Balancing patient needs and workforce realities: exploring safe practice options through delegation

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There is an ever-increasing demand on health care services due to increased client complexity, evolving models of care and changing technology. At the same time there are ongoing issues with the supply of health professional workforce due to changing workforce demographics, working patterns and workforce mobility as well as a reduction in labour supply as a result of an ageing population. Australia's National Health Workforce Strategic Framework 2006 -2016 was developed to increase workforce supply, improve workforce distribution, create attractive workplaces, and provide cohesive action. It is estimated that the health practitioner workforce will need to grow by 2.8% annually in order to meet the demand, and it is anticipated that demand is likely to exceed supply. The Australian Governments Skilling Australia for the Future (Skills Australia Act 2008) emphasises the need to increase workforce participation; improve productivity and competitiveness; identify and address skills shortages; and promote the development of a highly skilled workforce.

One third of all Australians live outside a major city however Wakerman, Humphrey's, Wells, Kuipers found that mortality and morbidity levels increased with the distance from major cities. The literature identified a range of potential causative factors including amongst other things, funding biasing larger populated areas affording a wider range of services and inpatient infrastructures and recruitment and retention issues in rural and remote areas. Attracting and retaining a skilled health workforce has been identified as a key priority for allied health practitioners. Issues around role definition, poorly perceived prestige, the influence of generic work, inadequate support and burnout have been identified as key issues in rural and remote areas.

Job satisfaction has been linked to retention in occupational therapy and nursing studies. People were less likely to consider changing positions and more likely to remain in their chosen career if work tasks were considered interesting or rewarding; if they had a sense of achievement, if there was variety, challenge and multidisciplinary team work; if they had a sense of achievement, if there was variety, challenge and multidisciplinary team work (Borderi, 1988; Brollier, 1985; Davis & Borderi, 1988; Jenkins, 1991; Okerlund, Jacksno, Parsons & Comsa, 1995; de Welsy & Clemson, 1992), and perceived autonomy (Borderi, 1988). In contrast, high workloads and perceived poor professional status were found to be the most frequent reasons to leave, followed by lack of resources and poor working conditions.

Despite allied health assistant roles having a low profile amongst job seekers and students considering career options, policy direction driven by health service demands and predicted workforce shortages supports the use of allied health assistants and partnerships with external providers and contracted services. This has led in part to the development of nationally recognised qualifications in allied health assistant training and an increase in the use of outsourcing enabled by the development of procurement registers and service agreements.

DELEGATION

The Chartered Society of Physiotherapy (2006) defined delegation as 'the process by which a registered practitioner can allocate work to a support worker who is deemed competent to undertake that task … with the registered practitioner retaining accountability'.

The Dietetic Association of Australia and the Speech Pathology Association of Australia specified that only experienced professional staff or staff who have been trained in delegation or supervision should delegate tasks to ensure safe practice (DAA 2007, SPA 2007).
MODELS OF DELEGATION

Considerable work has been undertaken in nursing regarding the use of delegation to enable a flexible and responsive service delivery model\(^{(18)}\). In the mid 1990’s a Functional Model of Delegation for Physiotherapists was developed\(^{(11)}\) and extended trials were undertaken\(^{(12, 13)}\). Results of a pre and post trial indicated an increase in productivity and a reduction in cost with no loss of clinical effectiveness, efficiency, nor patient satisfaction. The study identified initial difficulties in delegating due to the fears of loss of control of patients’ care and feelings of guilt however this was overcome as trust developed\(^{(11)}\). Three years after this initial study, it was demonstrated that the delegation could be sustained\(^{(12)}\). However a third study found that delegation operated successfully only if there was commitment from the management, the profession, and the individual physiotherapist\(^{(13)}\).

Nursing studies\(^{(22)}\) found that delegation was linked with increased confidence and increased job satisfaction. However Thoma and Hume 1998\(^{(22)}\) found that nurse graduates identified the biggest barrier to effective and efficient delegation to be a lack of academic preparation and opportunities to practice delegation in the undergraduate program.

The Centre of Allied Health Evidence commissioned a systematic literature review on the utilisation of support workers\(^{(24)}\). The review supported allied health assistants in community rehabilitation, but identified the need for further work around models of service delivery, developing clear boundaries, roles and responsibilities, training, supervision and accountability and outcomes. Advanced scope of practice roles were identified however their success was impacted on by role threat, organisational effectiveness, a need for clear delegation, and a need for responsive training programs\(^{(14)}\).

