HOSPITAL AND HEALTH SERVICES

-WORKPLACE INSTRUCTION-

FOR ALLIED HEALTH PROFESSIONALS IN

TITLE	WPI 3: Guidelines for skill-sharing between allied health professionals
DESCRIPTION	This workplace instruction (WPI) supports the process of establishing and maintaining formal competencies and supervision supports for skill-sharing clinical tasks within the The guidelines are contextualised within the multidisciplinary practice environment.
TARGET AUDIENCE	• Allied health professionals, managers, supervisors and other members of inter-professional health teams who partner with the

Document Details:

- This WPI has been developed to support the implementation of skill-shared practice within the local work unit. A framework is available at: http://qheps.health.qld.gov.au/ahwac/content/modcareresources6.htm
- Allied health professionals abide by the Code of Conduct for the Queensland Public Service.[1]

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1. Skill-sharing

Prior to implementing a skill-shared practice framework within the work unit, all allied health professional (AHP) staff are required to have a thorough knowledge and understanding of the definitions and underpinning principles as outlined below.

1.1 Definition

Skill-sharing between AHPs is synonymous with transprofessional practice considered by Thylefors et al (2005) to include the "transmission of expertise to other team members" (i.e. role expansion) and "blurring of traditional profession boundaries" (i.e. role release).[2] Transprofessional teamwork implies cross-training and flexibility in accomplishing tasks.[3]

[1] www.psc.qld.gov.au/library/document/catalogue/equity-ethics-grievance/qps-code-conduct.pdf

[2] Thylefors I, Persson O, Hellström D 2005, Team types, perceived efficiency and team climate in Swedish cross-professional teamwork, Journal of Interprofessional Care, 19(2): 102-114.

[3] SARRAH http://www.sarrahtraining.com.au/site/index.cfm?display=144985

In the context of the Skill-sharing and Delegation Practice (SSDP) framework, skill-sharing refers to two or more AHPs sharing knowledge, skills and responsibilities across professional boundaries in assessment, diagnosis, planning and/or implementation. The requirement for a particular role to practise in a transprofessional way must be embedded in the role description. There are significant clinical governance and supervision considerations associated with these roles.

Skill-sharing cannot be used as substitution of a profession or workforce group in the team as access to the expertise of the skill-sharing profession is required to support implementation of the model and for management of complex clients which fall outside of the models' limits.

All AHPs including new graduates can participate in transprofessional practice provided clinical governance processes (e.g. competency attainment, supervision and credentialing) are in place.[4]

1.2 Accountability and skill-sharing

Once training is complete and the skill-share trained AHP has been assessed as competent in performance of the shared task, they assume accountability and responsibility for their decisions and actions. That is, the AHP performs the skill-shared task as part of their independent scope of practice.

1.3 Principles of skill-sharing

The following overarching principles should be applied to guide the team's decision on sharing skills between AHPs from different professions:

- Skill-sharing has been demonstrated to be an appropriate approach to client care which can be implemented without detriment to clinical outcomes or safety.
- The primary motivation for skill-sharing is to serve the best interests of clients.
- A team-based risk assessment process should precede the decision to share a clinical task between members of the team, and the decision should be approved by the relevant professional delegate.
- Tasks may only be shared between professions if the team has adequate ongoing access to clinical governance, supervision and support of an AHP of the profession with the specific task in its historical scope of practice.
- In order to manage the risk associated with skill-sharing clinical tasks customarily undertaken by other AH professions, the AHP must acquire the necessary expertise (i.e. clinical prerequisites and underpinning knowledge) to safely perform the clinical task. The AHP is required to complete relevant training and demonstrate competence in the clinical task prior to being able to provide the task as part of their scope of practice in the team.
- AHPs in the team should be aware of the tasks that can be shared and of the CTIs that each relevant team member has been trained in and can provide as part of their scope of practice (i.e. their competency record).

[4] Speech Pathology Australia 2009, *Transdisciplinary Practice Position Statement*.

1.4 Skill-sharing in Practice

Before performing the task, the AHP must:

- refer to all relevant documentation including the clinical task instruction (CTI)
- seek informed consent according to the *Queensland Health Guide to Informed Decision making in Healthcare*.[5]

Additionally, it is a National Safety and Quality Health Service Standard that at least three approved client identifiers are checked before providing care, therapy or services.[6] These include date of birth and full name together with one of the following: Hospital UR number, Medicare number or address.

2. Supervision

In addition to standard supervision arrangements, AHPs performing clinical tasks across professional boundaries require additional "supervision and mentoring from a suitably qualified and experienced AHP from the relevant professional background".[7] During the training phase, the lead (supervising) profession provides more intensive, direct clinical supervision and monitoring (i.e. task supervision) specifically targeting the shared skill until the skill-share supervised AHP is assessed as competent.

A process for regular review of competence in the shared skill by the lead profession (e.g. 3-6 monthly depending on nature of the task) can be incorporated into the skill-shared practice model.

