HOSPITAL AND HEALTH SERVICES

-WORKPLACE INSTRUCTION-

FOR ALLIED HEALTH ASSISTANTS IN

TITLE	WPI 2: Guidelines for delegation to allied health assistants
DESCRIPTION	This workplace instruction (WPI) supports the process of establishing and maintaining formal clinical task instructions (CTIs) and the associated delegation and supervision supports for the allied health assistant (003 and 004) staff of 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 delegation of tasks to allied health assistants within the local work unit. A framework is available at http://qheps.health.qld.gov.au/ahwac/content/modcareresources6.htm
- The practice parameters detailed in this WPI are consistent with statewide industry training standards as developed by the Allied Health Professions Office of Queensland (AHPOQ) and integrated into the Queensland Health Operational Services Manual.[1]
- AHAs abide by the Code of Conduct for the Queensland Public Service.[2]

Version No.:	**Approval date:**	**Approved by:**
Author:	**Review Date:**	**Review Officer:**
Document Custodian:		

1. Delegation

1.1 Definition

Delegation is defined as the "process by which an allied health professional (AHP) delegates activities to an allied health assistant (AHA) who has appropriate education, knowledge and skills to undertake the activity safely".[3] It has also been identified that delegation "involves the conferring of authority on an AHA to perform activities that would otherwise be performed by an AHP".[4]

[1] Queensland Health 2012, *Operational Services Manual*, Queensland Government, Brisbane.
[2] www.psc.qld.gov.au/library/document/catalogue/equity-ethics-grievance/qps-code-conduct.pdf
[3] Government of Western Australia, Department of Health 2009, *Delegation, monitoring and evaluation of Allied Health Assistants*, WA Country Health Service (WACHS).
[4] Queensland Health 2010b, *Supervision & Delegation for Allied Health Assistants* [PowerPoint presentation], Allied Health Workforce Advice and Coordination Unit, Queensland Government.

1.2 Accountability and delegated activities [5]

It is important to explore the concepts of accountability and responsibility, in order to understand the different roles and responsibilities of various healthcare team members.[6]

A synopsis of the numerous references in the literature to accountability and responsibility related to delegation includes the following:[7,8,9]

- The delegating AHP is responsible for:
  - the overall management of the client and for the decision to delegate
  - the provision of verifiable "reasonable direction" regarding the delegated therapy program/plan content to the AHA.
- Accountability for delegated tasks is shared between the delegating AHP, the AHA and the employer:
  - The AHP is responsible for the process of delegation and for ensuring standards are maintained by monitoring the outcomes of the delegation. Therefore the AHP must be familiar with the assistant's capabilities and clearly communicate the task being delegated. The AHP must also provide the appropriate level of supervision.
  - AHAs are accountable for their own actions and should only undertake clinical tasks that have been properly delegated and that they are legally authorised and competent to perform.
  - The delegating AHP will not be accountable for the decisions and actions of those to whom he or she delegates, particularly if they choose to work outside the supplied "reasonable direction".
  - If the AHA is not comfortable accepting a delegated task they should discuss this with the delegating AHP.

1.3 Principles

The following overarching principles apply when delegating clinical support tasks to an AHA:[10, 11]

- The primary motivation for delegation of an activity is to serve the best interests of the client.
- The task being delegated should always be discussed and shall only be delegated when both the AHP and AHA are satisfied that the delegated task can be carried out safely. If the AHA does not feel confident undertaking the task, the AHA should not accept the delegated task and the AHP and AHA should take steps to ensure the appropriate knowledge and skills are acquired by the AHA before the task is delegated.

---

[5] Queensland Health 2010a, *Governance Guidelines for Allied Health Support Staff,* Allied Health Workforce Advice and Coordination Unit, Queensland Government.
[6] Department of Health 2013, *Delegated practice: Basic concepts* [PowerPoint], Queensland Government.
[7] Physiotherapy Board of Australia 2012, *Code of conduct for registered health practitioners*.
[8] NSW Health 2012, *Allied Health Clinical Supervision Guidelines*, South Eastern Sydney Local Health District, NSW Government.
[9] Queensland Health 2010a, p. 7.
[10] WACHS 2009, p. 4-5
[11] NSW Health 2012, p. 20.

