

Defining the role and scope of practice of allied health assistants within Queensland Public Health Services

Michelle Stute

Workforce Development Officer,

Prince Charles Hospital, Queensland

Andrea Hurwood

Team Leader,

Allied Health Professions Office, Queensland

Julie Hulcombe

Chief Allied Health Officer,

Allied Health Professions Office, Queensland

Julie_Hulcombe@health.qld.gov.au

* Corresponding author

Pim Kuipers

Principal Research Fellow, Metro South Health & Associate Professor, Population and

Social Health Research Program, Griffith Health Institute, Griffith University.

Acknowledgements

This work was done by the authors at the Allied Health Workforce Advice and Coordination Unit, with funding through Queensland Health. The substantial contributions of many AHPs and AHAs across Queensland, who participated in the survey and focus groups, are gratefully acknowledged.

Abstract

Background. The uptake and utilisation of allied health assistants as professional support staff has been variable across disciplines and jurisdictions. While these roles are potentially very important in the current health workforce context, there is little agreement on their roles or the most suitable methods to define these roles.

Method. Based on a review of literature, existing role descriptions and focus groups, a Delphi survey process was undertaken. This process comprising three rounds of discussion and clarification via email, with between 188 and 107 participants, was undertaken to define and establish consensus on AHA roles at three levels.

Results. Three cycles of editing, qualitative feedback and rating of agreement with statements resulted in substantial clarification of roles and a meaningful degree of consensus regarding the role and scope of such positions. High levels of agreement were not reached for more high-level or contested clinical tasks.

Conclusions. The Delphi process resulted in key tasks and roles being defined and contentious aspects clearly identified. The process facilitated engagement with workforce members most closely affected by these questions. It was a useful means of drawing together the opinions of the workforce and informing implementation trials to follow.

Key question summary

What is known about the topic?

- Allied health assistants are important members of health teams. Current developments in health services necessitate considerable growth in these positions.
- The role and scope of practice of allied health assistants is poorly defined and varies between disciplines, settings and facilities, which threatens the establishment of these positions

What does this paper add?

- This study describes a methodology used to define the role and scope of practice of allied health support staff which resulted in high levels of consensus and documentation of concerns regarding these positions.
- Tasks and roles have been defined at different AHA position levels

What are the implications for practitioners?

- The definition of roles and establishment of scope of practice of emerging positions can be substantially advanced by well researched and widely consultative methods.
- For more advanced AHA positions to be effectively implemented, tasks relating to treatment, leadership, documentation, assessment and team participation must be clearly elucidated and agreed.

Introduction

Allied health assistants (AHA) are support staff who undertake tasks delegated by an allied health professional (AHP). While the uptake and utilisation of AHAs has been variable across allied health professions and jurisdictions,(1) these roles are an important and growing response to current health workforce needs.(1) The use of AHAs can lead to more effective and efficient use of workforce skills, contribute to improving patient outcomes and assist in managing demands on allied health services.(2-5) While there have been key recommendations to expand the role and scope of practice of AHAs,(6) the most suitable mechanisms for doing so are not clear, and there is little agreement on the roles AHAs should undertake.(7)

Position statements from many allied health professional associations provide guidance on suitable tasks to delegate to an assistant; however they vary considerably in terms of the nature, and the extent of recommendations for such delegated tasks.(8-13) Likewise, beyond profession-specific settings, AHA guidelines pertaining to rural areas,(14, 15) community settings,(16) for roles in rehabilitation,(17) and across certain disciplines,(18) all tend to be relatively distinct. In an Australian attempt to summarise and review this work,(7) potential AHA tasks were identified and grouped into clinical and non clinical categories. In that review a number of contested tasks were also identified. Such contested tasks, which typically challenge professional boundaries, are extensive and include: admission, assessment, prescribing, interpreting, planning and modifying treatment, administering clinical modalities, and discharge.(7) To date, questions of the suitability of AHA roles to perform such tasks remain unresolved.(7)