Victorian Health embarked on a program of workforce redesign known as “Better Skills Best Care” designed to address impending workforce issues. The program sought opportunities to systematically redesign the workforce to improve efficiencies through restructuring and improving skills and knowledge. This included inter-sectorial partnerships, the development of the allied health assistant role and a range of pilot programs aimed at gaining an understanding of the key issues, areas of demand and opportunities to support clinical placements to support learners\(^{(2)}\).

As a consequence of workforce shortages and a policy direction to seek solutions to a shrinking workforce, generic support worker roles were developed in intermediate care services in the United Kingdom. Rehabilitation assistants were trained over an eighteen month period. Whist the pilot was deemed successful it found that more research was required\(^{(14)}\). In the United States of America and Canada the allied health assistant has been formalised through a requirement to hold a formal qualification whereas the allied health aide does not require a qualification\(^{(3)}\).

Quynh Le and Rosa McManamey identified that outsourcing is common in areas such as business, information technology and metropolitan hospitals but often not considered in rural and remote areas\(^{(17)}\). Outsourcing is defined as the contracting out activities previously performed in-house and is often associated with an improved range of services and flexibility, cost efficiency, and able to address needs that cannot be met locally. Further study on the impact of health outsourcing on the social fabric or rural communities was recommended in the context of health services’ contribution to community cohesion and sustainability.

The legal implications of outsourcing appear unclear until challenged, however for public health services, it appears that a non-delegable duty of care will apply in that the Government will remain liable for the due care of patients despite the introduction of an independent contractor who will be immediately responsible for the provision of that care\(^{(23)}\).
The liability of a hospital arises out of its undertaking an obligation to treat its patient, an obligation which carries with it a duty to use reasonable care in treatment, so that the hospital is liable, if a person engaged to perform the obligation on its behalf acts without due care.\(^{(29)}\)

**DELEGATION FRAMEWORK**

A number of delegation frameworks were identified in the literature and a few are outlined in this paper.

In 2002 Mills and Millsteed\(^{(18)}\) identified supervision and communication as key predictors for successful delegation. The type and nature of the supervision for allied health assistants needed to be considered in the context of the practice setting, the task, the patients’ acuity and the decision-making required for modification of treatment based on patients’ response. Success depended on the allied health assistants’ education, training, experience, skills and personal attributes.

The allied health practitioner has a legal and ethical responsibility for the quality of the supervision provided and for setting, encouraging, and evaluating the standard of work performed by the support worker to ensure safe effective efficient and competent work. A clear communication protocol needed to be established to ensure that the support worker understands the instructions and the limitations and scope of their clinical practice. Allied health assistants were required to demonstrate competence and supervisors needed to be at hand or easily contactable.\(^{(18)}\).

In 2006 Queensland Health sponsored an Allied Health Project\(^{(22)}\) that proposed a model for delegation and a decision-making framework. The framework identified five critical delegation decision making factors and a delegation which incorporated a range of delegation frameworks.

The five critical delegation decision making factors include:

1. potential for harm
2. complexity of the task
3. problem solving required
4. unpredictability of outcome
5. level of interaction required.

This was further elaborated in a flow chart including consideration of:
- right task (considering such things as legislation, professional guidelines, service provider guidelines)
- right circumstances (considering the patients needs, circumstances and resources)
- right person (examining the skills and competence of the delegator and the delegate and the patient)
- right communication (explaining how, expectations, expected results and potential complications, timelines for communication)
- right supervision (including developing a plan for mentoring and feedback)
- right evaluation (in terms of patient outcomes, and appraisal of the process)

Western Australian Country Health Service (2008)\(^{(3)}\) allied health assistant project also supported the concept of a delegation framework which included:

- Delegation: defined as a process by which the allied health practitioner delegates activities to the allied health assistant with appropriate education, knowledge and skills to undertake the activity safely.
- Monitoring: defined as an ongoing process of reviewing the activity delegated by an allied health professional to an allied health assistant to ensure set standards or requirements are being met.
• Supervision: defined as a monitoring strategy where the Allied Health Practitioner directly observes the competency of the Allied Health Assistant performing a delegated activity; their performance of an activity in different contexts (eg different clients); and for the purpose of developing competencies.

The expansion of supervision and the importance of effective feedback mechanism could be linked to continued improvements and patient safety.

It can be extrapolated that a similar framework would be useful when outsourcing allied health and other patient related services.