- The activity will only be conducted by the AHA in a context in which they are able to demonstrate competency.
- The level of supervision and feedback provided to an AHA should be appropriate, having regard for the knowledge and skill level of the AHA, the needs of the client, the service setting and the task assigned.
- Effective delegation is a skill that requires development. It is important that AHPs have access to support to develop skills in effective delegation. [Please refer to WPI 1: Guidelines for allied health professionals developing delegation skills for more information.]
- The delegating AHP:
  - establishes diagnosis, clinical management and treatment plans
  - should only delegate activities that are within the scope of their own professional practice and that they are competent to assess, plan, implement and evaluate
  - must only delegate activities that are within the scope of practice and level of competency, previously demonstrated experience and/or training and qualifications of an AHA
  - should determine whether it is appropriate to delegate a task to an AHA and only delegate if/when it is appropriate
  - is able to provide the type and frequency of monitoring (i.e. task supervision) the activity requires.
- The AHA:
  - must have the appropriate role, level of experience and competence (i.e. skills and knowledge) to carry out the activity
  - has responsibility for raising any issues related to undertaking the delegated task, and should request additional information and/or support as required.
  - should be aware of the extent of their expertise at all times and seek support from AHPs as required
  - shares responsibility for raising any issues and requesting additional support throughout the delegation and monitoring process.
- There are well-defined lines of accountability for the task (or specific aspects of the task) when more than one AHP is involved in delegating tasks.

In addition, the delegating AHP should provide the following when delegating a task:

- clear instructions on the outcomes to be achieved
- clear processes to be followed in undertaking the task
- guidance on how to manage any perceived risks
- alternative strategies to be utilised if modification is required
- clear guidance on when further advice or direction should be sought from the AHP.

An AHA may not independently:

- select clients for assessment or intervention
- interpret the outcomes of assessments for the purpose of forming a diagnosis or intervention plan.
- change any treatment (unless required to conform with the When to Stop CTI)
- alter a plan of care or treatment goals
- draft reports which contribute to care planning decisions
- discharge clients from treatment.[12]

The health consumer (client) shall provide informed consent prior to the provision of delegated clinical tasks by an AHA (i.e. this requires a clear explanation to the client that the intervention is to be provided by an AHA and not an AHP).[13] The delegating AHP shall then document this in the client's file.

1.31 When to delegate

The delegating AHP will need to consider a number of variables when determining whether a client is suitable to be treated by an AHA.[14] Most of these variables relate specifically to the client including:

- complexity of the client's condition
- whether the client's condition is stable
- whether the client's condition type is seen frequently within the service
- whether the client is highly anxious and/or emotional
- the ability of the client to engage as expected and required
- whether the client's social or environmental situation is likely to be unpredictable.

Other variables include:

- whether the AHA has demonstrated competence in the task/s being delegated
- whether appropriate support systems (e.g. monitoring and supervision strategies) are in place and operational.

These variables have been summarised in the *Allocation Analysis Tool* (Appendix 1).

[12]Adapted from Speech Pathology Australia 2007, *Parameters of Practice: Guidelines for delegation, collaboration and teamwork in speech pathology practice.*
[13]SARRAH 2011, *Allied Health Assistants in Rural and Remote Australia Position Paper*, Services for Australian Rural and Remote Allied Health.
[14]Smith R, Duffy J 2011, *Effective Workforce Programme Facilitators Manual,* Effective Workforce Solutions Ltd.

1.32 When to stop

Once a clinical task for a specific client has been delegated to an AHA there are a number of factors that may interfere with the delegated task being performed (in the first instance) or needing to be abandoned during the session:

- client declines/refuses treatment
- change in client's medical status including exacerbation of current symptoms (**check client's observation chart and/or vital signs before proceeding**) and/or onset of other symptoms including:
  - shortness of breath, wheezing
  - dizziness, light headedness, pallor, clammy skin
  - nausea, vomiting, diarrhoea, stomach cramps
  - confusion
  - pain/discomfort, swelling
  - wound breakdown, bleeding, dressings loosen/ fall off.
- emotional/behavioural changes – aggression, particular distress
- outdoor mobility compromised (e.g. weather)
- equipment malfunction
- client is not following instructions safely
- AHA's safety is compromised.