In light of such ambiguity, the processes by which AHA tasks and roles are defined within specific practice settings are particularly important. The approaches used to define the roles and/or scope of practice of support workers in health care are as varied as the roles themselves, including interviews,(2) focus groups,(19) and surveys.(20-22) Most studies have focussed on practice settings and stakeholders, with one UK study using a documentary analysis that spanned a 25 year period.(23)

In planning for the current project, it was determined that a comprehensive method was required. Namely, that a preparatory phase comprising literature and document reviews, role description analyses, and focus groups would comprise a strong foundation for a large scale Delphi survey.(24, 25) The Delphi survey aimed to define the role of AHAs to inform a potential clinical progression pathway for this workforce across three levels from trainee to full (standard) and advanced scope positions, as part of an industrial agreement. This work occurred in parallel with explorations of the training and support needs of AHAs. These strategies were initiated in the context of ongoing reform within Queensland public health services.

Methodology

Preparation to define AHA roles comprised the following. First, a literature review was undertaken, including familiarisation with relevant work conducted in Queensland Health, as well as nationally and internationally. Second, a pilot survey of current AHAs and AHPs was undertaken to determine the types of roles and qualifications held by assistants. Descriptions of AHA roles in Queensland public

health services were obtained and analysed. The nature of tasks being performed, levels of autonomy and supervision, differences between roles at different remuneration levels, qualifications recommended or required, and the nature of tasks excluded from the roles, were documented.

Third, 26 focus groups were conducted (separate AHA and AHP groups) in 13 sites across Queensland to provide actual practice information on the roles and tasks undertaken by AHAs. In the focus groups, two project officers presented findings of the literature review and pilot survey, recording participant responses and main points of group discussion regarding AHA roles. Proceedings in the form of transcribed notes were thematically analysed. Results of this analysis, combined with key information extracted from the literature review and pilot survey were summarised into role statements, which were the foundation for the Delphi survey.

Delphi Survey

The Delphi process, which is the focus of the current paper, comprised a series of progressive surveys sent out to a self selected panel of AHAs and AHPs. The rigour and suitability of this method in health services research has been noted,(25) particularly when it is based on careful preparation of source material, and uses successive rounds, as in the present study. In each round of the survey, panellists were provided with a list of statements describing the role of AHAs at three levels of practice: trainee, full (standard) scope, and advanced scope of practice. Panellists were asked to review each statement and indicate the extent to which they agreed or disagreed that the statement fits with their views on what the role and scope of

practice should be. They rated their level of agreement (1 – strongly disagree, to 10 – strongly agree), with ratings of 7-10 noted as high levels of agreement.

Panellists were also asked to provide qualitative feedback about the statement, briefly explaining why they agreed or disagreed with the statement. They also had the option to re-write the statement to more accurately reflect their views.

This feedback was used to revise statements that attracted relatively low levels of consensus (i.e. where less than 80% of panellists rated a high level of agreement with the statement). Each successive round incorporated the findings from the previous surveys, and provided panellists with an opportunity to comment on the revised role descriptions. Once consensus had been achieved (i.e. where at least 80% of panellists rated a high level of agreement) the role statement was not included in subsequent Delphi rounds.

Table 1 about here

Invitations to participate in the Delphi survey were advertised widely across all AHA and AHP positions in the Department through internal staff mechanisms and expressions of interest. In light of the diverse nature of the workforce and the geography of Queensland public health services, an electronically administered format was chosen. As reflected in Table 1, 188 AHAs and AHPs registered to participate in the Delphi, and 107 of these completed all three rounds of the survey

Figure 1 about here

Figure 1 illustrates the professional discipline area of Delphi group participants (whether as AHPs or AHAs). This chart is indicative of the major areas in which such roles currently exist (Physiotherapy, Occupational Therapy, etc) as well as those areas in which such roles are less common (Psychology, Radiography, etc.).

