestions for the name of experienced Nurse Practitioners who could be part of this research study. Your name was suggested as a candidate by the head of your Emergency Department.

Do I have to take part?
It is up to you to decide whether or not to take part of this research study. If you do decide to take part you will be given this information sheet to keep and later be asked to sign a consent form.
If you decide to take part you are still free to withdraw at any time and without giving a reason.

What will happen to me if I take part?
If you take part you will be invited for a one-to-one interview with the master student. The interview will take place at your hospital. The interview will take approximately one hour, and you are free to choose the date and time in discussion with the researcher. If you at any point during the interview feel like withdrawing, you are free to do so without any given reason. There will be no disadvantages or risks by taking part in this research project.

What are the possible benefits of taking part?
Norway and the UK are facing an aging population with the need for complex healthcare intervention and limited resources to meet these demands. Comparing and contrasting approaches can inform future policy decisions about resourcing and professional competencies. As an experienced Nurse Practitioner, your answers might be helpful in the work of improving healthcare systems for the better for both the patients and the nurses working there. There is no immediate benefit for you in taking part in this study.

Will what I say in this study be kept confidential?
Yes. All you say during the interview, except your name, will be recorded with an audio recorder. Your name and your recording will not be linked. Any quotes will be anonymised before publication, although a close friend or colleague may recognise your manner of speaking, as the number of participants in this study will be small.

All data from the interviews will be kept strictly confidential and can only be accessed by the researchers through a computer with double password protection. The data will be retained in accordance with the University's policy on Academic Integrity. The researchers will only disclose your identity if compelled by the law to do so, for example to prevent or investigate a serious crime. Any stored data will be destroyed at the end of the research project.

What should I do if I want to take part?
Please contact Lasse Andreassen or Jan Davison-Fischer (see below). If you are interested in being part of this research study Lasse will find a date and a time for an interview with you.

What will happen to the results of the research study?
The results of the interviews will together with similar interviews from Norwegian Emergency Departments be used in the master student dissertation. Depending on the outcome, the results might be published. All participants will be asked if they would like an electronic copy of the dissertation when finished.

Who is organising and funding the research?
The research study is being conducted by a student at Oxford Brookes University, Faculty of Health and Life Sciences. There is no external funding for this research study.

Who has reviewed the study?
This research study has been approved by the Faculty of Health and Life Sciences Research Ethics Committee, Oxford Brookes University. It's also received and approval from the Norwegian Ethics Committee, the Norwegian Organization for Data Storage and Diakonhjemmet Hospital in Oslo.

Contact for Further Information
If you would like further information about this research study you can contact Lasse Andreassen (+ 47 40061503/lasse.andreassen@studmed.uio.no) or Dr Jan Davison-Fischer at Oxford Brookes University (+ 44 7810170195 / j.fischer@brookes.ac.uk).

If you have any concerns about the way in which the study has been conducted, you are welcome to contact the Chair of the Faculty of Health and Life Sciences Research Ethics Committee on heabbott@brookes.ac.uk.

Thank you
We will contact you within two weeks to ask if you are willing to be part of this research study.

Thank you for taking the time to read the information sheet.

Best regards.

Dr. Jan Davison-Fischer
Senior Lecturer
Faculty of Health and Life Sciences
Oxford Brookes University
Jack Straw's Lane
Marston, Oxford
OX3 0FL, England
Telephone: +441865482740

Lasse Andreassen
Masters Student
University of Oslo/
Oxford Brookes University

CONSENT FORM

FREC 2013/44

"How do nurses in England and Norway perceive that the organisation of tasks between physicians and nurses in an emergency department influences the patients' waiting time?

Researchers:

Lasse Andreassen & Jan Davison-Fischer

Oxford Brookes University

Jack Straw's Lane

Marston, Oxford

OX3 0FL, England

Telephone: +447810170195

E-mail: j.fischer@brookes.ac.uk

		Please initial box
1.	I confirm that I have read and understand the information sheet for the above study and have had the opportunity to ask questions.	☐
2.	I understand that my participation is voluntary and that I am free to withdraw at any time, without giving reason.	☐
3.	I agree to take part in the above study.	☐

Please initial box

	Yes	No
4. I agree to the interview being audio recorded.	☐	☐
5. I agree to the use of anonymised quotes in publications. I realise that the sample of this study is small, and although every care will be taken to keep my identity confidential, this means that close acquaintances might recognise me.	☐	☐

Name of Participant	Date	Signature
Name of Researcher	Date	Signature

DRAFT INTERVIEW GUIDE - ENGLAND

Question:

"How do nurses in England and Norway perceive that the organisation of tasks between physicians and nurses in an emergency department influences the patients' waiting time?"

1) In your opinion: How are the tasks organised between the nurses and physicians in your Emergency Department, and are there any tasks being performed by the nurses that are not formalised?

2) In your opinion: Are some of the physicians' and nurses' responsibilities overlapping?

3) In your opinion: Is there any tasks being performed by the physicians today that after your opinion could as easily be taken over by an experienced nurse (3 years/triage experience) and why?

4) In your opinion: Would you be willing to take on more responsibilities than what you already have in your Emergency Department?

   If yes:

   a) Which responsibilities (and why)?
   b) Where would you set your limit in relation to take on new responsibilities (and why)?

   If not:

   a) Why not?
   b) What factors should be present for you to consider taking on new responsibilities?

5) In your opinion: How do you believe the patient will look at the quality of treatment being performed by a nurse in an Emergency Department, and how do you think they would have looked at the quality of treatment if the same task was performed by a doctor?

6) In your opinion: Do you believe that a task shift of tasks from doctors to nurses affects the patients waiting time and, if so, in what way?

7) In your opinion: Are you aware of any tasks that were historically the responsibility of doctors and which are now the responsibilities of nurses, and what do you think about this change?

8) In your opinion: Are there any tasks that you are performing but that you think would be better left to the doctors?

DRAFT INTERVIEW GUIDE - NORWAY

Question:

"How do nurses in England and Norway perceive that the organisation of tasks between physicians and nurses in an emergency department influences the patients' waiting time?"

1) In your opinion: How are the tasks organised between the nurses and physicians in your Emergency Department, and are there any tasks being performed by the nurses that are not formalised?

2) In your opinion: Are some of the physicians' and nurses' responsibilities overlapping?

3) In your opinion: Is there any tasks being performed by the physicians today that after your opinion could as easily be taken over by an experienced nurse (3 years/triage experience) and why?

4) In your opinion: Would you be willing to take on more responsibilities than what you already have in your Emergency Department?

   If yes:

   c) Which responsibilities (and why)?
   d) Where would you set your limit in relation to take on new responsibilities (and why)?

   If not:

   c) Why not?
   d) What factors should be present for you to consider taking on new responsibilities?

5) In your opinion: How do you believe the patient will look at the quality of treatment being performed by a nurse in an Emergency Department, and how do you think they would have looked at the quality of treatment if the same task was performed by a doctor?

6) In your opinion: Do you believe that a task shift of tasks from doctors to nurses affects the patients waiting time and, if so, in what way?

7) In your opinion: Are you aware of any tasks that were historically the responsibility of doctors and which are now the responsibilities of nurses, and what do you think about this change?

8) In your opinion: Are there any tasks that you are performing but that you think would be better left to the doctors?

P49215 Dissertation Module
Student/Supervisor Agreement

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lntroduction:

This agreement, between the supervisor and dissertation student, should be completed and signed at the first meeting.

The details in this agreement should embody the roles outlined below.

For further information about the supervisor and student responsibilities, please see the module VLE site.

The Responsibilities of the Supervisor include:

1. To be available for student supervision for up to 15 hours during the period of the module;
2. To use the supervision time in the agreed manner set out below;
3. To agree to and sign the Record of Supervision as completed by the student or to request ariy changes as is appropriate;
4. To read, comment on and feedback to the student each chapter of draft work within a five working day period;
5. To be available for a further five hours of supervision should the student be required to resit the module;
6. To guide and direct the student to other resources such as the statistics advisor.

The Responsibilities of the Student lnclude:

1. To use supervision time wisely by preparing for meetings/contact in advance;
2. To take the lead in identifying any learning needs for the module;
3. To take the initiative in arranging contact with the supervisor;
4. To avoid where possible, cancelling meetings/contact at a late stage;
5. To rnform the supervisor of any new or continuing issues that may affect successful completion of the module;
6. Complete the Record of Supervision and e mail this to the supervisor within five days of contact;

Module P49215 Dissertation Supervision Record

A new record of supervision should be completed after each incident of supervision; this is to include: meetings' answering questions on email or by telephone, reading and commenting on draft work/ethics applications.

A note should be made on this form of the time used by the supervisor and a running total calculated.

Student's Name:	Lasse Andreassen
Supervisor's Name:	Jan Davison-Fischer
Date:	25.09.14 – 12.30 – 13.30
Supervision Activity:	Discussing the interviews for the dissertation
Supervisor's feedback:	Transcribe those parts of the interview that are relevant for the study. Make it a priority to finish all the interviews as soon as possible and do other research later.
Student Response:	None.
Student's Action Plan:	Done as told.

Time Taken by Supervisor: 1 hour Hours Remaining: 14 hours

(+ x hours from applications)

Date of next Contact:

Signed (student): Lasse Andreassen

Signed (supervisor): Jan Davison-Fischer

Module P49215 Dissertation Supervision Record

A new record of supervision should be completed after each incident of supervision; this is to include: meetings' answering questions on email or by telephone, reading and commenting on draft work/ethics applications.

A note should be made on this form of the time used by the supervisor and a running total calculated.

Student's Name: Lasse Andreassen

Supervisor's Name: Jan Davison-Fischer

Date: 23.10.14 – 12.30 – 13.30

Supervision Activity: Discussing the draft for the dissertation.

The student would like to discuss the following:

1) Do I cover what I need to cover with this content?

2) Is this an ok way to present the literature? I was planning to do as you said: Present what the literature says, present the findings, and then discuss the findings with the literature.

3) I have hardly started, but find it very hard to figure out how to present the findings. I feel it will be easier to know how to discuss if I have good form on the presentation of the findings.

- Do I present what the participants said 1 - 22? Do I only pick what I find the most interesting and is answering the questions? Can I say two or four said XXXX and write it with my own words? Do I summon up what have been said for each question? Is it to many quotations? etc

4) Where do you think I should put my focus for the upcoming 2 - 3 weeks?

5) And finally: Do you know a place where I can get access to some statistics for the British health care system?

Supervisor's feedback:

1) Yes
2) Try not to use more than 3.500 words on the literature so you have enough space for the discussion
3) It's important to make your own voice heard in the presentation. You can have less quotations and more summaries of your findings
4) Start on the discussion where you link the findings and the literature
5) Links provided

Student Response: None.

Student's Action Plan: Done as told.

Time Taken by Supervisor: 1 hour Hours Remaining: 13 hours

(+ x hours from applications)

Date of next Contact:

Signed (student): Lasse Andreassen

Signed (supervisor): Jan Davison-Fischer

Module P49215 Dissertation Supervision Record

A new record of supervision should be completed after each incident of supervision; this is to include: meetings' answering questions on email or by telephone, reading and commenting on draft work/ethics applications.

A note should be made on this form of the time used by the supervisor and a running total calculated.

Student's Name: Lasse Andreassen

Supervisor's Name: Jan Davison-Fischer

Date: 28.11.14 – 12.00 – 13.00

Supervision Activity: Discussing the draft for the dissertation.

The student would like to discuss the following:

Since we did not have much time to discuss the content I just followed examples I found in some books and looked at the dissertation you gave me.
I have been working a lot lately, and I have changed a lot of my previous work as well. I feel the draft is pretty good, but I know it's easy to fall in love with your own work.

I believe the introduction, the definitions, the literature search, the literature review and the presentation of findings are quite good. I am sure there are thing to be changed, but I am overall very pleased with these chapters.

I have a literature list including 80 something articles, and I have used every single one of them. That should be more than enough.

The method chapter I am also pretty pleased with. I feel that parts of it is quite good (compared to what I have seen elsewhere), but not sure if I have covered all I need to cover. I did not write anything about grounded theory because I did not find this relevant for my study (or maybe I misunderstood what it is). Instead I have written quite a lot about ethical challenges and recruitment as I find this very relevant.

If you wonder why I put in some illustrations it's because it was recommended in some of the books. Not sure if you agree, but I think it add some color.

I have not started on the conclusion yet. What is there now is just some thoughts in Norwegian. I have 1.500 words left to finish the discussion and the conclusion. And then I probably have to delete some parts.

The discussion I am less pleased with (at least some parts). It's not finished, and I honestly find some parts of it quite difficult to discuss. When some of the questions have 22 equal answers and the literature say the same as the participants it's not much to discuss. I feel I sometimes just repeat my findings. But maybe thats how it's supposed to be. I did not find many answers in the literature.

Well, here it is. I would like you to read through and tell me what you think of the different parts and especially what need improvement. And most of all: Is this good enough?

When you are back I hardly have 3 weeks left, and that is really not much time. As I said, I hope you can help me so I can finish this before x-mas.

Supervisor's feedback: Went through the questions.

Student Response: None.

Student's Action Plan: Done as told.

Time Taken by Supervisor: 1 hour Hours Remaining: 12 hours

(+ x hours from applications)

Date of next Contact:

Signed (student): Lasse Andreassen

Signed (supervisor): Jan Davison-Fischer

Norsk samfunnsvitenskapelig datatjeneste AS
NORWEGIAN SOCIAL SCIENCE DATA SERVICES

Harald Hårfagres gate 29
N-5007 Bergen
Norway
Tel: +47-55 58 21 17
Fax: +47-55 58 96 50
nsd@nsd.uib.no
www.nsd.uib.no
Org.nr. 985 321 884

Eli Feiring
Institutt for helse og samfunn Universitetet i Oslo
Postboks 1130 Blindern
0318 OSLO

Vår dato: 24.06.2014 Vår ref: 38926 / 3 / JSL Deres dato: Deres ref:

TILBAKEMELDING PÅ MELDING OM BEHANDLING AV PERSONOPPLYSNINGER

Vi viser til melding om behandling av personopplysninger, mottatt 02.06.2014. Meldingen gjelder prosjektet:

38926	*Oppfatter sykepleiere i akuttmottak at en innføring av Nurse Practitioners/Advanced Clinical Practitioners kan bidra til å redusere pasientenes ventetid?*
Behandlingsansvarlig	*Universitetet i Oslo, ved institusjonens øverste leder*
Daglig ansvarlig	*Eli Feiring*
Student	*Lasse Andreassen*

Personvernombudet har vurdert prosjektet og finner at behandlingen av personopplysninger er meldepliktig i henhold til personopplysningsloven § 31. Behandlingen tilfredsstiller kravene i personopplysningsloven.