If the AHA has any doubts about the client's medical status at any time, they shall stop and immediately consult a health professional.

AHAs shall apply the Allied Health Professions' Office of Queensland (AHPOQ) clinical task instruction (CTI) *"When to Stop"* at all times when working with clients. This CTI will direct AHAs to clearly recognise danger or warning signs in a client, assess when to safely proceed and when to stop a task with a client.

1.4 Delegation in practice

The provision of clinical practice support in direct client care by AHAs is vital to the Queensland public health system in addressing the challenges of delivering effective, efficient and responsive care.[15] Within the work unit, the delegation model of care is operationalised within a collaborative practice model defined by the following:

- mutual respect
- protocols and guidelines for clinical decision-making
- clearly defined levels of accountability

[15] Department of Health 2013, *Delegated practice: Teamwork* [PowerPoint], Queensland Government.

- a belief that collaborative practice and partnership will ensure best health outcomes.[16]

This collaborative practice model is operationalised in the following manner:

- The AHA works under the clinical supervision of the AHP who in turn, shares this governance with the work unit manager / delegate (e.g. Team Leader). This work will be done in a supportive, collegial working relationship. The clinical supervision and governance is further devolved per the Team Leader and the senior AHA (where applicable) to help establish currency and competency with the less experienced staff to provide mentorship and support clinical development (Refer Figure 1).[15]

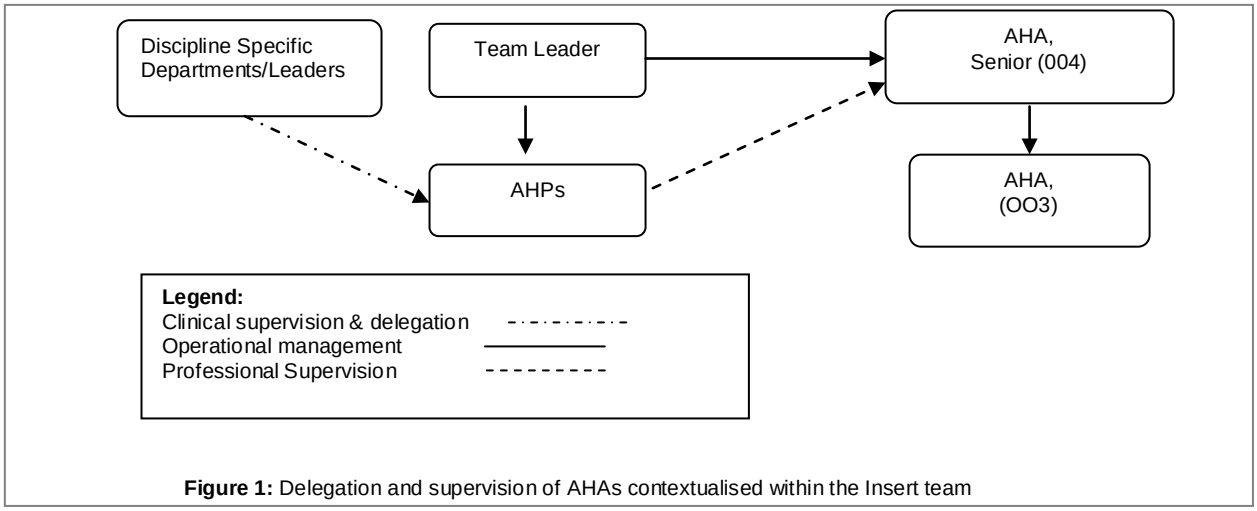

Figure 1: Delegation and supervision of AHAs contextualised within the Insert team

Because AHAs are a non-regulated health workforce group, it is the responsibility of the individual HHS to ensure the AHAs' work is consistent with the primary objectives and duties (Appendix 2) outlined in the *Queensland Health Operational Services Manual* and determine:

- the core clinical skills deemed essential for practice
- the practice context in which the scope of these skills can be utilised
- how delegation and supervision are structured and function.