The Delphi survey consisted of three rounds implemented over a 4 month period from February 2009 to May 2009. In order to maximise panel member confidence and engagement,(26) the administration of the Delphi survey, data management and feedback was conducted by an external consultant. Authors reviewed feedback in each round, monitored subsequent surveys prior to dissemination, and analysed the data. As an organisational planning and mapping exercise, the survey was conducted under the auspices of, and approved by the Queensland Health, Allied Health Workforce and Coordination Unit.

The results from rounds 1 and 2 of the survey were analysed and fed back to panellists in the following round. Statistical feedback to panellists included the response rate, the number of respondents for each round and for each question median scores and percentages of respondents in each category ('agreement', 'undecided' etc). Qualitative feedback included a summary of the comments made by participants and quotes of comments made by individuals. The use of such controlled feedback in the second and third rounds reduced 'noise' in the results and facilitated the attainment of consensus (27).

Table 2 about here

An example of the gradual refinement of a statement is provided in Table 2. The final statements from the Delphi were translated into draft role descriptions. Over the course of several months, from May – October 2009, consultations took place with key stakeholders, including policy makers, managers and unions. They concurred with all role statements in which the 80% threshold had been established through the Delphi process. Subsequent negotiations with these stakeholders resulted in agreement being established for all of the role statements for the full (standard) scope AHA position. For the advanced scope role description, concessions were made by Queensland public health services to acknowledge the lack of agreement about a number of the statements and allow implementation trials to commence.

Results

Despite slight attrition throughout the Delphi, composition in terms of representativeness of the participant group remained stable across professional groups, disciplines and geographically. Overall return rates were 74% (round 1), 73% (round 2) and 63% (round 3). Table 1 reflects that the geographical spread of participants in the survey was mostly from regional and metropolitan areas, with approximately 17% from rural and remote areas. Most participants were AHPs, and in keeping with the area of the study, 46% were AHAs.

Table 3 about here

Tables 3 and 4 indicate that a high level of agreement (more than 80% of panellists rating their agreement with the statement as 7 or more out of 10) was reached for 35 out of 42 statements by the end of round 3. This represents 83% of the total number of statements. Table 3 indicates that consensus levels rose in the second and third rounds of the survey compared with round 1, and that higher levels of agreement were achieved for the trainee level role statements.

Table 4 about here

Table 4 reflects that statements relating to patient education, group interventions, referrals, support and mentoring and training and development all showed over 80% consensus across all three positions. For the four skill-related statements, minor revisions were made and consensus was achieved after round one. High levels of consensus were not reached on two of the full (standard) scope statements (documentation and treatment) and five of the advanced scope of practice statements (documentation, treatment, leadership, assessment and team participation, Table 4).

Discussion

To provide insight into the results and levels of agreement between panellists, qualitative comments were reviewed. High levels of agreement were evident for all

trainee level role statements, as well as for those full (standard) and advanced scope statements in which there was minimal perceived clinical risk, some historical precedent, no perceived threat to the role of the professional (including to the role of students and new graduates), or where clinical judgement was not required. This is consistent with previous research on the implementation of such positions, (19, 28) and indicates that there are a number of AHA roles and functions which are readily accepted by most key stakeholders.(29)

Conversely, agreement was more difficult to achieve for full (standard) and advanced scope task statements relating to assessment, treatment, leadership, documentation and team participation. Such tasks have been described as “contested tasks” by other authors.(7) In the present study, contested aspects of these tasks were evident in concerns raised by panellists about legal implications (especially regarding documentation in medical records), perceived risk to the patient (of injury or reduced quality of care), and tasks requiring levels of clinical judgement (such as prescribing equipment, evaluating patient progress, modifying treatment programs and discharging patients).

Likewise, in some cases agreement levels were low when panellists noted ambiguity of terminology (for example, ‘modifying treatment programs’, and ‘assessment’). For tasks where assistants indicated they lacked confidence about their ability to perform the role, or were unclear about their legal status to act with that level of autonomy, agreement was not attained.