GOVERNANCE
The allied health practitioner, the brokered service provider, and the allied health assistant have a duty to provide reasonable care to patients. A breach of duty to take reasonable care is when less than reasonable care is taken (and is therefore negligent)\(^{(31)}\).

The allied health practitioner has a legal and ethical responsibility to ensure high professional standards to the client are maintained\(^{(24)}\). The supervising health professional must ensure that the allied health assistant / brokered service provider:
- is clearly identified as an assistant and understands their role
- is trained to the level appropriate for tasks required and provided with clear directions
- has clear identified communication lines
- is not delegated tasks outside of their competence
- quality of work is regularly evaluated for safety, effectiveness, efficiency and competence

The allied health assistant/ brokered provider has a legal and ethical responsibility to:
- abide by the code of conduct and code of ethics of the particular discipline delegating the task
- respect the rights and responsibilities of all individuals
- maintain confidentiality of patient information
- recognise the extent and limitations of their role and only undertake activities they are competent to perform
- obtain supervision from the delegating health professions irrespective of the experience and skills of the allied health assistant.
- maintain a supervision log to document the date, type, amount and medium used for supervision. This log could be incorporated into their performance and appraisal.
- maintain an up to date knowledge of policies, procedures and guidelines in relation to their work.
- maintain professional standards of personal behaviour

METHOD
A systematic problem solving process was implemented. This process included problem identification, pressure testing for causes including a review of controllability, a root cause analysis process including dichotomous problem analysis and test for solutions\(^{(30)}\). A model for delegation was then developed, trialled, evaluated and refined.

PROBLEM IDENTIFICATION
The Gold Coast Transition Care Program was established in 2006 with a multi-disciplinary team including four allied health assistants. Workforce shortages and budgetary issues had led to the decision to employ allied health assistant staff, and a policy directive had led to the outsourcing of services through brokered external service providers. Issues with service quality, scope of practice and utilisation rates precipitated the need to explore improved delegation and feedback mechanisms.
The problem was identified and refined to “Poor utilisation of allied health assistant and brokered service providers”.

CAUSE IDENTIFICATION
The root cause analysis assisted in cataloguing potential causes and assessing the impact of individual causes on the larger problem. The following outlines some of the findings of this analysis.

A review of brokered providers was undertaken and included an administrative analysis of the type and cost of services utilised and a formal review of the content, frequency and mechanisms for feedback utilised by the brokered providers. In addition, discussions were held with staff in regular team meetings as well as individually to ascertain usefulness of the feedback in terms of its contribution to the clinical management of clients and how it related to therapeutic goals that underpinned the model of care. Discussions were also held with the service providers.

The review identified problems in communication which impacted on patient care. Service providers generally supplied infrequent and brief feedback on service provision and client progress. Standardised documentation for provider feedback was rarely used and despite training, high turnover in brokered providers, meant that new staff were unsure or unaware of the contractual obligation to provide feedback. The service requests sent to the brokered services often lacked detail, included abbreviations and jargon that the providers often could not understand. Despite requesting a restorative approach, services appeared to implement a “do to/for” philosophy of care and workers arrived at clients’ houses with a poor if any understanding of what was required.

Issues with staff shortages, temporary leave cover for maternity and annual leave created a need to increase the use of brokered services. This proved difficult on many occasions due to a lack of availability of appropriately skilled staff to broker which lead to further cost inefficiencies with flow on effects of increased risk to service quality and client safety.

A literature review, including a multi-disciplinary review of professional association position statements, was undertaken to review allied health assistants scope of practice, role delineation and skill development. Feedback was also sought from the allied health assistants to determine their perceptions and expectations.

Allied health assistants’ time management was mapped and compared with other Transition Care Programs using state wide workforce data. This identified that the allied health assistants were spending 66% of their time on clinical activities compared to over 80% in other districts. They were also spending significant amounts of time completing administration tasks. This in turn led to administrative staff underutilisation and staff burn out in allied health staff.

Utilisation was further examined and it appeared that not all professions used the assistants equally, nor effectively. Whilst physiotherapists were the most frequent profession to delegate, speech pathologists, dietitians, and nursing staff used allied health assistants to deliver items and assist with transport only. Occupational therapists did not delegate activity of daily living retraining and infrequently delegated community re-integration and cognitive retraining.