"The role of the AHA is to supplement and not to replace the services provided by the AHP".[17]

In some HHSs, senior AHAs (at the 004 level or higher) may have responsibility for providing support, guidance, direction and, in some cases, operational management to 003 assistants and trainees as outlined in the *Queensland Health Operational Services Manual.*

[16]Townsville Hospital and Health Service 2013, Workplace Instructions - For the therapy assistants in Townsville community health services [draft].
[17]SARRAH 2011, p.2.

2. Education and Training

2.1 Overview

Individual tasks delegated to/and undertaken by AHAs will generally be underpinned by training and a written clinical task instruction (CTI) sourced from courses provided by nationally recognised training (e.g. Certificate IV in Allied Health Assistance) and/or from the CTI database published by AHPOQ.[18] The work unit may also identify specific tasks required to meet client's needs which may not have an existing CTI. In this case, a local CTI may be developed. Please refer to the *Guidelines for Writing Clinical Task Instructions* available at: http://qheps.health.qld.gov.au/ahwac/docs/MOC/clinical-tasks.pdf for additional information.

Tasks may be delegated to an AHA by a number of different AHPs within their team.

2.2 Training and demonstration of competency

Local CTIs do not replace attainment of a Certificate IV in Allied Health Assistance.

Training and competency assessment will be undertaken consistent with established formal training programs (Certificate IV). Where not included in a formal program, training will be coordinated by the delegating AHP in collaboration with the senior AHA (where relevant). A training schedule along with any required training resources (e.g. background material) will be negotiated between all relevant team members (AHAs and AHPs).

The CTI will be assessed by a team member (i.e. AHP) who possesses the competency to undertake the CTI. The AHA will demonstrate competence to provide that task, consistent with the CTI as detailed below:

- **Period of learning**
  - AHAs undertake any theoretical learning of underpinning knowledge relevant to the task. This may include training materials in written form or videos etc.
- **Period of observation**[19]
  - AHAs are required to observe the qualified AHP/senior AHA performing the task prior to applying the task with clients
  - The number of observations required will be informed by what both the trainee AHA and the AHP feel is appropriate.
  - This observation period allows AHAs to learn the practical aspects of the task and safely ask questions.
- **Period of supervised practice**
  - AHAs are required to undertake a period of supervised practice where they perform the task under the close observation and support of a qualified AHP/senior AHA in the field.

[18] http://qheps.health.qld.gov.au/ahwac/content/calderdale.htm
[19] Adapted from Smith R, Duffy J 2011, p.122

  - Tasks are initially performed on a model (may involve simulation) followed by a period of supervised clinical practice.
  - The number of times that the AHA practices the task should be dictated by what both parties feel is appropriate considering the complexity of the task, level of variability in the settings / client groups it is to be applied within and the pace of development of the AHA.
- **Assessment of competence**
  - Once both the AHA and qualified AHP are confident that the task can be performed safely, assessment should be undertaken in a clinical setting with a client allocated by the AHP.
  - Once the AHA demonstrates that he/she is competent in all of the criteria listed on the *Competency Assessment Grid* (Appendix 3), the qualified AHP can sign the trainee off as competent to undertake that task without direct supervision.
  - At this point the qualified AHP can delegate the task to the individual to perform without direct supervision
  - It may be helpful to set a maximum number of times that an individual can be assessed for competence in each task. If, at this point, the AHA is unable to demonstrate competence in a particular task it may be necessary to address the issue through the supervision process and with further training.
  - In this instance, where it has been identified that further development is required prior to sign-off of competence, the supervising AHP has the option of implementing a *Learning Development Plan* in collaboration with the AHA. A template of the *Learning Development Plan* is provided in Appendix 4.
- **Review of competence**
  - The process for re-evaluation of competence to perform tasks should be considered.
  - Use and currency of CTIs should be audited by the senior AHP of the profession responsible for delegating the task. Particular attention should be paid to infrequently delegated tasks as competence may be difficult to maintain in this case.