Personvernombudets vurdering forutsetter at prosjektet gjennomføres i tråd med opplysningene gitt i meldeskjemaet, korrespondanse med ombudet, ombudets kommentarer samt personopplysningsloven og helseregisterloven med forskrifter. Behandlingen av personopplysninger kan settes i gang.

Det gjøres oppmerksom på at det skal gis ny melding dersom behandlingen endres i forhold til de opplysninger som ligger til grunn for personvernombudets vurdering. Endringsmeldinger gis via et eget skjema, http://www.nsd.uib.no/personvern/meldeplikt/skjema.html. Det skal også gis melding etter tre år dersom prosjektet fortsatt pågår. Meldinger skal skje skriftlig til ombudet.

Personvernombudet har lagt ut opplysninger om prosjektet i en offentlig database, http://pvo.nsd.no/prosjekt.

Personvernombudet vil ved prosjektets avslutning, 15.04.2015, rette en henvendelse angående status for behandlingen av personopplysninger.

Vennlig hilsen

Katrine Utaaker Segadal

Juni Skjold Lexau

Kontaktperson: Juni Skjold Lexau tlf: 55 58 36 01

Dokumentet er elektronisk produsert og godkjent ved NSDs rutiner for elektronisk godkjenning.

Vedlegg: Prosjektvurdering
Kopi: Lasse Andreassen lasseandreassen108@gmail.com

Personvernombudet for forskning

Prosjektvurdering - Kommentar

Prosjektnr: 38926

Prosjektet er en internasjonal samarbeidsstudie. Universitetet i Oslo er behandlingsansvarlig institusjon for den norske delen. Personvernombudet forutsetter at ansvaret for behandlingen av personopplysninger er avklart mellom institusjonene. Vi anbefaler at det inngås en avtale som omfatter ansvarsfordeling, ansvarsstruktur, hvem som initierer prosjektet, bruk av data og eventuelt eierskap.

Utvalget informeres skriftlig om prosjektet og samtykker til deltakelse. Informasjonsskrivet er godt utformet.

Vi legger til grunn at rekruttering av deltakerne gjennomføres på en slik måte at frivilligheten ivaretas. Når det rekrutteres gjennom ledelsen, kan dette sikres ved at samtykke gis direkte til student/veileder (ikke via leder).

Personvernombudet legger til grunn at forsker etterfølger Universitetet i Oslo sine interne rutiner for datasikkerhet. Dersom personopplysninger skal lagres på mobile enheter, bør opplysningene krypteres tilstrekkelig.

Forventet prosjektslutt er 15.04.2015. Ifølge prosjektmeldingen skal innsamlede opplysninger da anonymiseres. Anonymisering innebærer å bearbeide datamaterialet slik at ingen enkeltpersoner kan gjenkjennes. Det gjøres ved å:
- slette direkte personopplysninger (som navn/koblingsnøkkel)
- slette/omskrive indirekte personopplysninger (identifiserende sammenstilling av bakgrunnsopplysninger som f.eks. bosted/arbeidssted, alder og kjønn)

This is a locked Word form. To enable editing commands, such as spell-check, search and replace etc. unlock the form by clicking the padlock icon in your Word toolbar (to show: view>toolbars>wordforms).
To complete the checkboxes, the form must be locked; this may be done by again clicking the padlock icon.

OXFORD BROOKES UNIVERSITY

UNIVERSITY RESEARCH ETHICS COMMITTEE

APPLICATION FOR APPROVAL OF A PROJECT INVOLVING HUMAN PARTICIPANTS, DATA OR MATERIAL

Registration No. *(office use only)* ☐☐☐☐☐☐

Period of Approval *(office use only)* ...../...../…… to ...../...../.....
Approval is for two years from the date the full approval letter was issued or six months after the study is due to be completed, whichever is longest.

This application form is to be used by researchers seeking approval from the University Research Ethics Committee.
Applications must be completed on the form; answers in the form of attachments will not be accepted, except where indicated. ***No handwritten applications will be accepted****. Applicants should contact the appropriate Faculty Research Ethics Officer (FREO) to establish procedures for ethics review in the Faculty.* ***Applicants must go through Faculty procedures and the FREO must sign off the application before it is copied and submitted to the University Research Ethics Committee.***

When the FREO has signed the application, please submit the completed application to Louise Wood, RBDO, Buckley Building, HCGL. Only those applications received by the submission deadline date shown on the University's Research Ethics web site (**www.brookes.ac.uk/res/ethics/committee**) will be considered at the next meeting.

Potential participants must not be contacted until written approval has been received from the Committee.

PROJECT TITLE: **"How do the nurses perceive that a task shift from the physicians' to the nurses' in an emergency department will influence the patients waiting time?"**

THIS PROJECT IS: *(tick as many as apply)*

- ☐ Staff Research Project
- ☒ Research Student Project
- ☐ Project by External Researcher *(please give details)*
  - ☐ Project by member of staff at another institution (*please give details of Post and Institution, including address)*
  - ☐ MPhil/PhD or professional doctorate student at another institution (*please give details of Department and Institution, including address)*
  - ☒ Masters student at another institution (*please give details of Department and Institution, including address)*

PRINCIPAL INVESTIGATOR(S): *PhD and doctoral students can be listed as Principal Investigator after their supervisors. The Director of Studies should also be identified.*

TITLE & NAME	*POST*	*DEPT & FACULTY*	*PHONE*	*EMAIL*
Dr Jan Davison-Fischer	Senior Lecturer	Health and Life Sciences	441865482740	j.fischer@brookes.ac.uk

OTHER INVESTIGATORS:

TITLE & NAME	*POST*	*DEPT & FACULTY*	*PHONE*	*EMAIL*
Mr Lasse Andreassen	Student	Health and Life Sciences and UiO Faculty of Medicine	+4722451500	lasseandreassen108@gmail.com

ADDRESS FOR CORRESPONDENCE (PRINCIPAL INVESTIGATOR):

Dr Jan Davison-Fischer
Senior Lecturer in Professional Education and Leadership
Faculty of Health and Life Sciences
Oxford Brookes University
Jack Straw's Lane
Marston, Oxford
OX3 0FL, England

DECLARATION BY INVESTIGATORS

The information contained herein is, to the best of my knowledge and belief, accurate. I have read the University's Code of Practice for Ethical Standards for Research Involving Human Participants, and accept responsibility for the conduct of the procedures set out in the attached application in accordance with the guidelines, the University's Code of Practice, where appropriate, the guidelines for observation and handling of animals in field research, and any other condition laid down by Oxford Brookes University's Research Ethics Committee. I have attempted to identify all risks related to the research that may arise in conducting this research and acknowledge my obligations and the rights of the participants.

I and my co-investigators or supporting staff have the appropriate qualifications, experience and facilities to conduct the research set out in the attached application and to deal with any emergencies and contingencies related to the research that may arise.

Signature(s): *Date* *....../....../…….*

Principal investigator(s)

Print name(s) of Principal Investigator(s) in block letters

DECLARATION BY FACULTY RESEARCH ETHICS OFFICER (FREO) (BROOKES STAFF AND STUDENTS ONLY)

DATE APPLICATION RECEIVED: *....../....../…….*

DATE ETHICS REVIEW COMPLETED *....../....../…….*

The Faculty Research Ethics Committee has reviewed this project and considers the methodological/technical and ethical aspects of the proposal to be appropriate to the tasks proposed and recommends approval of the project. The Faculty Research Ethics Committee considers that the investigator(s) has/have the necessary qualifications, experience and facilities to conduct the research set out in the attached application, and to deal with any emergencies and contingencies that may arise.

Comments/Provisos:

Signature(s): *Date* *....../....../…….*

FREO

Print name in block letters

UNIVERSITY RESEARCH ETHICS COMMITTEE USE ONLY

Date application received: *....../....../…….*

Date of meeting: *....../....../…….*

Email discussion deadline: *....../....../…….*

CRM Reference No: *……..*

Decision:

Date:	*....../....../.....*	*Approved*	☐	*Approved, subject to specific conditions*	☐	*Not approved*	☐	*Returned for further clarification*	☐
Date:	*....../....../.....*	*Approved*	☐	*Approved, subject to specific conditions*	☐	*Not approved*	☐	*Returned for further clarification*	☐
Date:	*....../....../.....*	*Approved*	☐	*Approved, subject to specific conditions*	☐	*Not approved*	☐	*Returned for further clarification*	☐

Date of final approval *....../....../…….*

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1. PROJECT DETAILS

1.1 PROPOSED DURATION OF DATA COLLECTION COMPONENT OF PROJECT From: September 2014 To: May 2015

1.2 LAY DESCRIPTION: *Provide a brief outline of the project, including what participants will be required to do. This description must be in everyday language which is free from jargon. Please explain any technical terms or discipline-specific phrases. (No more than 350 words)*

The waiting time for patients in Norwegian Emergency Departments has increased over the last year due to circumstances like an aging population with health problems and less access to experienced doctors to treat them (SSB, 2014). Since waiting time is considered a quality indicator in Emergency Departments, an increasing waiting time might indicate less quality for the patients.

In England an attempt has been made to address this problem by introducing specially trained nurses, often referred to as Nurse Practitioners or Advanced Clinical Practitioners, to reduce the patients waiting time. These specially trained nurses have taken over some tasks that traditionally were the job of the physicians. Here some of the patients groups are being treated by the ACP's and NP's. Studies have shown that the use of ACPs and NPs improved patients' overall outcome, reduced the patients waiting time and saved money for the hospitals.

In Norwegian Emergency Departments all patients are still treated by junior or middle-grade doctors (Frich, 2011). The aim of this project is to get the nurses perception on how a task shift from physicians to nurses in an Emergency Department might influence on the patients' waiting time. The answers will allow some comparisons between Norwegian and British approaches to emergency care.

20 participants, 10 from Norwegian Emergency Departments and 10 from British Emergency Departments, will be required two take part of a one hour semi-structured interview with the master's student. They will be asked the attached questions.

References:
Frich, Jan (2011). Jobbglidning - et ledelsesperspektiv. Overlegen 1
www.helsedirektoratet.no/samhandlingsreformen/Sider/default.aspx
www.ssb.no/helse/artikler-og-publikasjoner/eldres-bruk-av-helse-og-omsorgstjenester

1.3 AIMS OF AND JUSTIFICATION FOR THE RESEARCH: *State the aims and significance of the project. Where relevant, state the specific hypothesis to be tested. Also please provide a brief description of the proposed research, a justification as to why this research should proceed and an explanation of any expected benefits to the community.* ***Please provide full references for any work referred to****. (No more than 700 words)*

The aim of this project is to answer the research question "How do the nurses perceive that a task shift from the physicians' to the nurses' in an emergency department will influence the patients' waiting time?" to see if a task shift from the physicians to the nurses in the Emergency Departments (EDs) in Norway can be a way of reducing an increasing waiting time.

Background:

Hospital care in the UK has been facing challenges over the last few years with budgetary, regulatory and organisational pressures. One of the responses to these challenges has been the creation of the Advanced Clinical Practitioner (ACP) or Nurse Practitioner (NP) posts (Fawdon and Adams, 2013, Laurant et al, 2009), who receive and treat some of the ED patients. On admission to the ED an experienced nurse assesses the patients need for treatment via one of three routes: minor injury, minor illness or rapid assessment and treatment stream (RATS) (Fawdon and Adams, 2013). The ACP or NP will, sometimes with advices from a middle-grade doctor, interpret the investigation results and refer the patient to a specialist or discharge him or her.

In England 95% of the ED patients must be discharged or admitted to a ward within four hours to avoid financial penalties, and surveys have agreed or strongly agreed that that the use of ACPs improved patients overall outcome, reduced waiting time and saved money (Collins et al, 2014, Carter and Chochinov, 2007).

Norway has also been facing the same challenges over the last years with budgetary, regulatory and organisational pressures. An increasing population of old people with healtcare problems and lack of experienced doctors to treat them is part of this problem. As a result the waiting time for patients coming to the Emergency Departments have increased, and for minor injuries and minor illnesses the patients sometimes have to wait up to 6 – 8 hours to be discharged or admitted (SSB, 2014). In Norway all examinations and all treatment in the Emergency Departments are being done by junior doctors or middle-grade doctors like it was in UK before the introduction of task shifts and education of ACP's and NP's.

Aim of this project:

This project is a study to look at the perception of nurses of the impact of the division of labour on waiting time for patients being treated in a British Emergency Department by an ACP or NP and a Norwegian Emergency Department where patients are being treated by junior doctors or middle-grade doctors, and to see if the nurses perception of an introduction of task shifts in Norwegian Emergencies potentially can reduce the patients waiting time and improve the patients overall outcome.

To do this, Norwegian nurses working in Norwegian Emergency Departments will be asked some questions about their perception on task shifts. The same questions will be asked British nurses working as ACP's or NP's in British Emergency Departments. The thesis is that by introducing a task shift from the doctors to the nurses in Norwegian emergency departments the waiting time for the patients will be reduced, and the doctors will have more time to work on patients with more complicated diagnosis or higher triage.

Waiting time as a quality indicator will be used as the framework for this project.

The expected benefit to the community is to see if the nurses believe there are things that can be changed in the Norwegian Emergency Departments to reduce the patients waiting time by doing a task shift or introducing ACP's or NP's in Norway. Since waiting time is considered a quality indicator in Emergency Departments and as it can have an impact on disease progression, reducing the waiting time will benefit the patients by improve their overall outcome.

References:

Collins, Nina et al (2014). Outcomes of adding acute care nurse practitioners to a Level 1 trauma service with the goal of decreased length of stay and improved physician and nursing staisfaction. Lippincott, Williams & Wilkins

Delamaire, Marie-Laure and Lafortune, Gaetan (2010). Nurses in Advanced Roles. A description and evaluation of experiences in 12 developed countries. OECD Health Working Papers No 54

Fawdon, H. and Adams, J. (2013). Advanced clinical practitioner role in emergency department, Nursing Standard,28, 16 - 18

Laurant, M., Reeves, D., Hermens, R., Braspenning, J. Grol, R. and Sibbald, B. (2009). Substitution of doctors by nurses in primary care (Review). The Cochrane Collaboration

www.ssb.no/helse/artikler-og-publikasjoner/eldres-bruk-av-helse-og-omsorgstjenester

World Health Organization (2006). Working together for health. The World Health Report 2006

1.4 PROPOSED METHOD: *Provide an outline of the proposed method, including details of data collection techniques, tasks participants will be asked to do, the estimated time commitment involved, and how data will be analysed. If the project includes any procedure which is beyond already established and accepted techniques please include a description of it. (No more than 500 words.)*

The method for this project will be semi-structured interviews (Creswell, 2014) where invited participants from Norway and England working as experienced nurses in the Emergency Department will be asked some questions to determine whether they believe a task shift from the physicians' to the nurses' will help reducing the patients waiting time.