Delphi survey results also reflected considerable variation between disciplines in the tasks they were willing and able to delegate to an assistant. Those professions that had a long history of working with assistants (e.g. Physiotherapy) tended to use them more broadly. This variation meant that a comprehensive generic AHA role description was not attainable across all allied health. Separate role descriptions were developed for Pharmacy, Social Work and Radiography. Subsequent trials relied on discipline-specific task lists to complement a more basic generic role description.

In future, the trainee role may have some applicability for school based trainees, or where an allied health assistant has no previous experience. Based on these data and subsequent negotiations, implementation of an advanced scope of practice role for allied health assistants is challenging, partly due to lack of existing formal training and ongoing contention regarding the scope of practice at this level.

Finally, given that there was no educational or training precedent for the advanced scope position, panellists appeared to have difficulty conceptualising the role. However, the degree of agreement established is a meaningful starting point for future role development in conjunction with adequate training and clinical governance.

Procedurally, online administration of the survey was seen as very efficient, being both convenient and quick for panellists to engage. The use of an external consultant to administer the survey facilitated anonymity and allowed completion of

the process over a relatively contracted four month period. In addition to meeting programme milestones, the timeframe helped to maintain panellist motivation and interest.

Limitations

A key limitation of this study was that the panel was not representative of actual staff numbers in the workforce. This shortcoming was anticipated; however it was felt that a self selected sample of staff who were willing to participate was preferable to a poor response rate. Self selection appeared to ensure meaningful engagement and high response rates throughout the study. Further, while self selection is likely to have attracted participants who felt strongly about this issue, high levels of consensus were achieved, despite a diversity of opinion.

Conclusions

This study and methodology was one step in the process to define the role and scope of practice of AHAs within Queensland public health services. The Delphi process was a useful means of engaging the workforce, drawing opinions and informing subsequent negotiations and implementation.

It resulted in greater acceptance of the full range of patient related tasks that an allied health assistant can undertake at the full (standard) scope level, which will facilitate this positions and enable AHPs to work more efficiently and effectively to their full scope of practice. At the advanced scope level however, the same degree of agreement on the meaning of role statements was elusive, and linked with a lack of education and training frameworks for these roles.

References

1. Lizarondo L, Kumar S, Hyde L, Skidmore D. Allied health assistants and what they do: A systematic review of the literature. *J Multidiscip Healthc.* 2010;3:143-53. PubMed PMID: 21197363. Pubmed Central PMCID: 3004602. Epub 2011/01/05. eng.
2. Lassen KO, Grindersley E, Nyholm R. Effect of changed organisation of nutritional care of Danish medical inpatients. *BioMed Central Health Services Research.* 2008;8(168).
3. Rothwell G. One school district's experience working with speech-language pathology assistants. *Perspectives on School-Based Issues.* 2009;10(1):23-9.
4. Bergin S. Getting a foot in the door: can expanding the role of podiatry assistant improve access to public podiatry services? *Australian Journal of Primary Health.* 2009;15(1):45-9.
5. Duncan DG, Beck SJ, Hood K, Johansen A. Using dietetic assistants to improve the outcome of hip fracture: a randomised controlled trial of nutritional support in an acute trauma ward. *Age and Ageing.* 2006;35(2):148-53.
6. Duckett SJ. Interventions to facilitate health workforce restructure. *Australia and New Zealand Health Policy.* 2005;2(1):14.
7. Healthcare Management Advisors. Allied Health Assistants. Melbourne: Department of Human Services, 2009.
8. Australian Physiotherapy Association. Position Statement: Working with a Physiotherapy Assistant or Other Support Worker. . Accessed online at <http://www.physiotherapyasnau>. 2008.
9. Dietetics Association of Australia. Scope of Practice - Support staff in nutrition and dietetic services. Access online at <http://www.daaasnau>. 2007.
10. Pharmaceutical Society of Australia. The role of non-pharmacies dispensary assistants/technicians. Accessed online at <http://www.psaorgau>. 2003.
11. Speech Pathology Australia. Parameters of Practice: Guidelines for delegation, collaboration and teamwork in speech pathology practice. 2007:Melbourne.
12. Australian Association of Occupational Therapists. OT Australia Position Statement, Occupational Therapy Assistants. July 2009:Accessed online at <http://www.ausot.com.au/images/OT%20Assistants.pdf>.
13. Australasian Podiatry Council. Policy: The role of Podiatry Assistants in podiatric practice. April 2009:Accessed online at: <http://www.apodc.com.au/podiatry-assistants>.
14. Lin I, Goodale B. Improving the supervision of therapy assistants in Western Australia: the Therapy Assistant Project (TAP). *Rural Remote Health.* 2006 Jan-Mar;6(1):479. PubMed PMID: 16454619. Epub 2006/02/04. eng.
15. Lin I, Goodale B, Villanueva K, Spitz S. Supporting an emerging workforce: characteristics of rural and remote therapy assistants in Western Australia. *Aust J Rural Health.* 2007 Oct;15(5):334-9. PubMed PMID: 17760918. Epub 2007/09/01. eng.