2.3 Training and competency records

A register of the training undertaken and CTIs possessed by each AHA should be maintained by the work unit manager / delegate (e.g. Team Leader). Please refer to Appendix 5 for an example *CTI Training Register*.

This record should be reviewed for currency bi-annually, timed to coincide with the AHAs' performance appraisal and development (PAD) review schedule.

2.4 Responsibilities

Manager / Delegate (e.g. Team Leader):

- Ensure the AHA workforce is supported to obtain and maintain the CTIs required by the team to meet service requirements.
- Ensure the AHPs in the team are able to access information on the CTIs possessed by individual AHAs in order to support appropriate delegation decision-making.
- Provide opportunity for all team members to develop and maintain skills required to work in a delegation model of care and include this within performance review and orientation/induction processes of all team members.

Delegating AHP:

- Ensure that delegation and supervision of AHAs is undertaken consistent with this WPI.
- Determine the appropriateness of delegating a particular clinical task and the associated level of supervision required, based on an assessment of risk and clinical reasoning.
- Obtain skills in delegation and supervision to allow the AHP to work within the delegation model of care outlined in this WPI.
- Respect, understand and reinforce through appropriate modelling the AHA practice boundaries.
- Be clear of their own role and accountabilities when supervising or delegating clinical tasks to AHAs.

AHA:

- Ensure all efforts are made to obtain skills and CTIs required to work in the delegation model of care outlined in this WPI and consistent with their role description.
- Be familiar with, and work within the practice boundaries detailed in their training and in this WPI.

3. Clinical supervision and monitoring AHA performance

3.1 Clinical Supervision

Also known as professional supervision,[20] clinical supervision can be defined as a formal process of support and learning that involves:

- developing a mutual commitment between the AHA and AHP to reflect on the clinical practice of the AHA
- developing knowledge and skills competence
- clarifying boundaries and scope of practice
- planning and utilising personal and professional resources
- identifying training and educational needs
- developing accountability for their work quality.[21]

[20] Queensland Health 2011, Allied Health Professional Supervision Guide, Cunningham Centre, Queensland Government, Toowoomba available at: http://qheps.health.qld.gov.au/cunningham-centre/docs/allied-health/ah-psp/sup-gde18jul.pdf

Guidelines have been developed by AHPOQ to ensure consistency in the way governance activities support AHAs employed by the Queensland public health system.[22] Though an assistant should only have one primary clinical practice supervisor, there may be several AHPs of the same or different disciplines who delegate tasks to the assistant.[23] Clinical supervision should be undertaken by an AHP although a senior AHA may co-supervise in collaboration with an AHP in some work units.

This is particularly important when the line manager is not the clinical supervisor, when more than one AHP is delegating to the AHA and when the AHA is located at a different site to the delegating AHPs.[24]

Where an AHA is new to the service and/or new to the particular clinical area, they will initially require more frequent clinical supervision. It is the responsibility of the supervising and/or delegating AHP (potentially the same person) to:

- assess and verify the AHA's competency within the clinical context
- define and clarify the tasks to be undertaken by the AHA within their scope of practice
- ensure the AHA has a clear understanding of the tasks to be undertaken within that context.

3.2 Principles

An AHP should have a supervisory role over all clinical activities of an AHA and should identify the frequency and form of supervision that is appropriate considering the activity to be delegated, setting, context and the skill set of the AHA.

3.3 Responsibilities

AHPs and AHAs will undertake the following steps to minimise risks to the client:

AHP:

- Factor risk assessment and mitigation strategies into delegation decisions
- Communicate potential for risk and risk mitigation strategies to the AHA as part of the process of delegating the activity
- Delegate activities consistent with the principles of delegation
- Establish appropriate monitoring and supervision strategies
- Contribute to the training and development of AHAs through the provision of feedback, guidance, mentoring and supervision.

[21] Queensland Health 2010b, *Supervision & Delegation for Allied Health Assistants* [PowerPoint presentation], Allied Health Workforce Advice and Coordination Unit, Queensland Government.
[22] http://qheps.health.qld.gov.au/ahwac/content/modcareprojects3.htm
[23] Queensland Health 2010a, p.7
[24] Queensland Health 2010a, p. 4.