Data for this project will be obtained through interviews with 10 experienced British nurses and 10 experienced Norwegian nurses (see attached interview guide). Participants will be identified through a purposive sampling method (Creswell, 2014), as the head of department or lead nurse will be asked to identify experienced staff and facilitate initial contact with the researcher. The interviews will take place at the participating hospitals or a suitable nearby location. Each interview is stipulated to take approximately one hour, and it will be a one-to-one semi-structured interview. Interviews in the UK will be audio recorded and transcribed. In recognition of societal attitudes to audio recording, interviews in Norway will not be recorded, but detailed notes will be made by the researcher (Malterud, 2011).

The data from the interviews will be compared, and the result will also be compared to literature on waiting time as a quality indicator in Emergency Departments. The study will use thematic analysis to examine the data (Lathlean, 2010).

A part of the study will be carried out in Oslo, Norway. This project have already received permission from the Norwegian Ethics Committee and from one of two involved hospitals (see 1.9). The collection of data for the Norwegian part of the project will be delayed until permission from the OBU Faculty Ethics Committee has been given.

The results of the interviews in this project will be submitted to the supervisor and discussed. This will happen after the interviews are completed but before the analysis of the answers start. Only the supervisor and the student will have access to the notes from the interviews. The supervisor will not have access to the link between the identity of the persons being interviewed and the notes from the interviews.

The interviews will be conducted for the Norwegian part from August till September, and for the British part from September to November. The analysis will take place from December to January.

References
Creswell, John W. (2014). Research Design. Qualitative, Quantitative and Mixed Methods Approaches. Los Angeles: Sage Publications Inc.
Lathlean, J. (2010) Qualitative Analysis. Chapter 34. In: The Research Process in Nursing. Editors. K. Gerrish and A. Lacey. 6th edition. Oxford: Wiley Blackwell
Malterud, Kirsti (2011). Kvalitative metoder i medisinsk forskning. En Innføring. Oslo: Universitetsforlaget

1.5 INVESTIGATORS' QUALIFICATIONS, EXPERIENCE AND SKILLS
List the academic qualifications and outline the experience and skills relevant to this project that the researchers and any supporting staff have in carrying out the research and in dealing with any emergencies, unexpected outcomes, or contingencies that may arise.

The research supervisor Dr. Jan Davison-Fischer is an experienced qualitative researcher and dissertation supervisor. Lasse Andreassen has been trained in research methods by the University of Oslo.

1.6 PLEASE EXPLAIN WHEN, HOW, WHERE, AND TO WHOM RESULTS WILL BE DISSEMINATED, INCLUDING WHETHER PARTICIPANTS WILL BE PROVIDED WITH ANY INFORMATION ON THE FINDINGS OR OUTCOMES OF THE PROJECT:

The research findings will be disseminated through a Masters dissertation by Lasse Andreassen. If appropriate, results may be published in practitioner and academic journals.

All the participants will be offered a digital copy of the student's dissertation by e-mail upon project completion.

1.7 WILL THE RESEARCH BE UNDERTAKEN *ONLY* ON-SITE AT OXFORD BROOKES UNIVERSITY (including all campuses)?

☐ YES, only on-site ☒ NO, not only on-site *(If NO, give details of off-campus location, including other sites where research is being undertaken and other countries providing data):*

The research will take place both at Emergency Departments at hospitals in Oxford or London, England, and at Emergency Departments at hospitals in Oslo, Norway. The Norwegian Ethics Committee have already given permission for doing interviews at Norwegian Emergency Departments, but as mentioned earlier, no data will be collected before the British part of the study has been approved.

Contact will initially be made with the (Accident &) Emergency Departments at the John Radcliffe Hospital in Oxford and at St Mary's Hospital in London. For this, permission from the Research & Development Departments of these hospitals will be obtained first. If there should be any problems with recruitment at these Trusts, the study may approach other London NHS Trusts for permission.

1.8 OTHER APPROVALS REQUIRED *Has permission to conduct the research in, at or through another institution or organisation (e.g. a school) been obtained? Individuals proposing to conduct research involving contact with children or vulnerable adults must first get agreement from the individual with appropriate authority in the institution or organization through which the research is being conducted. (Copies of letters of approval to be provided).*

☐ YES ☒ NO ☐ NOT APPLICABLE

(If YES, please specify from whom and attach a copy. If NO, please explain when this will be obtained.)

Approval from the Research and Development departments of NHS Trusts is pending and will be forwarded to the Chair of the Faculty of Health and Life Sciences Research Ethics Committee before data collection will commence.

1.9 IS THIS PROTOCOL BEING SUBMITTED TO ANOTHER ETHICS COMMITTEE, OR HAS IT BEEN PREVIOUSLY SUBMITTED TO AN ETHICS COMMITTEE? *This includes an NHS Local Research Ethics Committee or any other institutional committee of collaborating partners or research sites.*

☒ YES ☐ NO *(If YES, please provide details including correspondence setting out conditions of approval.)*

The Norwegian part of this project has already been approved by NSD Personvernombudet in Oslo, Norway and the local ethics committee at Diakonhjemmet Hospital. An application have also been submitted to Lovisenberg Hospital in Oslo for approval.

2. PARTICIPANT DETAILS

2.1 DO YOU INTEND TO RECRUIT: *(Tick as many as applicable)*

		YES	NO
a)	students or staff of this University (i.e. recruitment on-site at Brookes)	☐	☒
b)	adults (over the age of 16 years and competent to give consent)	☒	☐
c)	children/legal minors (anyone under the age of 16 years)	☐	☒
d)	patients or clients of professionals	☐	☒
e)	anyone who is in custody, custodial care, or for whom a court have assumed responsibility	☐	☒
f)	any other person whose capacity to consent may be compromised	☐	☒
g)	a member of an organisation where another individual may also need to give consent	☐	☒

2.2 NUMBER, AGE RANGE AND SOURCE OF PARTICIPANTS

Provide number, age range and source of participants. Please provide an explanation for your proposed sample size (including details of statistical power of the sample, where appropriate) and state any exclusion or inclusion criteria.

For this study the plan is to interview 10 nurses from different emergency departments at local hospitals in Oxford and/or London, England working as experienced nurses, Nurse Practitioners or Advanced Clinical Practitioners. They will be asked about their work, and the focus will be on their view and their thought of how they as Nurse Practitioners or Advanced Clinical Practitioners true task shifts can save their patients for unnecessary waiting time and at the same time improve their patients overall outcome.

The respondents age range will most probably be from 20 - 65. Noone under the age of 18 will be included in the British part of this project.

The plan is also to interview up to 10 experienced nurses working at two different emergency departments in Oslo, Norway. The focus for these interviews will be how they think task shifts and an implementing of the role of Nurse Practitioners or Advanced Clinical Practitioners in Norwegian emergency departments will help reducing the patients waiting time, and how they think it might improve or reduce the patients overall outcome. They will also be asked in Norwegian Emergency Departments.

The aim is here to talk to nurses who have been working in an Emergency Department for a few years (experienced nurses), and their age range will probably be from 22 to 62 years old. Noone under the age of 18 will be included in the Norwegian part of the project.

2.3 MEANS BY WHICH PARTICIPANTS ARE TO BE RECRUITED

Please provide specific details of how you will be recruiting participants. How will people be told you are doing this research? How will they be approached and asked if they are willing to participate? If you are mailing to or phoning people, please explain how you have obtained or will obtain their names and contact details. This information will need to be included in the participant information sheet. *If a recruitment advertisement is to be used, please ensure you attach a copy to this application.*

The heads of Emergency Departments (London, Oxford and Oslo) mentioned in this application will be contacted with a letter. After they have received their letters, Dr. Jan Davison-Fischer or Lasse Andreassen will contact the heads by calling them. He will explain the aim for this project. If they are interested in participating they will receive written information including the interview guide and a letter of consent and ask to suggest some nurses from each hospital that might be willing to participate in this project. The aim is to obtain up to five interviews from each hospital.

The suggested nurses will be contacted, and those who say yes to participate will receive an invitation letter explaining the aim of the projects and a participant information sheet about how and when the interview will take place. The will also receive a copy of the interview guide, a consent form and a suggested time for the interview.

2.4 WILL PARTS OF THIS PROJECT BE CARRIED OUT BY INDEPENDENT CONTRACTORS?

☐ YES ☒ NO *If YES, please explain who the independent contractors are, what their role will be and how their work will be monitored. Responsibility for proper conduct of the project remains with the Principal Investigator.]*

2.5 ARE ANY OF THE PARTICIPANTS IN A DEPENDENT RELATIONSHIP WITH ANY OF THE INVESTIGATORS, PARTICULARLY THOSE INVOLVED IN RECRUITING FOR OR CONDUCTING THE PROJECT?

Research involving persons in dependent or unequal relationships (for instance, teacher/student) may compromise a participant's ability to give consent which is free from any form of pressure (real or implied) arising from this unequal power relationship. Therefore, UREC recommends that, where possible, researchers choose participant cohorts where no dependent relationship exists. If, after due consideration, the investigator believes that research involving people in dependent relationships is purposeful and defensible, then UREC will require additional information setting out the case and detailing how risks inherent in the dependent relationship will be managed. UREC will also need to be reassured that refusal to participate will not result in any discrimination or penalty.

NB. Reasons of convenience alone will not normally be considered adequate justification for conducting research in situations where dependent relationships exist.

☐ YES ☒ NO *(If YES, please explain the relationship (e.g. teacher/student, student/lecturer, employer/employee) and the steps to be taken by the investigators to ensure that the participant's participation is purely voluntary and not influenced by the relationship in any way.)*

2.6 PAYMENT OR INCENTIVES: DO YOU PROPOSE TO PAY OR REWARD PARTICIPANTS?

☐ YES ☒ NO *(If YES, how, how much and for what purpose?)*

Some participants might be offered lunch before, during or after the interview if they only are able to take time off during their break. This is not considered a reward or payment, but more a practical arrangement to make sure the Nurse Practitioners or the Advanced Clinical Practitioners will be able to participate.

3. RISK AND RISK MANAGEMENT

3.1 DOES THE RESEARCH INVOLVE:

	YES	NO
• use of a questionnaire or similar research instrument or measure? (attach copy)	☐	☒
• use of written or computerised tests	☐	☒
• interviews? (attach interview questions)	☒	☐
• diaries? (attach diary record form)	☐	☒
• participant observation?	☐	☒
• observation of participants (in a non-public place) without their knowledge?	☐	☒
• audio-recording interviewees or events?	☒	☐
• video-recording interviewees or events?	☐	☒
• access to personal and/or confidential data? (including student, patient or client data) without the participant's specific consent	☐	☒
• administration of any questions, tasks, investigations, procedures or stimuli which may be experienced by participants as physically or mentally painful, stressful or unpleasant during or after the research process?	☐	☒
• performance of any acts which might diminish the self-esteem of participants or cause them to experience embarrassment, regret or depression?	☐	☒
• investigation of participants involved in illegal activities?	☐	☒
• procedures that involve deception of participants?	☐	☒
• administration of any substance or agent?	☐	☒
• use of non-treatment of placebo control conditions?	☐	☒
• collection of body tissues or fluid samples?	☐	☒
• collection and/or testing of DNA samples?	☐	☒
• collection and/or testing of gametes or embryo tissue?	☐	☒
• participation in a clinical trial?	☐	☒
• administration of ionising radiation to participants?	☐	☒

- research overseas? ☐ ☒

3.2 POTENTIAL RISK TO PARTICIPANTS AND RISK MANAGEMENT PROCEDURES
Identify, as far as possible, all potential risks to participants (e.g. physical, psychological, social, legal or economic), associated with the proposed research. Please explain what risk management procedures will be put in place.

The only part the participants play in this project is to be part of an interview. There will be no risk to participants associated with the proposed study.

3.3 ARE THERE ANY SPECIFIC RISKS TO RESEARCHERS THAT ARE GREATER THAN THOSE ENCOUNTERED IN NORMAL DAY TO DAY LIFE? *(Where research is undertaken at an off-campus location, whether in the UK or abroad, researchers should consult the University guidelines regarding risk assessment. Further details are available at: www.brookes.ac.uk/services/hr/health_safety/docs/index.html* **sections OBUHSN 36 & 38.** *The Dean of Faculty or the Director has the overall responsibility for risk assessment regarding the health and safety of researchers. Useful advice for the safety of researchers is available on the Social Research Association website at:* www.the-sra.org.uk *and where appropriate, researchers should read the guidelines on observation, care and handling of animals in field research www.brookes.ac.uk/res/ethics/field.*

☐ YES ☒ NO *(If YES, please describe)*:

3.4 PLEASE EXPLAIN HOW THE POTENTIAL BENEFITS OF THE RESEARCH OUTWEIGH ANY RISKS TO PARTICIPANTS. *Briefly describe the main benefits and contribution of the study. Include any immediate benefits to participants as well as the overall contribution to knowledge or practice.*

There will be no direct benefits for the participants except their chance to share their knowledge and maybe help to inform future improvements of the Emergency Departments at Norwegian and UK hospitals. At the same time there will be no risks to the participants either.

3.5 ADVERSE / UNEXPECTED OUTCOMES
Please describe what measures you have in place in the event of any unexpected outcomes or adverse effects to participants arising from involvement in the project.

There are no adverse outcomes foreseen and the risk of the project do not exceed those of everyday life. A full risk analysis will be carried out as part of routine supervision activities before fieldwork commences. In the event of an unexpected outcome, the researcher will contact his supervisor's mobile telephone immediately and, if appropriate, inform the chair of the Faculty Research Ethics Committee by e-mail.

3.6 DEBRIEFING, SUPPORT AND/OR FEEDBACK TO PARTICIPANTS (as appropriate)
What, if any, debriefing, support or feedback will participants receive following the study and when? Participants may need to talk about the experience of being involved in the study or about issues it has raised for them. Depending on risks to participants you may need to consider having additional support for participants during/after the study (e.g., external counseling). Further information on the aims of the research, their own performance and/or the results of the study may also be appropriate.

There will be no routine debriefing. Participants who ask for feedback will be offered a digital copy of the student's dissertation by e-mail upon project completion.

3.7 MONITORING
Please explain how the conduct of the study will be monitored, for example via your Associate Dean for Research and Knowledge Transfer or supervisory team, (especially where several people are involved in recruiting or interviewing, administering procedures) to ensure that it conforms with the procedures set out in this application, the University's Code of Practice and any guidelines published by their professional association.

Supervision will take place through regular contact with the OBU supervisor Dr. Jan Davison-Fischer.