16. Centre for Allied Health Evidence. Final report on the systematic review of the literature on utilisation of support workers in community based rehabilitation. Adelaide: April 2006.
17. Pullenayegum S, Fielding B, Du Plessis E, Peate I. The value of the role of the rehabilitation assistant. *British Journal of Nursing*. 2005;14(14):778-84.
18. ACT Health Allied Health Adviser's Office. Literature Review - Feasibility of supporting the introduction of the Certificate IV in Allied Health Assistance: Podiatry and the Certificate IV in Allied Health Assistance: Nutrition in the Australian Capital Territory. Canberra: ACT Health, 2007.
19. Mackey H. An extended role for support workers: the views of occupational therapists... including commentary by Workman B. *International Journal of Therapy and Rehabilitation*. 2004;11(6):259.
20. Walters P, Arena J. Do you know what a dietetic technician can do? A focus on clinical technicians and their expanded roles and responsibilities. *Journal of the American Dietetic Association*. 1997;97(10):139-41.
21. Thelen B, Byham-Gray L, Touger-Decker R, O'Sullivan Maillet J, Khan H. Survey of current job functions of renal dietitians. *Journal of Renal Nutrition*. 2009;19(6):450-61.
22. Lin I, Goodale B, Villanueva K, Spitz S. Supporting an emerging workforce: characteristics of rural and remote therapy assistants in Western Australia. *Australian Journal of Rural Health*. 2007;15(5):334-9.
23. Webb F, Farndon L, Borthwick A, Nancarrow S, Vernon V. The development of support workers in allied health care: A case study of podiatry assistants. *British Journal of Podiatry*. 2004;7(3):83-7.
24. Fischer RG. The Delphi method: a description, review and criticism. *Journal of academic librarianship*. 1978;4(2):64-70.
25. McKenna HP. The Delphi technique: a worthwhile research approach for nursing? *Journal of Advanced Nursing*. 2006;19(6):1221-5.
26. Hasson F, Keeney S, McKenna H. Research guidelines for the Delphi survey technique. *Journal of Advanced Nursing*. 2000;32(4):1008-15.
27. van Stralen MM, Lechner L, Mudde AN, de Vries H, Bolman C. Determinants of awareness, initiation and maintenance of physical activity among the over-fifties: a Delphi study. *Health Education Research*. 2010;25(2):233-47.
28. Nancarrow S, Mackey H. The introduction and evaluation of an occupational therapy assistant practitioner. *Australian Journal of Occupational Therapy*. 2005;52(4):293-301.
29. Lizarondo L, Kumar S, Hyde L, Skidmore D. Allied health assistants and what they do: A systematic review of the literature. *Journal of multidisciplinary healthcare*. 2010;3:143.