AHA:

- Accept responsibility for delegated activities consistent with the principles of delegation
- Apply the AHPOQ CTI "*When to Stop*" at all times when working with clients. This CTI will direct AHAs to clearly recognise danger or warning signs in a client, assess when to safely proceed and when to stop a task with a client.
- Provide post-task feedback on client performance and outcomes of the delegated task to ensure the delegated task remains appropriate for the client.

3.4 Frequency of clinical supervision

The *Governance guidelines for AH support staff* (2010) makes a number of recommendations that should be used to guide the minimum requirements for the frequency of clinical supervision for AHAs – Table 1.

The frequency of clinical supervision will also depend on a range of factors that include:

- supervisory experience (AHP) and developmental level (AHA)
- complexity of the caseload
- practice setting (e.g. AHA working in a rural or remote setting).

Table 1: Minimum requirements for clinical supervision for AHAs[25]

Frequency	Description	Frequency
High	Applies to AHAs who: • are completing or are yet to undertake a formal qualification relevant to their role • have had a recent change in role • have not previously received formal supervision or support • have only been in a work area for short period of time (e.g. 3-month rotation) • have recently become a supervisor or mentor.	Minimum one hour per week
Medium	Applies to AHAs who: • do not fit into low or high frequency categories • have been in a work area for short period of time (e.g. 3-month rotation) or change of work area (e.g. rural practice).	Minimum one hour per fortnight
Low	Applies to AHAs who: • have been working as an AHA for over 5 years • demonstrate high levels of competency in their current field of practice.	Minimum one hour per month

[25] Queensland Health 2010a, p.7

3.5 Monitoring performance

For the purposes of this document in order to avoid any unnecessary confusion between the definitions for clinical and task supervision, task supervision will be referred to as monitoring.

Monitoring has been described as "a process of ensuring the delegated task is being completed safely and competently in the manner required" that allows AHPs to:

- ensure the AHA is competent to undertake that task
- ensure the task is being completed appropriately and is compliant with instructions
- modify the task and/or instruction as required
- determine where the AHA may need further support or development
- ensure the outcomes of the task are appropriate.[23]

In order to effectively monitor an AHA's performance of delegated tasks, a number of variables (related to the task, client, setting, competence of the AHA and level of risk involved) will need to be considered – Table 2.

Table 2: Variables that impact monitoring performance[26]

Variable	Impact
Nature of the delegated task	• the complexity associated with undertaking the task • whether the task carries risk of injury to the client, health professional, or other person
Characteristics of the client and their medical condition	• the severity and complexity of the client's health issue • the stability of the client's health condition • the risk of deterioration in the client's condition • the potential impact of the task on the client's condition • the level of client anxiety
Characteristics related to the setting/environment	• proximity to the delegating AHP • frequency of contact with the delegating AHP • the setting (for example, whether working in a community, acute or school setting) • proximity to other health professionals and other support infrastructure
Qualifications, training and skills of the AHA	• their current skills and competencies • their level of experience in undertaking the task or similar tasks
Level of risk	• level of risk associated with undertaking the task

[26] Adapted from Department of Health 2012, *Supervision and delegation framework for allied health assistants*, Workforce Leadership and Development Branch, Victorian Government.

Please refer to Appendix 6 for a decision-making table that guides the frequency and type of monitoring required for delegated tasks.

Prior to delegating a task, the AHP should have considered how they will monitor the AHA's performance. Client safety will be addressed by following the principles of delegation, supervision and monitoring outlined in this WPI.