4. INFORMED CONSENT

4.1 HAVE YOU ATTACHED TO YOUR APPLICATION A COPY OF THE PARTICIPANT INFORMATION SHEET?
(Guidelines for drafting this are provided on the UREC web page at: www.brookes.ac.uk/res/ethics/consent *Whenever possible, Oxford Brookes University letterhead should be used for information sheets.)*

☒ YES ☐ NO *(If NO, please explain.)*

THE FOLLOWING IS A LIST OF ITEMS NORMALLY EXPECTED TO BE INCLUDED IN AN INFORMATION SHEET. PLEASE USE IT IN CHECKING THAT YOUR DOCUMENTS INCLUDE:

	YES	NOT APPLICABLE
• clear identification of the University, the Department(s) involved, the project title, the Principal and other investigators (including contact details)	☒	
• details of what involvement in the project will require (e.g., involvement in interviews, completion of questionnaire, audio/ video-recording of events), estimated time commitment, any risks involved	☒	
• advice that the project has received clearance by the UREC	☒	☐
• if the sample size is small, advice to participants that this may have implications for privacy/anonymity	☒	☐
• a clear statement that if participants are in a dependent relationship with any of the researchers that involvement in the project will not affect ongoing assessment/grades/management or treatment of health *(as relevant)*	☐	☒
• assurance that involvement in the project is voluntary and that participants are free to withdraw consent at any time, and to withdraw any unprocessed data previously supplied	☒	
• advice as to arrangements to be made to protect confidentiality of data, including that confidentiality of information provided is subject to legal limitations	☒	☐
• a statement that the data generated in the course of the research be retained in accordance with the University's policy of Academic Integrity and must be kept securely in paper or electronic form for a period of ten years after the completion of a research project. www.brookes.ac.uk/res/policy/academic_integrity.pdf	☒	☐
• advice that if participants have any concerns about the conduct of this research project that they can contact the Chair of the University Research Ethics Committee at Oxford Brookes University, including the e-mail address: ethics@brookes.ac.uk.	☒	
• any other relevant information	☒	☐

4.2 HAVE YOU ATTACHED TO YOUR APPLICATION A COPY OF THE CONSENT FORM? - *if you are not obtaining consent in writing please explain how the informed consent process is to be documented. (Guidelines for drafting a consent form are provided on the UREC web page. Whenever possible, Oxford Brookes University letterhead should be used for consent forms.)*

☒ YES ☐ NO *(If NO, please explain how you consent will be documented.)*

DOES THE CONSENT FORM INCLUDE THE FOLLOWING:

	YES	NO	NOT APPLICABLE
• appropriate letterhead	☒	☐	☐
• title of the project and names of investigators	☒		
• confirmation that the project is research	☒		
• confirmation that involvement in the project is voluntary and that participants are free to withdraw at any time, or to withdraw any unprocessed data previously supplied	☒		
• confirmation of particular requirements of participants, including for example whether interviews are to be audio-/video-recorded, whether anonymised quotes will be used in publications	☒		☐
• advice of legal limitations to data confidentiality (in studies where the participants are named or de-identified)	☐		☒
• if the sample size is small, confirmation that this may have implications for anonymity	☒		☐
• any other relevant information	☒		☐

5. CONFIDENTIALITY/ANONYMITY

5.1 WILL THE RESEARCH INVOLVE:

	YES	NO
• complete anonymity of participants (i.e., researchers will not know the identity of participants as participants are part of a random sample and are required to return responses with no form of personal identification)?	☐	☒
• anonymised samples or data (i.e., an irreversible process whereby identifiers are removed from data and replaced by a code, with no record retained of how the code relates to the identifiers. It is then impossible to identify the individual to whom the sample of information relates)?	☒	☐
• de-identified samples or data (i.e., a reversible process in which the identifiers are removed and replaced by a code. Those handling the data subsequently do so using the code. If necessary, it is possible to link the code to the original identifiers and identify the individual to whom the sample or information relates)?	☐	☒
• participants having the option of being identified in any publication arising from the research?	☐	☒
• participants being referred to by pseudonym in any publication arising from the research?	☒	☐
• the use of personal data? *(If YES, you may need to register with the University)*	☐	☒

Please bear in mind that where the sample size is very small, it may be impossible to guarantee anonymity/confidentiality of participant identity. Participants involved in such projects need to be advised of this limitation.

5.2 WHICH OF THE FOLLOWING METHODS OF ASSURING CONFIDENTIALITY OF DATA WILL BE IMPLEMENTED? *Please select all relevant options.*

- data and codes and all identifying information to be kept in separate locked filing cabinets ☒
- access to computer files to be available by password only ☒
- other *(please describe)* ☐

5.3 LEGAL LIMITATIONS TO DATA CONFIDENTIALITY: *Participants need to be aware that the confidentiality of the information they provide can only be protected within the limitations of the law - i.e. it is possible for data to be subject to subpoena, freedom of information claim or mandated reporting by some professions.* ***This only applies to named or de-identified data. If your participants are named or de-identified, you may need to specifically state these limitations****.*

☒ YES ☐ NO *(please explain)* ☐ Not applicable

6 DATA ACCESS, STORAGE AND SECURITY

6.1 WILL THE PRINCIPAL INVESTIGATOR BE RESPONSIBLE FOR SECURITY OF DATA COLLECTED?

☒ YES ☐ NO *(If NO, please provide further details including any differences between arrangements in the field, and on return to campus.)*

6.2 ACCESS TO DATA

☒ **Access by named researchers only**
☐ **Access by people other than named researcher(s)** *(Please explain:)*

6.3 STORAGE OF DATA

☒ **Stored at Oxford Brookes University**
☐ **In a secure shared repository** *(This should be explained to participants in the information sheet)*

☒ **Stored at another site** *(Please explain where and for what purpose:)*

On Lasse Andreassens' laptop.

6.4 DOES DATA STORAGE COMPLY WITH THE UNIVERSITY'S GUIDELINES FOR THE MANAGEMENT OF RESEARCH DATA AND RECORDS? *(See Oxford Brookes University Code of Practice for Academic Integrity, at:* www.brookes.ac.uk/res/policy/academic_integrity.pdf

☒ YES ☐ NO *(If NO, please explain.)*

7. FUNDING

7.1 IS THIS PROJECT BEING EXTERNALLY FUNDED?

☐ YES ☒ NO *(If NO, please skip the remaining questions.)*

7.2 SOURCE OF FUNDING?

7.3 PROJECT GRANT TITLE AND PROPOSED DURATION OF GRANT *(Where applicable)*

7.4 DOES THE PROJECT REQUIRE APPROVAL BEFORE CONSIDERATION BY A FUNDING AGENCY?

☐ YES ☐ NO

IF YES: DEADLINE FOR THE FUNDING AGENCY?

7.5 HOW WILL PARTICIPANTS BE INFORMED OF THE SOURCE OF THE FUNDING? *The source of funding should normally be explained in the participant information sheet.*

8. CHECKLIST

Please check that the following documents are attached to your application. Please note that where questionnaire or interview questions are submitted in draft form, a copy of the final documentation must be submitted for final approval when available.

	ATTACHED		NOT APPLICABLE
Recruitment advertisement (question 2.3)	☒		☐
Participant information sheet (question 4.1)	☒		☐
Consent form (question 4.2)	☒		☐
Evidence of external approvals related to the research (question 1.9)	☒		☐
Questionnaire (question 3.1)	☒ draft	☐ final	☐
Interview Schedule (question 3.1)	☒ draft	☐ final	☐
Other (please specify: Interview guide)	☐		☒

For further details about completion of this form, please contact your Faculty Research Ethics Officer in the first instance.

Oxford University Hospitals NHS
NHS Trust

JT/LoA **Ref:433 /PID 10975**

Mr Lasse Andreassen
Oxford Brookes University
Jack Straw's Lane
Marston
Oxford
OX3 0FL

Research Support services Manager
OUH R&D
Joint Research Office, Block 60
The Churchill Hospital
Headington
Oxford
OX3 7LE

Email: jenny.turner@ouh.nhs.uk
Tel: 01865 572236
Fax: 01865 572242

22 September 2014

Dear Mr Andreassen

Letter of access for research

This letter confirms your right of access to conduct research through **Oxford University Hospital NHS Trust** for the purpose and on the terms and conditions set out below. This right of access commences on **22 September 2014** and ends on **31 December 2014** unless terminated earlier in accordance with the clauses below.

You have a right of access to conduct such research as confirmed in writing in the letter of permission for research from this NHS organisation. Please note that you cannot start the research until the Principal Investigator for the research project has received a letter from us giving permission to conduct the project.

The information supplied about your role in research at **Oxford University Hospital NHS Trust** has been reviewed and you do not require an honorary research contract with this NHS organisation. We are satisfied that such pre-engagement checks as we consider necessary have been carried out.

You are considered to be a legal visitor to **Oxford University Hospital NHS Trust** premises. You are not entitled to any form of payment or access to other benefits provided by this NHS organisation to employees and this letter does not give rise to any other relationship between you and this NHS organisation, in particular that of an employee.

While undertaking research through **Oxford University Hospital NHS Trust**, you will remain accountable to your employer **(Oxford Brookes University)** but you are required to follow the reasonable instructions of **Rob Way** in this NHS organisation or those given on her/his behalf in relation to the terms of this right of access.

Where any third party claim is made, whether or not legal proceedings are issued, arising out of or in connection with your right of access, you are required to co-operate fully with any investigation by this NHS organisation in connection with any such claim and to give all such assistance as may reasonably be required regarding the conduct of any legal proceedings.

You must act in accordance with **Oxford University Hospital NHS Trust** policies and procedures, which are available to you upon request, and the Research Governance Framework.

You are required to co-operate with **Oxford University Hospital NHS Trust** in discharging its duties under the Health and Safety at Work etc Act 1974 and other health and safety legislation and to take reasonable care for the health and safety of yourself and others while on **Oxford University Hospital NHS Trust** premises. You must observe the same standards of care and propriety in dealing with patients, staff, visitors, equipment and premises as is expected of any other contract holder and you must act appropriately, responsibly and professionally at all times.

If you have a physical or mental health condition or disability which may affect your research role and which might require special adjustments to your role, if you have not already done so, you must notify your employer and the Trust Fiona.parker@ouh.nhs.uk prior to commencing your research role at the Trust.

You are required to ensure that all information regarding patients or staff remains secure and *strictly confidential* at all times. You must ensure that you understand and comply with the requirements of the NHS Confidentiality Code of Practice (http://www.dh.gov.uk/assetRoot/04/06/92/54/04069254.pdf) and the Data Protection Act 1998. Furthermore you should be aware that under the Act, unauthorised disclosure of information is an offence and such disclosures may lead to prosecution.

You should ensure that, where you are issued with an identity or security card, a bleep number, email or library account, keys or protective clothing, these are returned upon termination of this arrangement. Please also ensure that while on the premises you wear your ID badge at all times, or are able to prove your identity if challenged. Please note that this NHS organisation accepts no responsibility for damage to or loss of personal property.

We may terminate your right to attend at any time either by giving seven days' written notice to you or immediately without any notice if you are in breach of any of the terms or conditions described in this letter or if you commit any act that we reasonably consider to amount to serious misconduct or to be disruptive and/or prejudicial to the interests and/or business of this NHS organisation or if you are convicted of any criminal offence. You must not undertake regulated activity if you are barred from such work. If you are barred from working with adults or children this letter of access is immediately terminated. Your employer will immediately withdraw you from undertaking this or any other regulated activity and you MUST stop undertaking any regulated activity immediately.

Your substantive employer is responsible for your conduct during this research project and may in the circumstances described above instigate disciplinary action against you.

Oxford University Hospital NHS Trust will not indemnify you against any liability incurred as a result of any breach of confidentiality or breach of the Data Protection Act 1998. Any breach of the Data Protection Act 1998 may result in legal action against you and/or your substantive employer.

If your current role or involvement in research changes, or any of the information provided in your Research Passport changes, you must inform your employer

through their normal procedures. You must also inform your nominated manager in this NHS organisation.

Yours sincerely

Fiona Parker
Research Support Services Manager
Oxford University Hospital NHS Trust

cc:

Maxine Grout, HR Advisor - Medical Support, Block 229, Carillion Building, JOHN RADCLIFFE HOSPITAL, Headley Way, Headington
Oxford, OX3 9DU

Oxford Brookes University: mkoekenhoff@brookes.ac.uk

Welcome to the Integrated Research Application System

IRAS Project Filter

The integrated dataset required for your project will be created from the answers you give to the following questions. The system will generate only those questions and sections which (a) apply to your study type and (b) are required by the bodies reviewing your study. Please ensure you answer all the questions before proceeding with your applications.

Please enter a short title for this project (maximum 70 characters)
Task organisation in Emergency Departments

1. Is your project research?

(●) Yes ( ) No

2. Select one category from the list below:

( ) Clinical trial of an investigational medicinal product
( ) Clinical investigation or other study of a medical device
( ) Combined trial of an investigational medicinal product and an investigational medical device
( ) Other clinical trial to study a novel intervention or randomised clinical trial to compare interventions in clinical practice
( ) Basic science study involving procedures with human participants
( ) Study administering questionnaires/interviews for quantitative analysis, or using mixed quantitative/qualitative methodology
(●) Study involving qualitative methods only
( ) Study limited to working with human tissue samples (or other human biological samples) and data (specific project only)
( ) Study limited to working with data (specific project only)
( ) Research tissue bank
( ) Research database

If your work does not fit any of these categories, select the option below:

( ) Other study

2a. Please answer the following question(s):

a) Does the study involve the use of any ionising radiation?	( ) Yes	(●) No
b) Will you be taking new human tissue samples (or other human biological samples)?	( ) Yes	(●) No
c) Will you be using existing human tissue samples (or other human biological samples)?	( ) Yes	(●) No

3. In which countries of the UK will the research sites be located? *(Tick all that apply)*

- [x] England
- [ ] Scotland
- [ ] Wales
- [ ] Northern Ireland

3a. In which country of the UK will the lead NHS R&D office be located:

- (●) England
- ( ) Scotland
- ( ) Wales
- ( ) Northern Ireland
- ( ) This study does not involve the NHS

4. Which review bodies are you applying to?

- [x] NHS/HSC Research and Development offices
- [ ] Social Care Research Ethics Committee
- [ ] Research Ethics Committee
- [ ] National Information Governance Board for Health and Social Care (NIGB)
- [ ] National Offender Management Service (NOMS) (Prisons & Probation)

For NHS/HSC R&D offices, the CI must create Site-Specific Information Forms for each site, in addition to the study-wide forms, and transfer them to the PIs or local collaborators.