	Round 1	Round 2	Round 3
Panel size	All AHA and AHP Invited (5000 +) 188 Accepted 140 Completed	140 surveys distributed (to those who completed round 1) 137 Completed	137 surveys distributed (to those who completed round 2) 107 Completed
Geographic representation	37% Metropolitan 46% Regional 17% Rural/remote	36% Metropolitan 46% Regional 18% Rural/remote	33% Metropolitan 50% Regional 17% Rural/remote
Expertise/ Heterogeneity	46% AHA 54% AHP	45% AHA 55% AHP	45% AHA 55% AHP

Table 1 Panel composition

	Example Delphi role description statement (Groups, Advanced scope level)
Round 1	“Leads group treatment sessions with patient treatment plans approved by AHP, but with indirect supervision of AHP. AHA gives feedback to AHP on individual and group performance.”
Round 2	“Leads a defined range of group interventions with indirect supervision of AHP, where patient treatment plans are developed and approved by AHP. AHA gives feedback to AHP on individual and group performance.”
Round 3	“Leads a defined range of group interventions with access to supervision by an allied health professional, where patient treatment plans are approved by the professional. The assistant gives feedback to the professional on individual and group performance.”

Table 2. Example of the gradual refinement of a role description statement through three rounds of the Delphi process.

	Trainee	Full (standard) scope	Advanced scope
Round 1	80.9%	81.5%	76.4%
Round 2	87%	85.9%	82.7%
Round 3	87.8%	85.3%	81.7%

Table 3. Percentage of panellists indicating agreement with the statement at 7 or more out of 10 (average for all statements).

AHA Role Statement	Trainee	Full (standard) scope	Advanced scope
Skills (Communication)	92%	94%	95%
Training and development	94%	94%	94%
Skills (Professional behaviour)	90%	93%	92%
Skills (Health knowledge)	93%	93%	88%
Support and mentoring	88%	82%	87%
Groups	84%	85%	85%
Referrals	91%	87%	82%
Skills (Administrative and other support)	92%	81%	81%
Patient education	86%	88%	80%
Documentation	83%	79%	76%
Treatment	80%	77%	76%
Leadership and work unit management	88%	88%	77%
Clinical practice - assessment	87%	87%	72%
Team participation	82%	84%	71%

Table 4. Percentage of panellists who rated their agreement with the statement at 7 or more out of 10, noting instances where 80% agreement was not reached (***bold italic***)

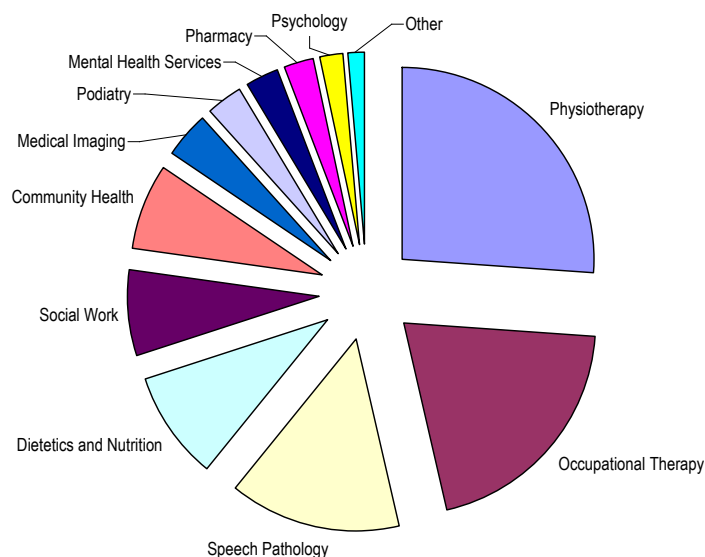


Figure 1. Discipline area representation