A range of strategies can be utilised to clinically supervise and/or monitor an AHA's performance including:

- Direct
  - observation of task performance
  - clinical supervision (face-to-face or via tele/video-conference)
  - verbal and/or written feedback from the AHP
  - provision of immediate guidance, feedback and intervention as required.
- Indirect and remote
  - processes are in place to ensure the monitoring AHP is easily contactable and accessible to provide direction, guidance and support as required.
  - tracking task performance
  - monitoring client progress
  - review of clinical notes/records, log books, diary and timetables
  - measurement of outcomes using assessment tools. [27,28]

The AHA is 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".[29]

Other principles of reflective practice[30] include:

- Reflection can occur before, during or after an event.
- It is imperative that reflective practice is conducted in a supportive environment to allow individuals to freely share information that promotes learning.
- Reflective practice may be conducted during structured supervision sessions or as a self-directed reflective journal/record keeping activity.
- When reflection occurs in supervision, it can be in relation to reflecting on day-to-day clinical practice, triggered by a challenging clinical encounter or in anticipation of having to manage a complex situation.

[27]WACHS 2009, p.12
[28]Department of Health (Victoria) 2012, p.28
[29]Health Education and Training Institute 2012, *The Superguide: a handbook for supervising allied health professionals*, NSW Government, Sydney.
[30]Health Education and Training Institute 2012, p.21.

4. Evaluation

Evaluation forms an integral part of the delegation and monitoring process and involves consideration at a number of levels:[31] It may include some/ all of the processes listed below. The form of evaluation should be collaboratively determined by the team.

- Audit delegation practice
  - client and staff satisfaction surveys
  - compliments and complaints register
  - incident register
- Audit CTIs
  - Are they still utilised?
  - Are some clinical tasks no longer delegated?
  - Do new CTIs need to be written?[31]
- Monitor supporting systems
  - audit *CTI Training Registers*.

[31] WACHS 2009, p.14

Appendix 1: Allocation Analysis Tool[32]

Before allocating a client (delegated task), the AHP must consider the following variables	**GO**	**RISK identified STOP & Consider**
Is the presentation of the client's condition complex?	No	Yes
Is the client's condition stable?	Yes	No
Is the client's condition seen frequently in your service?	Yes	No
Is the client highly anxious and/or emotional?	No	Yes
Is the client able to engage as expected and required?	Yes	No
Is the client's situation (social/environmental) likely to be unpredictable?	No	Yes
Has the AHA demonstrated competence in the task/s being delegated?	Yes	No
Are support systems in place and operational?	Yes	No

[32] Adapted from Smith R, Duffy J 2011, p. 97.

Appendix 2: Allied Health Assistant roles included in the Operational Services Manual[33]

003 Allied Health Assistant	004 Allied Health Assistant - Advanced
Primary Objectives	**Primary Objectives**
Contribute to patient care by providing clinical support tasks delegated under the direct or indirect supervision of an allied health professional	Contribute to patient care by providing advanced clinical support tasks delegated under the direct or indirect supervision of an allied health professional
Duties	**Duties**
• Provide a defined range of clinical screening assessments as delegated and allowed by testing guidelines and legislation • Provide a defined range of treatments as prescribed by the allied health professional and work under their general direction including using decision support tools, clinical pathways and patient guidelines. • Initiate changes to treatment programs using results from standardised assessment tools. • Provide basic education on a defined range of topics to patients or groups of patients. • Lead group treatment sessions together with an allied health professional or experienced assistant and provide feedback • Contribute to patient records according to organisational and legal requirements. • Contribute to a multi-disciplinary team through departmental and team meetings, case conferences, team projects and activities. • Refer to and liaise with health care providers within the immediate team. • Quality improvement activities under guidance of an allied health professional. • Oversee or organise a work group as required. • Support and mentor less experienced allied health assistants	• Provide a defined range of specialised clinical screening assessments for patients with complex needs, as delegated and allowed by testing guidelines and legislation. • Provide a defined range of treatments for patients with complex conditions including using decision support tools, clinical pathways and patient guidelines. • Initiate changes to treatment programs using results from standardised assessment tools. • Provide comprehensive education to patients or groups of patients • Lead a defined range of group interventions for patients with diverse and complex needs. • Contribute as a member of a multi-disciplinary team, leading departmental and team meetings, case conferences, projects and activities. • Contribute to patient records according to organisational and legal requirements. • Refer to and liaise with health care providers within the immediate team and community services using decision support tools, clinical pathways and patient specific guidelines. • Initiate, plan and evaluate quality improvement activities under the guidance of an allied health professional • Support, mentor & supervise less experienced allied health assistants including teaching and assessment of generic competencies.
Knowledge/ Skills/ Abilities	**Knowledge/ Skills/ Abilities**
• Apply knowledge in the health care system of allied health, basic computer literacy, basic anatomy, medical conditions and terminology. • Communicate within a team with a good understanding of scope of practice • Participate in quality improvement activities under the guidance of an allied health professional • Observe or assist the allied health professional in the provision of simple treatments during clinical assessments	• Apply advanced knowledge in the health care system of allied health, basic computer literacy, basic anatomy, medical conditions & terminology. • Demonstrated communication & interpersonal skills, liaise and supervise effectively, with an understanding of the scope of practice in a complex and demanding work environment • Initiate, plan and evaluate quality improvement activities under the guidance of an allied health professional • Under supervision from an allied health professional, provide range of assessments & treatments for complex patients conditions
Qualifications/Training	**Qualifications/Training**
• No formal qualifications required.	• Certificate IV in Allied Health Assistance (HLT42507) or equivalent.