It looks like your project is research requiring NHS R&D approval but does not require review by a REC within the UK Health Departments Research Ethics Service – is that right?

(●) Yes ( ) No

4b. Please confirm the reason(s) why the project does not require review by a REC within the UK Health Departments Research Ethics Service:

- [ ] Projects limited to the use of samples/data samples provided by a Research Tissue Bank (RTB) with generic ethical approval from a REC, in accordance with the conditions of approval.
- [ ] Projects limited to the use of data provided by a Research Database with generic ethical approval from a REC, in accordance with the conditions of approval.
- [ ] Research limited to use of previously collected, non-identifiable information
- [ ] Research limited to use of previously collected, non-identifiable tissue samples within terms of donor consent
- [ ] Research limited to use of acellular material
- [ ] Research limited to use of the premises or facilities of care organisations (no involvement of patients/service users as participants)
- [x] Research limited to involvement of staff as participants (no involvement of patients/service users as participants)

5. Will any research sites in this study be NHS organisations?

(●) Yes ( ) No

5a. Are all the research costs and infrastructure costs for this study provided by an NIHR Biomedical Research Centre, NIHR Biomedical Research Unit, NIHR Collaboration for Leadership in Health Research and Care (CLAHRC) or NIHR Research Centre for Patient Safety & Service Quality in all study sites?

( ) Yes (●) No

If yes, NHS permission for your study will be processed through the NIHR Coordinated System for gaining NHS Permission (NIHR CSP).

5b. Do you wish to make an application for the study to be considered for NIHR Clinical Research Network (CRN) support and inclusion in the NIHR Clinical Research Network (CRN) Portfolio? Please see information button for further details.

( ) Yes (●) No

If yes, NHS permission for your study will be processed through the NIHR Coordinated System for gaining NHS Permission (NIHR CSP) and you must complete a NIHR Clinical Research Network (CRN) Portfolio Application Form immediately after completing this project filter and before completing and submitting other applications.

6. Do you plan to include any participants who are children?

○ Yes ◉ No

7. Do you plan at any stage of the project to undertake intrusive research involving adults lacking capacity to consent for themselves?

○ Yes ◉ No

Answer Yes if you plan to recruit living participants aged 16 or over who lack capacity, or to retain them in the study following loss of capacity. Intrusive research means any research with the living requiring consent in law. This includes use of identifiable tissue samples or personal information, except where application is being made to the NIGB Ethics and Confidentiality Committee to set aside the common law duty of confidentiality in England and Wales. Please consult the guidance notes for further information on the legal frameworks for research involving adults lacking capacity in the UK.

8. Do you plan to include any participants who are prisoners or young offenders in the custody of HM Prison Service or who are offenders supervised by the probation service in England or Wales?

○ Yes ◉ No

9. Is the study or any part of it being undertaken as an educational project?

◉ Yes ○ No

Please describe briefly the involvement of the student(s):
MSC student dissertation

9a. Is the project being undertaken in part fulfilment of a PhD or other doctorate?

○ Yes ◉ No

10. Will this research be financially supported by the United States Department of Health and Human Services or any of its divisions, agencies or programs?

○ Yes ◉ No

11. Will identifiable patient data be accessed outside the care team without prior consent at any stage of the project (including identification of potential participants)?

○ Yes ◉ No

Integrated Research Application System
Application Form for Research involving qualitative methods only

The student should complete this form on behalf of the Chief Investigator. Guidance on the questions is available wherever you see this symbol displayed. We recommend reading the guidance first. The complete guidance and a glossary are available by selecting Help.

Please define any terms or acronyms that might not be familar to lay reviewers of the application.

Short title and version number: (maximum 70 characters - this will be inserted as header on all forms)
Task organisation in Emergency Departments

PART A: Core study information

1. ADMINISTRATIVE DETAILS

A1. Full title of the research:

How do nurses in England and Norway perceive that the organisation of tasks between physicians and nurses in an emergency department influences the patients' waiting time?

A2-1. Educational projects

Name and contact details of student(s):

Student 1

Title	Forename/Initials	Surname
Mr	Lasse	Andreassen

Address	Vakero terrasse 1 A
	Oslo
Post Code	0282
E-mail	lasseandreassen108@gmail.com
Telephone	004740061503
Fax	

Give details of the educational course or degree for which this research is being undertaken:

Name and level of course/ degree:
MSC dissertation

Name of educational establishment:
Oxford Brookes University

Name and contact details of academic supervisor(s):

Academic supervisor 1

Title	Forename/Initials	Surname
Dr	Jan	Davison-Fischer

Address	Oxford Brookes University, Faculty of Health and Life Sciences

	Jack Straw's Lane
	Marston
Post Code	OX3 0FL
E-mail	j.fischer@brookes.ac.uk
Telephone	+44 1865 48 2740
Fax	

Please state which academic supervisor(s) has responsibility for which student(s):
Please click "Save now" before completing this table. This will ensure that all of the student and academic supervisor details are shown correctly.

Student(s)	Academic supervisor(s)
Student 1 Mr Lasse Andreassen	☐ Dr Jan Davison-Fischer

A copy of a current CV for the student and the academic supervisor (maximum 2 pages of A4) must be submitted with the application.

A2-2. Who will act as Chief Investigator for this study?

- ○ Student
- ◉ Academic supervisor
- ○ Other

A3-1. Chief Investigator:

	Title	Forename/Initials	Surname
	Dr	Jan	Davison-Fischer
Post	Faculty of Health and Life Sciences		
Qualifications	PhD (Manchester), MSc (LSE), MA (Oxon), GDL (Law), PCTHE (OBU) Senior Lecturer in Professional Education and Leadership		
Employer	Oxford Brookes University		
Work Address	Jack Straw's Lane Marston		
Post Code	OX3 0FL		
Work E-mail	j.fischer@brookes.ac.uk		
* Personal E-mail	j.fischer@brookes.ac.uk		
Work Telephone	00441865482740		
* Personal Telephone/Mobile	00447810170195		
Fax			

** This information is optional. It will not be placed in the public domain or disclosed to any other third party without prior consent.*
A copy of a current CV (maximum 2 pages of A4) for the Chief Investigator must be submitted with the application.

A4. Who is the contact on behalf of the sponsor for all correspondence relating to applications for this project?
This contact will receive copies of all correspondence from REC and R&D reviewers that is sent to the CI.

Title Forename/Initials Surname

	Dr Jan Davison-Fischer
Address	Faculty of Health and Life Sciences
	Oxford Brookes University
	Jack Straw's Lane
Post Code	OX3 0FL
E-mail	j.fischer@brookes.ac.uk
Telephone	00441865482740
Fax	

A5-1. Research reference numbers. *Please give any relevant references for your study:*

Applicant's/organisation's own reference number, e.g. R & D (if available):	FREC 2013/44
Sponsor's/protocol number:	FREC 2013/44
Protocol Version:	2.0
Protocol Date:	15/07/2014
Funder's reference number:	n/a
Project website:	

Additional reference number(s):

Ref.Number Description	Reference Number

Registration of research studies is encouraged wherever possible. You may be able to register your study through your NHS organisation or a register run by a medical research charity, or publish your protocol through an open access publisher. If you have registered your study please give details in the "Additional reference number(s)" section.

A5-2. Is this application linked to a previous study or another current application?

○ Yes ◉ No

Please give brief details and reference numbers.

2. OVERVIEW OF THE RESEARCH

To provide all the information required by review bodies and research information systems, we ask a number of specific questions. This section invites you to give an overview using language comprehensible to lay reviewers and members of the public. Please read the guidance notes for advice on this section.

A6-1. Summary of the study. *Please provide a brief summary of the research (maximum 300 words) using language easily understood by lay reviewers and members of the public. Where the research is reviewed by a REC within the UK Health Departments Research Ethics Service, this summary will be published on the website of the National Research Ethics Service following the ethical review.*

The waiting time for patients in Norwegian Emergency Departments has increased over the last year due to circumstances like an aging population with health problems and less access to experienced doctors to treat them (SSB, 2014). Since waiting time is considered a quality indicator in Emergency Departments, an increasing waiting time might indicate less quality for the patients.

In England an attempt has been made to address this problem by introducing specially trained nurses, often referred to as Nurse Practitioners or Advanced Clinical Practitioners, to reduce the patients waiting time. These specially trained nurses have taken over some tasks that traditionally were the job of the physicians. Here some of the patients groups are being treated by the ACP's or NP's. Studies have shown that the use of ACPs and NPs improved patients' overall outcome, reduced the patients waiting time and saved money for the hospitals.

In Norwegian Emergency Departments all patients are still treated by junior or middle-grade doctors (Frich, 2011). The

aim of this project is to get the nurses perception on how a task shift from physicians to nurses in an Emergency Department might influence on the patients' waiting time. The answers will allow some comparisons between Norwegian and British approaches to emergency care.

20 participants, 10 from Norwegian Emergency Departments and 10 from British Emergency Departments, will be required two take part of a one hour semi-structured interview with the master's student. They will be asked the attached questions.

References:
Frich, Jan (2011). Jobbglidning - et ledelsesperspektiv. Overlegen 1
www.helsedirektoratet.no/samhandlingsreformen/Sider/default.as px
www.ssb.no/helse/artikler-og-publikasjoner/eldres-bruk-av-helse -og-omsorgstjenester

A6-2. Summary of main issues. *Please summarise the main ethical, legal, or management issues arising from your study and say how you have addressed them.*

Not all studies raise significant issues. Some studies may have straightforward ethical or other issues that can be identified and managed routinely. Others may present significant issues requiring further consideration by a REC, R&D office or other review body (as appropriate to the issue). Studies that present a minimal risk to participants may raise complex organisational or legal issues. You should try to consider all the types of issues that the different reviewers may need to consider.

The aim of this project is to answer the research question “How do nurses in England and Norway perceive that the organisation of tasks between physicians and nurses in an emergency department influences the patients’ waiting time?” to see if a task shift from the physicians to the nurses in the Emergency Departments (EDs) in Norway can be a way of reducing an increasing waiting time.

Background:

Hospital care in the UK has been facing challenges over the last few years with budgetary, regulatory and organisational pressures. One of the responses to these challenges has been the creation of the Advanced Clinical Practitioner (ACP) or Nurse Practitioner (NP) posts (Fawdon and Adams, 2013, Laurant et al, 2009), who receive and treat some of the ED patients. On admission to the ED an experienced nurse assesses the patients need for treatment via one of three routes: minor injury, minor illness or rapid assessment and treatment stream (RATS) (Fawdon and Adams, 2013). The ACP or NP will, sometimes with advices from a middle-grade doctor, interpret the investigation results and refer the patient to a specialist or discharge him or her.

In England 95% of the ED patients must be discharged or admitted to a ward within four hours to avoid financial penalties, and surveys have agreed or strongly agreed that that the use of ACPs improved patients overall outcome, reduced waiting time and saved money (Collins et al, 2014, Carter and Chochinov, 2007).

Norway has also been facing the same challenges over the last years with budgetary, regulatory and organisational pressures. An increasing population of old people with healtcare problems and lack of experienced doctors to treat them is part of this problem. As a result the waiting time for patients coming to the Emergency Departments have increased, and for minor injuries and minor illnesses the patients sometimes have to wait up to 6 – 8 hours to be discharged or admitted (SSB, 2014). In Norway all examinations and all treatment in the Emergency Departments are being done by junior doctors or middle-grade doctors like it was in UK before the introduction of task shifts and education of ACP's and NP's.

Aim of this project:

This project is a study to look at the perception of nurses of the impact of the division of labour on waiting time for patients being treated in a British Emergency Department by an ACP or NP and a Norwegian Emergency Department where patients are being treated by junior doctors or middle-grade doctors, and to see if the nurses perception of an introduction of task shifts in Norwegian Emergencies potentially can reduce the patients waiting time and improve the patients overall outcome.

To do this, Norwegian nurses working in Norwegian Emergency Departments will be asked some questions about their perception on task shifts. The same questions will be asked British nurses working as ACP's or NP's in British Emergency Departments. The thesis is that by introducing a task shift from the doctors to the nurses in Norwegian emergency departments the waiting time for the patients will be reduced, and the doctors will have more time to work on patients with more complicated diagnosis or higher triage.

Waiting time as a quality indicator will be used as the framework for this project.

The expected benefit to the community is to see if the nurses believe there are things that can be changed in the Norwegian Emergency Departments to reduce the patients waiting time by doing a task shift or introducing ACP's or NP's in Norway. Since waiting time is considered a quality indicator in Emergency Departments, and as it can have an impact on disease progression, reducing the waiting time might benefit the patients by improve their overall outcome.

References:
Collins, Nina et al (2014). Outcomes of adding acute care nurse practitioners to a Level 1 trauma service with the goal of decreased length of stay and improved physician and nursing staisfaction. Lippincott, Williams & Wilkins
Delamaire, Marie-Laure and Lafortune, Gaetan (2010). Nurses in Advanced Roles. A description and evaluation of experiences in 12 developed countries. OECD Health Working Papers No 54
Fawdon, H. and Adams, J. (2013). Advanced clinical practitioner role in emergency department, Nursing Standard,28, 16 - 18
Laurant, M., Reeves, D., Hermens, R., Braspenning, J. Grol, R. and Sibbald, B. (2009). Substitution of doctors by nurses in primary care (Review). The Cochrane Collaboration
www.ssb.no/helse/artikler-og-publikasjoner/eldres- bruk-av-helse-og-omsorgstjenester
World Health Organization (2006). Working together for health. The World Health Report 2006

Methode:

Data for this project will be obtained through interviews with 10 experienced British nurses and 10 experienced Norwegian nurses (see attached interview guide). Participants will be identified through a purposive sampling method (Creswell, 2014), as the head of department or lead nurse will be asked to identify experienced staff and facilitate initial contact with the researcher. The interviews will take place at the participating hospitals or a suitable nearby location. Each interview is stipulated to take approximately one hour, and it will be a one-to-one semi-structured interview. Interviews in the UK will be audio recorded and transcribed. In recognition of societal attitudes to audio recording, interviews in Norway will not be recorded, but detailed notes will be made by the researcher (Malterud, 2011).

The data from the interviews will be compared, and the result will also be compared to literature on waiting time as a quality indicator in Emergency Departments. The study will use thematic analysis to examine the data (Lathlean, 2010).

A part of the study will be carried out in Oslo, Norway. This project have already received permission from the Norwegian Ethics Committee and from both of the two involved hospitals.