On review of these issues various causes became evident. As was identified in the literature\(^{11,22}\), clinical staff appeared to lack confidence and skills in the delegation process. In a time-pressured environment a culture of avoidance developed. This was reinforced by the observation that as confident and skilled staff were replaced by those who lacked familiarity in the use of assistants and brokered services, usage rates declined and allied health assistants reported a change in the type of work that they were delegated.
Communication pathways were also identified as problematic as the service grew and expanded. Internal referral forms for allied health assistants had been adopted when the team had been small, however instructions were brief and lacked clarity often requiring the assistant to follow up with the therapist, and at times delaying or preventing service delivery. Verbal and written feedback to the therapist lacked structure and was reliant on the individuals’ communication skills.

Despite the allied health assistants’ either having completed or in the process of completing a formal qualification, a review of their on the job competencies revealed various skills gaps. These skill gaps related mainly to assisting occupational therapy and speech pathology clinicians in implementing home exercise and skill retraining activities. There was reluctance by allied health assistants to accept tasks such as retraining clients to return to independence with personal activities of daily living largely because of perceived role prestige and an expressed wish to distance themselves from personal care work. In the case of speech pathology, there appeared to be a reluctance to delegate tasks to allied health assistants due to issues of complexity and the absence of a formal measurable feedback mechanism.

Policies, procedures and workplace guidelines to direct engagement of both allied health assistants & brokered services were outdated and appeared to be discounted by new staff. Exacerbating this was a lack of clarity around the role of both allied health assistant staff and brokered service providers.

**SOLUTION**

A systematic approach was utilised to develop solutions to the identified problems.

A clear role for allied health assistants needed to be developed and documented. Allied health professionals, assistants and nursing staff were consulted in order to ascertain the tasks which could be outsourced or delegated to brokered service providers and / or allied health assistants. These tasks were reconciled against the range of tasks identified in the literature and documented. This list was designed to be dynamic with additions and deletions as appropriate.

Outdated policies and procedures were replaced by a delegation framework and new workplace guideline. The guideline formalised the process, listed the agreed tasks and identified responsibilities reflective of the literature. It also provided clarity and clinical reasoning with the aim of addressing duty of care issues, improved use of allied health assistants’ time, provision of improved feedback mechanisms, and improved linking of delegated tasks to client goals.

Two way communication was improved through the development of an activity request form. This two page document included relevant patient information and a tool for allied health assistants and brokered providers to provide weekly feedback to the client’s treating team. Opportunities for input, review and feedback into these documents was sought before finalisation. Ongoing staff training was provided.

In recognition of the a lack of staff confidence and skills of staff in delegating, a staged roll out of the new delegation framework and feedback processes was implemented. This involved a number of steps:

**Step 1:** Update policy / process / forms and development of an allied health assistant supervision log

**Step 2:** In-service training with all allied health and nursing staff including understanding roles and responsibilities, principles of adult learning and teaching and assessing competencies, communication and supervision requirements

**Step 3:** In-service training with in house allied health assistants including
understanding roles and responsibilities, rationale behind teaching and assessing competencies, communication and supervision requirements

Step 4: In-service training with current brokered service partners including understanding roles and responsibilities, developing competencies, communication and supervision requirements

Step 5: Ongoing review of stakeholder feedback regarding the delegation process and forms

Step 6: Ongoing review and training of new staff

Step 7: Ongoing review of policies, procedures & workplace guidelines related to task delegation including supervision and communication processes

RESULTS
A review was conducted three months after the introduction of the new delegation framework and demonstrated the following improvements:

- Improved use of in house allied health assistant staff by allied health professionals and nursing staff
- Broader scope of practice for in house allied health assistant staff with a reduction in administration duties and an increase in clinical time
- Improved use of brokered services with services requested matching services delivered and improved compliance with restorative model of care
- Introduction of activity of daily living diagrammatic care plans in patients showers
- Constructive, informative and regular feedback from brokered service providers
- Use of broader range of brokered providers, though this could be attributed in part to the expansion in the number of providers utilised
- Demonstration that neither a 100% allied health assistant or 100% brokered provider model is appropriate but rather a mix is required to provide the best opportunity to maximise quality of care and client safety.

CONCLUSION
In a time pressured clinical environment, it is often easy to overlook or avoid unfamiliar tasks and to blame others. Through a systematic review of the problem supported by a literature review, solutions were identified, trialed and evaluated. As a result, a simple pathway was developed for new and experienced allied health practitioners to ensure effective and appropriate decision making, whilst providing a mechanism for feedback. The results from application to a community program included improved quality of service delivery by partner organisations, improved responsiveness of partner organisations, more effective use of allied health assistants, more cost effective use of public program financial resources, and positioning of the service to meet quality and safety standards and increasing patient demands.

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