[33] Queensland Health 2012, p. 44.

Appendix 3: Competency Assessment Grid

ID:	Name of clinical task instruction:				
Assessment criteria		**DATE TAUGHT**	**DATE MODELLED**	**DATE COMPETENT**	**FURTHER DEVELOPMENT/ COMMENTS**
1	Insert specific criteria				
2	Insert specific criteria				
3	Insert specific criteria				
4	Insert specific criteria				
5	Insert specific criteria				
6	Insert specific criteria				
7	Insert specific criteria				
8	Insert specific criteria				
9	Insert specific criteria				
10	Insert specific criteria				

Sign and date when achieved	**Name of staff member**	**Signature**	**Date**
	Name of assessor	**Signature**	**Date**
	Date of review		

Appendix 4: Learning Development Plan

Learning Development Plan			
Identified area(s) for development	**Action plan to support development**	**Evidence to demonstrate development**	**Date of review**
1.			
2.			
3.			
4.			
5.			
6.			
Sign and date when achieved	**Signature and name of staff member**		
	Signature of assessor		
	Date of review		

Appendix 5: CTI Training Register – Delegation

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

Appendix 6: Determining the frequency and type of monitoring[34]

Task Complexity **Delegation**	**Simple routine task** **Recurrent delegation**	**Simple non-routine task** **New delegation**	**Complex routine task** **Recurrent delegation**	**Complex non-routine task** **New delegation**
Client Condition	Stable	Stable	Fluctuating	High degree of fluctuation/ instability
	Simple condition/issues	More complex condition	More complex condition	Complex condition/issues
Skills & Competencies	Demonstrated advanced competency	Demonstrated advanced competency	Demonstrated basic competency/ competency assessment required	Demonstrated basic competency/ competency assessment required
	Recent experience	Past experience	Past experience	No past experience
	Frequently conducted	Occasionally conducted	Occasionally conducted	Never conducted
Impact on Service	Minimal	Some quality impact	Moderate impact on quality	Significant impact on quality
Adverse Risk	Minimal	Mildly attributable to performance	Moderately attributable to performance	Directly attributable to performance
Timeframe	Significant time can elapse before error has an impact	Some time before impact evident	Some time before impact evident	Immediate/rapid impact evident
Frequency of Monitoring	*Intermittent monitoring*	*Regular monitoring*	*Frequent monitoring*	*Frequent, continuous monitoring*
Type of Monitoring	*Indirect monitoring*[*]	*Direct & indirect monitoring + some supervision*	*Direct & indirect monitoring + frequent supervision*	*Direct monitoring*[#] *+ supervision at all times*

**Indirect monitoring: involving observation of activity performance, clinical supervision, which may be face-to-face or via teleconference, and verbal or written feedback from the AHP*

#Direct monitoring: involving tracking of activity performance, monitoring of patient progress, review of notes or records, review of log books, diary and timetables, and measurement of outcomes using assessment tools

[34] WACHS 2009, p.13.