References:
Creswell, John W. (2014). Research Design. Qualitative, Quantitative and Mixed Methods Approaches. Los Angeles: Sage Publications Inc.
Lathlean, J. (2010) Qualitative Analysis. Chapter 34. In: The Research Process in Nursing. Editors. K. Gerrish and A. Lacey. 6th edition. Oxford: Wiley Blackwell
Malterud, Kirsti (2011). Kvalitative metoder i medisinsk forskning. En Innføring. Oslo: Universitetsforlaget

3. PURPOSE AND DESIGN OF THE RESEARCH

A7. Select the appropriate methodology description for this research. *Please tick all that apply*:

- [ ] Case series/ case note review
- [ ] Case control
- [ ] Cohort observation
- [ ] Controlled trial without randomisation
- [ ] Cross-sectional study
- [ ] Database analysis
- [ ] Epidemiology
- [ ] Feasibility/ pilot study
- [ ] Laboratory study
- [ ] Metanalysis
- [x] Qualitative research
- [x] Questionnaire, interview or observation study

☐ Randomised controlled trial

☐ Other (please specify)

The method for this project will be semi-structured interviews (Creswell, 2014) where invited participants from Norway and England working as experienced nurses in the Emergency Department will be asked some questions to determine whether they believe a task shift from the physicians' to the nurses' will help reducing the patients waiting time.

Data for this project will be obtained through interviews with 10 experienced British nurses and 10 experienced Norwegian nurses. Participants will be identified through a purposive sampling method (Creswell, 2014), as the head of department or lead nurse will be asked to identify experienced staff and facilitate initial contact with the researcher. The interviews will take place at the participating hospitals or a suitable nearby location. Each interview is stipulated to take approximately one hour, and it will be a one-to-one semi-structured interview. Interviews in the UK will be audio recorded and transcribed. In recognition of societal attitudes to audio recording, interviews in Norway will not be recorded, but detailed notes will be made by the researcher (Malterud, 2011).

The data from the interviews will be compared, and the result will also be compared to literature on waiting time as a quality indicator in Emergency Departments. The study will use thematic analysis to examine the data (Lathlean, 2010).

The results of the interviews in this project will be submitted to the supervisor and discussed. This will happen after the interviews are completed but before the analysis of the answers start. Only the supervisor and the student will have access to the notes from the interviews. The supervisor will not have access to the link between the identity of the persons being interviewed and the notes from the interviews.

The interviews will be conducted for the Norwegian part from August till September, and for the British part from September to November. The analysis will take place from December to January.

References

Creswell, John W. (2014). Research Design. Qualitative, Quantitative and Mixed Methods Approaches. Los Angeles: Sage Publications Inc.
Lathlean, J. (2010) Qualitative Analysis. Chapter 34. In: The Research Process in Nursing. Editors. K. Gerrish and A. Lacey. 6th edition. Oxford: Wiley Blackwell
Malterud, Kirsti (2011). Kvalitative metoder i medisinsk forskning. En Innføring. Oslo: Universitetsforlaget

A10. What is the principal research question/objective? *Please put this in language comprehensible to a lay person.*

The question for this study is:
“How do nurses in England and Norway perceive that the organisation of tasks between physicians and nurses in an emergency department influences the patients’ waiting time?”
Waiting time is the time the patients spend in the Emergency Department before they are examined and either admitted or discharged.

A11. What are the secondary research questions/objectives if applicable? *Please put this in language comprehensible to a lay person.*

There is only one research question.

A12. What is the scientific justification for the research? *Please put this in language comprehensible to a lay person.*

The waiting time for patients in Norwegian Emergency Departments has increased over the last year due to circumstances like an aging population with health problems and less access to experienced doctors to treat them (SSB, 2014). Since waiting time is considered a quality indicator in Emergency Departments, an increasing waiting time might indicate less quality for the patients.

In England an attempt has been made to address this problem by introducing specially trained nurses, often referred to as Nurse Practitioners or Advanced Clinical Practitioners, to reduce the patients waiting time. These specially trained nurses have taken over some tasks that traditionally were the job of the physicians. Here some of the patients groups are being treated by the ACP’s and NP’s. Studies have shown that the use of ACPs and NPs improved patients' overall outcome, reduced the patients waiting time and saved money for the hospitals.

In Norwegian Emergency Departments all patients are still treated by junior or middle-grade doctors (Frich, 2011). The aim of this project is to get the nurses perception on how a task shift from physicians to nurses in an Emergency

Department might influence on the patients' waiting time. The answers will allow some comparisons between Norwegian and British approaches to emergency care.

20 participants, 10 from Norwegian Emergency Departments and 10 from British Emergency Departments, will be required two take part of a one hour semi-structured interview with the master's student. They will be asked the attached questions.

References:
Frich, Jan (2011). Jobbglidning - et ledelsesperspektiv. Overlegen 1
www.helsedirektoratet.no/samhandlingsreformen/Sider/default.as px
www.ssb.no/helse/artikler-og-publikasjoner/eldres-bruk-av-helse -og-omsorgstjenester

A13. Please summarise your design and methodology. *It should be clear exactly what will happen to the research participant, how many times and in what order. Please complete this section in language comprehensible to the lay person. Do not simply reproduce or refer to the protocol. Further guidance is available in the guidance notes.*

The method for this project will be semi-structured interviews (Creswell, 2014) where invited participants from Norway and England working as experienced nurses in the Emergency Department will be asked some questions to determine whether they believe a task shift from the physicians' to the nurses' will help reducing the patients waiting time.

Data for this project will be obtained through interviews with 10 experienced British nurses and 10 experienced Norwegian nurses. Participants will be identified through a purposive sampling method (Creswell, 2014), as the head of department or lead nurse will be asked to identify experienced staff and facilitate initial contact with the researcher. The interviews will take place at the participating hospitals or a suitable nearby location. Each interview is stipulated to take approximately one hour, and it will be a one-to-one semi-structured interview. Interviews in the UK will be audio recorded and transcribed. In recognition of societal attitudes to audio recording, interviews in Norway will not be recorded, but detailed notes will be made by the researcher (Malterud, 2011).

The data from the interviews will be compared, and the result will also be compared to literature on waiting time as a quality indicator in Emergency Departments. The study will use thematic analysis to examine the data (Lathlean, 2010).

A part of the study will be carried out in Oslo, Norway. This project have already received permission from the Norwegian Ethics Committee and from two involved hospitals. The collection of data for the Norwegian part of the project will be delayed until permission from the OBU Faculty Ethics Committee has been given.

The results of the interviews in this project will be submitted to the supervisor and discussed. This will happen after the interviews are completed but before the analysis of the answers start. Only the supervisor and the student will have access to the notes from the interviews. The supervisor will not have access to the link between the identity of the persons being interviewed and the notes from the interviews.

The interviews will be conducted for the Norwegian part from August till September, and for the British part from September to November. The analysis will take place from December to January.

References
Creswell, John W. (2014). Research Design. Qualitative, Quantitative and Mixed Methods Approaches. Los Angeles: Sage Publications Inc.
Lathlean, J. (2010) Qualitative Analysis. Chapter 34. In: The Research Process in Nursing. Editors. K. Gerrish and A. Lacey. 6th edition. Oxford: Wiley Blackwell
Malterud, Kirsti (2011). Kvalitative metoder i medisinsk forskning. En Innføring. Oslo: Universitetsforlaget

A14-1. In which aspects of the research process have you actively involved, or will you involve, patients, service users, and/or their carers, or members of the public?

- ☐ Design of the research
- ☐ Management of the research
- ☐ Undertaking the research
- ☐ Analysis of results
- ☐ Dissemination of findings
- ☑ None of the above

Give details of involvement, or if none please justify the absence of involvement.
The caretakers (nurses working in Emergency Departments) will be interviewed to answer the question “How do nurses in England and Norway perceive that the organisation of tasks between physicians and nurses in an emergency department influences the patients’ waiting time?”
No patients, service users or members of the Public will be involved in this study.

4. RISKS AND ETHICAL ISSUES

RESEARCH PARTICIPANTS

A15. What is the sample group or cohort to be studied in this research?

Select all that apply:

- ☐ Blood
- ☐ Cancer
- ☐ Cardiovascular
- ☐ Congenital Disorders
- ☐ Dementias and Neurodegenerative Diseases
- ☐ Diabetes
- ☐ Ear
- ☐ Eye
- ☐ Generic Health Relevance
- ☐ Infection
- ☐ Inflammatory and Immune System
- ☐ Injuries and Accidents
- ☐ Mental Health
- ☐ Metabolic and Endocrine
- ☐ Musculoskeletal
- ☐ Neurological
- ☐ Oral and Gastrointestinal
- ☐ Paediatrics
- ☐ Renal and Urogenital
- ☐ Reproductive Health and Childbirth
- ☐ Respiratory
- ☐ Skin
- ☐ Stroke

Gender:	Male and female participants
Lower age limit: 22	Years
Upper age limit: 65	Years

A17-1. Please list the principal inclusion criteria (list the most important, max 5000 characters).

For this study the plan is to interview 10 nurses from different emergency departments at local hospitals in Oxford and/or London, England working as experienced nurses, Nurse Practitioners or Advanced Clinical Practitioners. They will be asked about their work, and the focus will be on their view and their thought of how they as Nurse Practitioners or Advanced Clinical Practitioners true task shifts can save their patients for unnecessary waiting time and at the same time improve the overall outcome.

The respondents age range will most probably be from 20 - 65. Noone under the age of 18 will be included in the British part of this project.

The plan is also to interview up to 10 experienced nurses working at two different emergency departments in Oslo, Norway. The focus for these interviews will be how they think task shifts and an implementing of the role of Nurse Practitioners or Advanced Clinical Practitioners in Norwegian emergency departments will help reducing the patients waiting time, and how they think it might improve or reduce the patients overall outcome.

The aim is here to talk to nurses who have been working in an Emergency Department for a few years (experienced nurses), and their age range will probably be from 25 to 62 years old. Noone under the age of 18 will be included in the Norwegian part of the project.

(An experienced nurse is here a nurse whos been working in the Emergency Department for at least 3 years, and cover all the different positions in their Department.)

A17-2. Please list the principal exclusion criteria (list the most important, max 5000 characters).

Nurses working less than 3 years (full time) or not having triage experience in an Emergency Department and retired nurses.

RESEARCH PROCEDURES, RISKS AND BENEFITS

A18. Give details of all non-clinical intervention(s) or procedure(s) that will be received by participants as part of the research protocol. *These include seeking consent, interviews, non-clinical observations and use of questionnaires.*

Please complete the columns for each intervention/procedure as follows:

1. Total number of interventions/procedures to be received by each participant as part of the research protocol.
2. If this intervention/procedure would be routinely given to participants as part of their care outside the research, how many of the total would be routine?
3. Average time taken per intervention/procedure (minutes, hours or days)
4. Details of who will conduct the intervention/procedure, and where it will take place.

Intervention or procedure	1	2	3	4
Semi-structured qualitative interview	1	0	60	The interviews will be conducted by Lasse Andreassen (student). The interviews will take place either before or after the nurses shift. The interviews will be arranged either at a suitable meeting room in the hospital or a nearby location.

A21. How long do you expect each participant to be in the study in total?

60 minutes. The only part the participants play in this project is to be part of an interview. They will most probably only be in the study for as long as the interview last, but the collection of data will take approximately two months.

A22. What are the potential risks and burdens for research participants and how will you minimise them?

For all studies, describe any potential adverse effects, pain, discomfort, distress, intrusion, inconvenience or changes to lifestyle. Only describe risks or burdens that could occur as a result of participation in the research. Say what steps would be taken to minimise risks and burdens as far as possible.

We do not anticipate any risk to participants beyond those of everyday life.

There are no adverse outcomes foreseen and the risk of the project do not exceed those of everyday life. A full risk analysis was carried out as part of routine supervision activities. In the event of an unexpected outcome, the researcher will contact his supervisor's mobile telephone immediately and, if appropriate, inform the chair of the Faculty Research Ethics Committee by e-mail.

A23. Will interviews/ questionnaires or group discussions include topics that might be sensitive, embarrassing or upsetting, or is it possible that criminal or other disclosures requiring action could occur during the study?

○ Yes ◉ No

A24. What is the potential for benefit to research participants?

There will be no direct benefit for the participants except their chance to share their knowledge and maybe help to inform the ongoing debate about future improvements of the Emergency Departments at Norwegian and UK hospitals. At the same time there will be no risks to the participants either.

A26. What are the potential risks for the researchers themselves? *(if any)*

None.

RECRUITMENT AND INFORMED CONSENT

In this section we ask you to describe the recruitment procedures for the study. Please give separate details for different study groups where appropriate.

A27-1. How will potential participants, records or samples be identified? Who will carry this out and what resources will be used?*For example, identification may involve a disease register, computerised search of social care or GP records, or review of medical records. Indicate whether this will be done by the direct care team or by researchers acting under arrangements with the responsible care organisation(s).*

Participants will be approached through a gatekeeper (their matron or a nursing consultant). If they are willing to participate, they will contact the research student to arrange the qualitative interview. The researcher will then double-check that participants meet the inclusion criteria.

A27-2. Will the identification of potential participants involve reviewing or screening the identifiable personal information of patients, service users or any other person?

○ Yes ◉ No

Please give details below:

A28. Will any participants be recruited by publicity through posters, leaflets, adverts or websites?

○ Yes ◉ No

A29. How and by whom will potential participants first be approached?

The matrons or heads of selected Emergency Departments (London, Oxford and Oslo) will be contacted by letter. After they have received their letters, Dr. Jan Davison-Fischer or Lasse Andreassen will contact the heads by calling them. They will explain the aim for this project. If the heads of the Emergency Departments are interested in participating they will receive written information including the interview guide and a letter of consent and ask to distribute this to experienced nurses working in their hospitals.

The nurses who would like to participate will in the information sheet have contact information to the researchers and can call or e-mail them if they are interested to set up an appointment for an interview.

Those interested in participating in an interview will receive the interview guide together with an information sheet, a consent form, a copy of the approvals from Norway and England and a suggested time for the interview.

A30-1. Will you obtain informed consent from or on behalf of research participants?

◉ Yes ○ No

If you will be obtaining consent from adult participants, please give details of who will take consent and how it will be done, with details of any steps to provide information (a written information sheet, videos, or interactive material).

Arrangements for adults unable to consent for themselves should be described separately in Part B Section 6, and for children in Part B Section 7.

If you plan to seek informed consent from vulnerable groups, say how you will ensure that consent is voluntary and fully informed.

All the participants will be given a consent form to to sign before the interview take place. The form is attached to this application. None of the staff participants are vulnerable.

If you are not obtaining consent, please explain why not.

Please enclose a copy of the information sheet(s) and consent form(s).

A30-2. Will you record informed consent (or advice from consultees) in writing?

(●) Yes ( ) No

A31. How long will you allow potential participants to decide whether or not to take part?