The AHP is also encouraged to engage in reflective practice described as "an effective process to develop self-awareness and facilitate changes in professional behaviour" as a means of "identifying strengths and weaknesses, determining actions required to improve skills and developing clinical reasoning skills to ensure the delivery of safe client care".[8]

Involvement in skill-sharing practice should be reflected in performance appraisal and development (PAD) review schedules and supported by appropriate continuing professional development.

3. Training and demonstration of competency

In order to safely undertake skill-sharing, AHPs are required to acquire the knowledge and clinical prerequisites that underpin the particular clinical task/s. Clinicians are required to document the clinical reasoning which informs their decision to provide a specific intervention.

The *Clinical Reasoning Record* (Appendix 1) serves as a training tool, which clinicians complete and discuss in clinical supervision, or in less formal discussions with clinicians from the profession within which the local CTI originated. The *Clinical Reasoning Record* should be used until competence in the clinical task has been demonstrated.

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[5] http://www.health.qld.gov.au/consent/documents/ic-guide.pdf

[6] http://qheps.health.qld.gov.au/psq/safetyandquality/standards/standard-five.htm

[7] Department of Health 2013, *Allied Health Advanced Clinical Practice Framework*, Allied Health Professions Office of Queensland, Queensland Government.

The three-tiered Training, Modelled, Competent (TMC) methodology (i.e. periods of formal teaching, observation and simulation followed by assessment of competence), or similar evidence-based training and competency assessment process should be applied to assist AHPs learn the skill-shared tasks – Table 1. Competence in the task must be assessed by an occupationally competent assessor (i.e. a person qualified in the profession from which the CTI originates).

Table 1: CF training – skill-sharing[9]

Strand	Focus	Elements
Theoretical Evidence of knowledge	What the clinician knows and understands as part of the learning experience	• Background knowledge: – SSDP framework – responsibility/accountability – communication and other local support systems – skill-share practice in the local area • Underpinning clinical knowledge
Work-based Evidence of performance	What the clinician can do	• Clinical task training • Modelling on peers or other forms of simulation • Observation / assessment in supervised use of task with patients (direct or indirect supervision including telehealth)

While developing competence in the shared task, skill-share supervised AHPs should provide regular post-task feedback to the lead AHP using a tool such as the *Clinical Reasoning Record*. Once competent, the supervisee should only need to provide feedback to the lead AHP on those occasions where a situation develops that they consider outside their scope of practice and/or acquired skill set. In this instance, the client should be referred back to the lead clinician.

A register of the training undertaken and CTIs possessed by each AHP should be maintained by the team's professional delegate (e.g. AH Team Leader). The *CTI Training Register* (Appendix 2) should be reviewed for currency bi-annually, timed to coincide with the AHP's PAD review schedule.

[8]Health Education and Training Institute 2012, *The Superguide: a handbook for supervising allied health professionals*, NSW Government, Sydney.
[9]Smith R, Duffy J 2011, *Effective Workforce Programme Facilitators Manual,* Effective Workforce Solutions Ltd.

4. Evaluation

Evaluation is regarded as an integral part of skill-shared practice that requires consideration at multiple levels including task performance, clinical decision-making and client outcomes. More specifically, evaluation should be linked to the outcomes articulated in the awareness raising stage of the CF[10] in order to provide quality, efficient, responsive and clinically governed services.

Examples of methods of evaluating the model of skill-shared practice include:

- An audit of skill-share practice
  - client and staff satisfaction surveys
  - compliments and complaints register
  - incident register
- An audit of CTIs
  - Are they still utilised?
  - Are some clinical tasks no longer shared?
  - Do new CTIs need to be written?[11]
- Monitoring of supporting systems
  - audit CTI Training Registers
  - annual credential check.

[10]Smith R, Duffy J 2011, p.131.

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Insert statewide accepted name for the task

Clinical Reasoning Record

This serves as a training tool which clinicians complete and discuss in clinical supervision. The clinical reasoning record should be used until competency in the clinical task has been demonstrated.

Client name:	**DOB:**
Address:	
Date of Assessment:	
Persons present:	

Headings are a guide only. Use and alter where required.

Before completing please review examples available in the AHPOQ CTI Database

1. Environmental Considerations

The location of a task (i.e. usual location for dressing), environmental issues that may impact on assessment (i.e. must be performed in a quiet location) or equipment.

2. Client Considerations

This may include medical conditions, disability and/or other social considerations

3. Functional Considerations:

Does the patient have any functional impairment/s that may impact on their ability to complete the screen?

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CF Facilitator:	**Author:**
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4. Carer Considerations

Identify if carers (family, voluntary or community services) are involved, their capacity to assist and if additional assistance is required.

5. Clinical Reasoning Considerations

6. Recommendation for choice and plan

Signature	
Name	
Position	
Date	

Appendix 2: CTI Training Register – Skill-sharing

Name:			
ID Code	**Clinical Task Instruction**	**Date Competent**	**Signature of assessor**
	Insert specific CTI		
	Insert specific CTI		
	Insert specific CTI		
	Insert specific CTI		
	Insert specific CTI		
	Insert specific CTI		
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