Participants control the time spent between discovering about the research and arranging an appointment for an interview. The participants can take at least two weeks to decide from they receive the information letter till the interview will take place. They can also change their mind during the interview, and at any time withdraw without giving any reason (up to the point at which the confidentiality mechanisms result in interview recordings being anonymous). We do not expect to interview participants within 24 hours of them finding out about the research.

A33-1. What arrangements have been made for persons who might not adequately understand verbal explanations or written information given in English, or who have special communication needs?*(e.g. translation, use of interpreters)*

None. This study only include experienced nurses working at Emergency Departments at Norwegian and English hospitals. Noone who does not understand verbal explanations or written information given in English will be asked to participate.

A35. What steps would you take if a participant, who has given informed consent, loses capacity to consent during the study? *Tick one option only.*

(●) The participant and all identifiable data or tissue collected would be withdrawn from the study. Data or tissue which is not identifiable to the research team may be retained.

( ) The participant would be withdrawn from the study. Identifiable data or tissue already collected with consent would be retained and used in the study. No further data or tissue would be collected or any other research procedures carried out on or in relation to the participant.

( ) The participant would continue to be included in the study.

( ) Not applicable – informed consent will not be sought from any participants in this research.

( ) Not applicable – it is not practicable for the research team to monitor capacity and continued capacity will be assumed.

Further details:

CONFIDENTIALITY

In this section, personal data means any data relating to a participant who could potentially be identified. It includes pseudonymised data capable of being linked to a participant through a unique code number.

Storage and use of personal data during the study

A36. Will you be undertaking any of the following activities at any stage (including in the identification of potential participants)?*(Tick as appropriate)*

- [ ] Access to medical records by those outside the direct healthcare team
- [ ] Access to social care records by those outside the direct social care team
- [ ] Electronic transfer by magnetic or optical media, email or computer networks
- [ ] Sharing of personal data with other organisations
- [ ] Export of personal data outside the EEA
- [ ] Use of personal addresses, postcodes, faxes, emails or telephone numbers
- [x] Publication of direct quotations from respondents
- [ ] Publication of data that might allow identification of individuals
- [x] Use of audio/visual recording devices
- [x] Storage of personal data on any of the following:
  - [x] Manual files (includes paper or film)
  - [ ] NHS computers
  - [ ] Social Care Service computers
  - [ ] Home or other personal computers
  - [ ] University computers
  - [ ] Private company computers
  - [ ] Laptop computers

Further details:
The researcher will attempt to secure participants' confidentiality and to ensure that no link between the quotations and the respondents can be established.
An audio recorder will be used during the interviews. Before the interview the respondent will be asked for a written consent to use a recorder. The interview will be deleted after it has been transcribed.

As an experienced researcher, the supervisor will screen the publication of any direct quotes for the risk of compromise to confidentiality.

A37. Please describe the physical security arrangements for storage of personal data during the study?

The audio recording will not retain any identifying information. All the transcribed (and anonymised) interviews will be stored at the researchers computer with fingerprint Access and double password. This information will not be shared with anyone.
The only record of participants' names will be on the consent forms, which will be stored in a locked filling cabinet on university premises.

A38. How will you ensure the confidentiality of personal data?*Please provide a general statement of the policy and procedures for ensuring confidentiality, e.g. anonymisation or pseudonymisation of data.*

The confidentiality of personal data will be ensured by keeping the name of the participants, which is only retained on the consent form, and the data separate. After the project is finished, all data will be destroyed. Any publication will carefully avoid identifying information.

A40. Who will have access to participants' personal data during the study? *Where access is by individuals outside the direct care team, please justify and say whether consent will be sought.*

The research student will have access to consent forms and the supervisor may access these for audit purposes. Disclosure may also be compelled by a court of law.

Storage and use of data after the end of the study

A41. Where will the data generated by the study be analysed and by whom?

The student researcher, guided by his supervisor, will analyse the data. This will be on university premises.

A42. Who will have control of and act as the custodian for the data generated by the study?

	Title	Forename/Initials	Surname
	Dr	Jan	Davison-Fischer
Post	Senior Lecturer		
Qualifications	as above		
Work Address	as above		
Post Code			
Work Email	j.fischer@brookes.ac.uk		
Work Telephone	07810170195		
Fax			

A43. How long will personal data be stored or accessed after the study has ended?

- (●) Less than 3 months
- ( ) 3 – 6 months
- ( ) 6 – 12 months
- ( ) 12 months – 3 years
- ( ) Over 3 years

A44. For how long will you store research data generated by the study?

Years: 0
Months: 5

A45. Please give details of the long term arrangements for storage of research data after the study has ended. *Say where data will be stored, who will have access and the arrangements to ensure security.*

The data will not be stored after the study has ended. All data will be destroyed as soon as the study has ended.

INCENTIVES AND PAYMENTS

A46. Will research participants receive any payments, reimbursement of expenses or any other benefits or incentives for taking part in this research?

( ) Yes (●) No

A47. Will individual researchers receive any personal payment over and above normal salary, or any other benefits or incentives, for taking part in this research?

( ) Yes (●) No

A48. Does the Chief Investigator or any other investigator/collaborator have any direct personal involvement (e.g. financial, share holding, personal relationship etc.) in the organisations sponsoring or funding the research that may give rise to a possible conflict of interest?

○ Yes ◉ No

NOTIFICATION OF OTHER PROFESSIONALS

A49-1. Will you inform the participants' General Practitioners (and/or any other health or care professional responsible for their care) that they are taking part in the study?

○ Yes ◉ No

If Yes, please enclose a copy of the information sheet/letter for the GP/health professional with a version number and date.

PUBLICATION AND DISSEMINATION

A50-1. Will the research be registered on a public database?

○ Yes ◉ No

Please give details, or justify if not registering the research.
This study is too small and as part of an educational project does not qualify for inclusion in public databases. If a publication of the results through a peer-reviewed journal is possible, then this approach to dissemination will be pursued.

Registration of research studies is encouraged wherever possible.
You may be able to register your study through your NHS organisation or a register run by a medical research charity, or publish your protocol through an open access publisher. If you are aware of a suitable register or other method of publication, please give details. If not, you may indicate that no suitable register exists. Please ensure that you have entered registry reference number(s) in question A5-1.

A51. How do you intend to report and disseminate the results of the study? *Tick as appropriate:*

☑ Peer reviewed scientific journals
☑ Internal report
☐ Conference presentation
☐ Publication on website
☐ Other publication
☐ Submission to regulatory authorities
☐ Access to raw data and right to publish freely by all investigators in study or by Independent Steering Committee on behalf of all investigators
☐ No plans to report or disseminate the results
☐ Other (please specify)

The researcher will use the results to write an MSc dissertation. If the results merit it, a peer-reviewed publication will be produced.

A52. If you will be using identifiable personal data, how will you ensure that anonymity will be maintained when publishing the results?

We are not using identifiable personal data.

A53. Will you inform participants of the results?

◉ Yes ○ No

Please give details of how you will inform participants or justify if not doing so.
Participants will be given the opportunity to opt into receiving a summary of the research findings by email.

5. Scientific and Statistical Review

A54-1. How has the scientific quality of the research been assessed? *Tick as appropriate:*

- ☐ Independent external review
- ☐ Review within a company
- ☐ Review within a multi−centre research group
- ☑ Review within the Chief Investigator's institution or host organisation
- ☐ Review within the research team
- ☑ Review by educational supervisor
- ☐ Other

Justify and describe the review process and outcome. If the review has been undertaken but not seen by the researcher, give details of the body which has undertaken the review:
The project has been reviewed by a peer-review panel as part of the university-internal ethics approval process. It has also been reviewed by the educational supervisor.

For all studies except non-doctoral student research, please enclose a copy of any available scientific critique reports, together with any related correspondence.

For non-doctoral student research, please enclose a copy of the assessment from your educational supervisor/ institution.

A59. What is the sample size for the research? *How many participants/samples/data records do you plan to study in total? If there is more than one group, please give further details below.*

Total UK sample size:	10
Total international sample size (including UK):	20
Total in European Economic Area:	20

Further details:
10 nurses in the UK and 10 nurses in Norway will be interviewed.

A60. How was the sample size decided upon? *If a formal sample size calculation was used, indicate how this was done, giving sufficient information to justify and reproduce the calculation.*

Experience and institutional guidance suggest that a larger sample will not be manageable for an MSc student. Yet, the sample size is large enough that data saturation may occur.

A62. Please describe the methods of analysis (statistical or other appropriate methods, e.g. for qualitative research) by which the data will be evaluated to meet the study objectives.

The project will utilise thematic analysis, once the interviews have been transcribed.

6. MANAGEMENT OF THE RESEARCH

A63. Other key investigators/collaborators. *Please include all grant co−applicants, protocol co−authors and other key members of the Chief Investigator's team, including non-doctoral student researchers.*

Title Forename/Initials Surname

Post
Qualifications
Employer
Work Address

Post Code
Telephone
Fax
Mobile
Work Email

A64. Details of research sponsor(s)

A64-1. Sponsor

Lead Sponsor

Status: ○ NHS or HSC care organisation ◉ Academic ○ Pharmaceutical industry ○ Medical device industry ○ Other

Commercial status: Non-Commercial

If Other, please specify:

Contact person

Name of organisation	Oxford Brookes University
Given name	Hazel
Family name	Abbott
Address	Jack Straws Lane
Town/city	Oxford
Post code	OX3 0FL
Country	UNITED KINGDOM
Telephone	01865482639
Fax	
E-mail	heabbott@brookes.ac.uk

Is the sponsor based outside the UK?
○ Yes ◉ No

Under the Research Governance Framework for Health and Social Care, a sponsor outside the UK must appoint a legal representative established in the UK. Please consult the guidance notes.

A65. Has external funding for the research been secured?

- ☐ Funding secured from one or more funders
- ☐ External funding application to one or more funders in progress
- ☑ No application for external funding will be made

What type of research project is this?

- ◉ Standalone project
- ○ Project that is part of a programme grant
- ○ Project that is part of a Centre grant
- ○ Project that is part of a fellowship/ personal award/ research training award
- ○ Other

Other – please state:

A66. Has responsibility for any specific research activities or procedures been delegated to a subcontractor (other than a co-sponsor listed in A64-1) ? *Please give details of subcontractors if applicable.*

○ Yes ◉ No

A67. Has this or a similar application been previously rejected by a Research Ethics Committee in the UK or another country?

○ Yes ◉ No

Please provide a copy of the unfavourable opinion letter(s). You should explain in your answer to question A6-2 how the reasons for the unfavourable opinion have been addressed in this application.

A68-1. Give details of the lead NHS R&D contact for this research:

	Title	Forename/Initials	Surname
	Ms	Katie	Flight
Organisation	Oxford University Hospitals NHS Foundation Trust		
Address	Joint Research Office		
	Block 60, Churchill Hospital		
	Oxford		
Post Code	OX3 7LE		
Work Email	ouhtma@nhs.net		
Telephone	01865572233		
Fax			
Mobile			

Details can be obtained from the NHS R&D Forum website: http://www.rdforum.nhs.uk

A69-1. How long do you expect the study to last in the UK?

Planned start date: 15/09/2014
Planned end date: 23/01/2015
Total duration:
Years: 0 Months: 4 Days: 9

A71-1. Is this study?

- ○ Single centre
- ◉ Multicentre

A71-2. Where will the research take place? *(Tick as appropriate)*

- ☑ England
- ☐ Scotland
- ☐ Wales
- ☐ Northern Ireland
- ☑ Other countries in European Economic Area

Total UK sites in study 2

Number of sites anticipated in the Community 2

Does this trial involve countries outside the EU?

◉ Yes ○ No

- ☐ USA
- ☑ Other international (please specify)

Norway (this country is in the EEA but not in the EU)

A72. Which organisations in the UK will host the research? *Please indicate the type of organisation by ticking the box and give approximate numbers if known:*

☑ NHS organisations in England	2
☐ NHS organisations in Wales	
☐ NHS organisations in Scotland	
☐ HSC organisations in Northern Ireland	
☐ GP practices in England	
☐ GP practices in Wales	
☐ GP practices in Scotland	
☐ GP practices in Northern Ireland	
☐ Joint health and social care agencies (eg community mental health teams)	
☐ Local authorities	
☐ Phase 1 trial units	
☐ Prison establishments	
☐ Probation areas	
☐ Independent (private or voluntary sector) organisations	
☐ Educational establishments	
☐ Independent research units	
☐ Other (give details)	

Total UK sites in study: 2

A73-1. Will potential participants be identified through any organisations other than the research sites listed above?

○ Yes ◉ No

A74. What arrangements are in place for monitoring and auditing the conduct of the research?

The research will be monitored through routine supervision arrangements within the educational institution. Standard university audit arrangements are in place.

A76. Insurance/ indemnity to meet potential legal liabilities

***Note:** in this question to NHS indemnity schemes include equivalent schemes provided by Health and Social Care (HSC) in Northern Ireland*

A76-1. What arrangements will be made for insurance and/or indemnity to meet the potential legal liability of the sponsor(s) for harm to participants arising from the management of the research? *Please tick box(es) as applicable.*

Note: Where a NHS organisation has agreed to act as sponsor or co-sponsor, indemnity is provided through NHS schemes. Indicate if this applies (there is no need to provide documentary evidence). For all other sponsors, please describe the arrangements and provide evidence.

☐ NHS indemnity scheme will apply (NHS sponsors only)

☑ Other insurance or indemnity arrangements will apply (give details below)

The university has indemnity cover for its students' research activity, including management.

Please enclose a copy of relevant documents.

A76-2. What arrangements will be made for insurance and/ or indemnity to meet the potential legal liability of the sponsor(s) or employer(s) for harm to participants arising from the design of the research? *Please tick box(es) as applicable.*

Note: Where researchers with substantive NHS employment contracts have designed the research, indemnity is provided through NHS schemes. Indicate if this applies (there is no need to provide documentary evidence). For other protocol authors (e.g. company employees, university members), please describe the arrangements and provide evidence.

☐ NHS indemnity scheme will apply (protocol authors with NHS contracts only)

☑ Other insurance or indemnity arrangements will apply (give details below)

The university has indemnity cover for its students' research activity, including design.

Please enclose a copy of relevant documents.

A76-3. What arrangements will be made for insurance and/ or indemnity to meet the potential legal liability of investigators/collaborators arising from harm to participants in the conduct of the research?

Note: Where the participants are NHS patients, indemnity is provided through the NHS schemes or through professional indemnity. Indicate if this applies to the whole study (there is no need to provide documentary evidence). Where non-NHS sites are to be included in the research, including private practices, please describe the arrangements which will be made at these sites and provide evidence.

☐ NHS indemnity scheme or professional indemnity will apply (participants recruited at NHS sites only)

☐ Research includes non-NHS sites (give details of insurance/ indemnity arrangements for these sites below)

The university has indemnity cover for its students' research activity, including conduct. The study does not include patients, but the sites will be NHS.

Please enclose a copy of relevant documents.

A78. Could the research lead to the development of a new product/process or the generation of intellectual property?

○ Yes ◉ No ○ Not sure

PART C: Overview of research sites

Please enter details of the host organisations (Local Authority, NHS or other) in the UK that will be responsible for the research sites. *For NHS sites, the host organisation is the Trust or Health Board. Where the research site is a primary care site, e.g. GP practice, please insert the host organisation (PCT or Health Board) in the Institution row and insert the research site (e.g. GP practice) in the Department row.*

Research site		Investigator/ Collaborator/ Contact	
Institution name	Oxford University Hospitals NHS Trust	Title	Mr
Department name	A&E (Emergency Department), John Radcliffe Hospital	First name/ Initials	Rob
Street address	Headley Way	Surname	Way
Town/city	Oxford		
Post Code	OX3 9DU		
Institution name	Imperial College Healthcare NHS Trust	Title	Ms
Department name	A&E (Emergency Department), St Mary's Hospital	First name/ Initials	Mary
Street address	Praed Street	Surname	Dawood
Town/city	London		
Post Code	W2 1NY		
Institution name	Diakonhjemmet hospital	Title	Ms
Department name	outside the scope of IRAS	First name/ Initials	Anne Merete
Street address	Diakonveien 2	Surname	Nitter-Hauge
Town/city	Oslo		
Post Code	0219		
Institution name	Bærum hospital	Title	Ms
Department name	ouside the scope of IRAS	First name/ Initials	Susanne
Street address	Bærumsveien	Surname	Nobø
Town/city	Sandvika		
Post Code	1300		

PART D: Declarations

D1. Declaration by Chief Investigator

1. The information in this form is accurate to the best of my knowledge and belief and I take full responsibility for it.

2. I undertake to abide by the ethical principles underlying the Declaration of Helsinki and good practice guidelines on the proper conduct of research.

3. If the research is approved I undertake to adhere to the study protocol, the terms of the full application as approved and any conditions set out by review bodies in giving approval.

4. I undertake to notify review bodies of substantial amendments to the protocol or the terms of the approved application, and to seek a favourable opinion from the main REC before implementing the amendment.

5. I undertake to submit annual progress reports setting out the progress of the research, as required by review bodies.

6. I am aware of my responsibility to be up to date and comply with the requirements of the law and relevant guidelines relating to security and confidentiality of patient or other personal data, including the need to register when necessary with the appropriate Data Protection Officer. I understand that I am not permitted to disclose identifiable data to third parties unless the disclosure has the consent of the data subject or, in the case of patient data in England and Wales, the disclosure is covered by the terms of an approval under Section 251 of the NHS Act 2006.

7. I understand that research records/data may be subject to inspection by review bodies for audit purposes if required.

8. I understand that any personal data in this application will be held by review bodies and their operational managers and that this will be managed according to the principles established in the Data Protection Act 1998.

9. I understand that the information contained in this application, any supporting documentation and all correspondence with review bodies or their operational managers relating to the application:

    - Will be held by the REC (where applicable) until at least 3 years after the end of the study; and by NHS R&D offices (where the research requires NHS management permission) in accordance with the NHS Code of Practice on Records Management.
    - May be disclosed to the operational managers of review bodies, or the appointing authority for the REC (where applicable), in order to check that the application has been processed correctly or to investigate any complaint.
    - May be seen by auditors appointed to undertake accreditation of RECs (where applicable).
    - Will be subject to the provisions of the Freedom of Information Acts and may be disclosed in response to requests made under the Acts except where statutory exemptions apply.
    - May be sent by email to REC members.

10. I understand that information relating to this research, including the contact details on this application, may be held on national research information systems, and that this will be managed according to the principles established in the Data Protection Act 1998.

11. Where the research is reviewed by a REC within the UK Health Departments Research Ethics Service, I understand that the summary of this study will be published on the website of the National Research Ethics Service (NRES), together with the contact point for enquiries named below. Publication will take place no earlier than 3 months after issue of the ethics committee's final opinion or the withdrawal of the application.

Contact point for publication*(Not applicable for R&D Forms)*

NRES would like to include a contact point with the published summary of the study for those wishing to seek further information. We would be grateful if you would indicate one of the contact points below.

(•) Chief Investigator

( ) Sponsor

- ◯ Study co-ordinator
- ◯ Student
- ◯ Other – please give details
- ◯ None

Access to application for training purposes *(Not applicable for R&D Forms)*

Optional – please tick as appropriate:

☐ I would be content for members of other RECs to have access to the information in the application in confidence for training purposes. All personal identifiers and references to sponsors, funders and research units would be removed.

Signature: .....

Print Name: Dr. Jan Davison-Fischer

Date: 02/09/2014 *(dd/mm/yyyy)*

D2. Declaration by the sponsor's representative

If there is more than one sponsor, this declaration should be signed on behalf of the co−sponsors by a representative of the lead sponsor named at A64-1.

I confirm that:

1. This research proposal has been discussed with the Chief Investigator and agreement in principle to sponsor the research is in place.

2. Any necessary indemnity or insurance arrangements, as described in question A76, will be in place before this research starts. Insurance or indemnity policies will be renewed for the duration of the study where necessary.

3. Arrangements will be in place before the study starts for the research team to access resources and support to deliver the research as proposed.

4. Arrangements to allocate responsibilities for the management, monitoring and reporting of the research will be in place before the research starts.

5. The duties of sponsors set out in the Research Governance Framework for Health and Social Care will be undertaken in relation to this research.

6. Where the research is reviewed by a REC within the UK Health Departments Research Ethics Service, I understand that the summary of this study will be published on the website of the National Research Ethics Service (NRES), together with the contact point for enquiries named in this application. Publication will take place no earlier than 3 months after issue of the ethics committee's final opinion or the withdrawal of the application.

Signature: .....

Print Name: Hazel Abbott

Post: Senior Lecturer

Organisation: Oxford Brookes University

Date: 08/09/2014 *(dd/mm/yyyy)*

D3. Declaration for student projects by academic supervisor(s)

1. I have read and approved both the research proposal and this application. I am satisfied that the scientific content of the research is satisfactory for an educational qualification at this level.

2. I undertake to fulfil the responsibilities of the supervisor for this study as set out in the Research Governance Framework for Health and Social Care.

3. I take responsibility for ensuring that this study is conducted in accordance with the ethical principles underlying the Declaration of Helsinki and good practice guidelines on the proper conduct of research, in conjunction with clinical supervisors as appropriate.

4. I take responsibility for ensuring that the applicant is up to date and complies with the requirements of the law and relevant guidelines relating to security and confidentiality of patient and other personal data, in conjunction with clinical supervisors as appropriate.

Academic supervisor 1

Signature:	.....
Print Name:	Dr. Jan Davison-Fischer
Post:	Senior Lecturer
Organisation:	Oxford Brookes University
Date:	02/09/2014 *(dd/mm/yyyy)*

Oxford University Hospitals NHS

NHS Trust

HH/JT/RA /10975

Mr Rob Way
Nurse Consultant
OUHT
A&E
JR Hospital
OX3 9DU

From the R & D Lead
OUH Research & Development
Joint Research Office
Block 60, Churchill Hospital
Old Road, Headington
Oxford OX3 7LE

Tel: (01865)572974
Fax: (01865) (5)72242
rahman.ahmed@ouh.nhs.uk

22 Sep. 14

Dear Mr Rob Way,

Re: How do nurses in England and Norway perceive that the organisation of tasks between physicians and nurses in an emergency department influences the patients' waiting time?

Research and Development Reference: 10975
Research Ethics Committee Reference: FREC 2013/44

Confirmation of Trust Management Approval

On behalf of the Oxford University Hospitals NHS Trust, I am pleased to confirm Trust Management Approval and Indemnity for the above research on the basis described in the application, protocol and other supporting documents.

Conditions of Approval

Your attention is drawn to the attached conditions of approval. Breach of these conditions may result in Trust Management Approval being revoked.

Recruitment

The agreed total recruitment target for your study at the OUH site is 10 participants by31/12/2014 as specified in the CUREC application form.

To support requirements of the OUH Trust and national recruitment targets, we will be monitoring and publishing outcomes of recruitment for your study. This will include reporting performance against the 70 calendar day period from the time of receipt of a valid research application in R&D to the time of recruitment of the first participant to your study.

Your first participant recruitment target date is 24/11/2014.
In the meantime, if you recruit your first participant into the study then please send the date to researchrecruitment@nhs.net
The R&D office will contact you in due course by email to ask about the recruitment progress against this target.

Ethics Correspondence
In order to facilitate good communications and avoid unnecessary delays please copy all correspondence with the Research Ethics Committee (REC) to R&D, providing copies of all relevant documents.

Research Sponsorship

It is noted that Oxford Brookes University has agreed to Sponsor this trial.

Site Specific Assessment

This Trust Management Approval letter also incorporates site specific assessment for the Oxford University Hospitals NHS Trust site.

Approved Documents

Document Type	Version	Date
Application for Ethics Approval (Oxford Brookes University)	UREC Form E2U	
Consent Form	2.0	09 September 2014
First Contact Letter	2.0	09 September 2014
Interview Guide/Protocol		
Investigator's CV	Mr Rob Way	
Investigator's CV	Mr Lasse Andreassen	
Investigator's CV	Dr Jan Davison-Fischer	
Letter from Sponsor		05 September 2014
NHS R&D Form		
NHS SSI Form	OUH NHS Trust	
Participant Information Sheet	2.0	09 September 2014
Response Letter from CI		11 August 2014
University REC Favourable Opinion		15 August 2014

I wish you every success with the study.

Yours sincerely,

P.P.

Ms Heather House
Research and Development Lead

Copy to:	Chief Investigator: Dr Jan Davison-Fischer	j.fischer@brookes.ac.uk
	Sponsor: Oxford Brookes University	j.fischer@brookes.ac.uk
	OUH Study Finance	study.finance@nhs.net

Oxford University Hospitals NHS
NHS Trust

Standard Conditions of Approval by Oxford University Hospitals NHS Trust for Research studies other than Clinical Trials of Investigational Medicinal Products or Medical Device Trials

Issued to Chief Investigators and Principal Investigators

1) **Commencement of the Study**

Before the study commences the Chief Investigator/Principal Investigator is responsible for the following:

a) Ensuring that all members of the research team are appropriately qualified to undertake their role(s) through education, training and experience

b) Establishing a Study Master File/Site File, which should be maintained throughout the study and be readily available to the study team.

c) Ensuring that all members of the research team who have access to patients, their organs, tissues, data or access to NHS staff, information and facilities have OUH substantive/honorary contracts or appropriate research passports/honorary research contracts/letters of access in place prior to their involvement in the study.

d) Ensuring that all appropriate approvals are in place and remain so for the duration of the study

e) Ensuring that all investigators in the study are aware of and comply with the Regulatory Framework surrounding research practice, which includes but is not limited to:
   - The Department of Health Research Governance Framework for Health and Social Care 2005
   - Mental Capacity Act 2005
   - The Human Tissue Act 2004
   - The Declaration of Helsinki 2000
   - The Human Rights Act 1998
   - The Data Protection Act 1998
   - ICH Good Clinical Practice 1996

2) **Conduct of the Study**

a) The study will be conducted according to the all applicable regulations, principles of Good Clinical Practice and applicable OUH Trust policies.

b) The study will be conducted in accordance with the approved protocol.

c) Essential documents will be made available for audit and inspection purposes where required.

d) The Trust must be made aware of any Intellectual Property that arises from the research study.

3) **Protocol Amendments**

a) Where the OUH (NHS) Trust has taken on the role of Sponsor, investigators must submit protocol amendments to R&D Department **prior** to submission the Research Ethics Committee and MHRA, to assess any implications for the Sponsor.

b) All **substantial** amendments must be submitted to the appropriate Research Ethics Committee for approval. Documents should also be forwarded to the R&D Department for assessment as to whether the amendment affects Trust Management Approval.

c) In order for the Trust to meet its responsibilities under the Research Governance Framework **all amendments, including non-substantial amendments** must be submitted to R&D department. You should include all supporting documents.

d) Submission of substantial amendments will be acknowledged by a letter confirming on-going Trust Management Approval, non-substantial amendments will be acknowledged by email.

e) **NO** substantial amendment, except those that relate to an urgent safety measures, should be implemented until all appropriate approvals have been obtained.

4) **Change of key Site Personnel - Chief investigator/Principal Investigator**

a) Any change of nominated Chief investigator/Principal Investigator (e.g. due to relocation, maternity leave, retirement etc.) at the OUH (NHS) Trust should be notified to the R&D Department **immediately**; the host organisation needs to ensure any on-going studies have been reviewed and appropriate oversight is in place; or where needed studies have been terminated within the required timeframes.

b) All other changes in study staff should be maintained via a study delegation log.

5) **Safety reporting**

a) Appropriate safety reporting procedures will be agreed according to the perceived risks to study participants and/or the Trust. Any safety reporting requirements will be communicated in writing by the R&D Lead to the Chief/Principal Investigator.

6) **REC Annual Progress Reports and Monitoring of the Study**

a) The Chief Investigator should ensure that the REC Annual Progress Reports are completed and submitted in a timely manner on each anniversary of the REC Approval, and copied to R&D.

b) The need for on-site monitoring of the study will be assessed according to risk to study participants and/or the Trust. Any special requirements will be communicated to the Chief Investigator/Principal Investigator in writing.

c) The Trust may audit a number of hosted CTIMPs and interventional studies.

7) **NIHR and NHS Quality Accounts**

a) The Trust is obliged to submit data to the Department of Health annually. The Chief Investigator/Principal Investigator must provide to R&D department in a timely manner, such information about the study as to enable to Trust to meet its obligations.

b) In particular the Chief Investigator/Principal Investigator will forward the first participant recruited date to R&D department by emailing the information to the email address provided in the NHS permission letter.

8) **Conclusion of the Trial**

a) The Trust R&D Department should be informed within 60 days of the close of the study and a final report provided.

b) If the study is stopped early, the Trust R&D Department should be informed within 30 days outlining the reasons.

9) **Termination of Trust Management Approval**

a) The Trust reserves the right to revoke Trust Management Approval or Sponsorship for any project that is not conducted according to Trust policy or the applicable regulatory or legal framework. However, any such action will not be taken without prior discussion with the R&D Lead and/or the Medical Director together with the Chief or Principal Investigator. Furthermore, all researchers undertaking research at the Trust are subject to the Misconduct and Fraud Policy.

All Trust policies for the conduct of research within the organisation can be found at www.oxfordradcliffe.nhs.uk/research