Delegated practice: basic concepts

Resource

Estimate: 10 mins

Professor Lynn Robinson is the Director of Research and Development at the Centre for Innovation in Professional Learning (CIPL), The University of Queensland, where her interests are in large-scale professional workforce capacity development, particularly using online networks. Before joining CIPL in 2010, she had a long career in the health care sector encompassing general practice, hospital administration, health system reform and health systems research. She has had a lifelong interest in education and has taught many thousands of health professionals on topics related to clinical leadership, teamwork, innovation and quality and safety.

Multimedia resource
In addition to the lecture transcript below, this lecture is available as a multimedia presentation (audio over PowerPoint slides).
# Delegated practice: basic concepts

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<td>Overview</td>
<td>In this introduction to practice delegation, we will cover the broad concepts. Firstly, where different delegated practice models fit into the modern health care system. We will then cover the very important concepts of accountability and responsibility which are key to understanding the roles and responsibilities of the different members of the health care team. And this will lead us into exploring the nature and important contribution of clinical supervision to the delegated practice model of care.</td>
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Let's just have a look at some of the areas in which delegated practice models are actually operating now in the health care system, or are foreshadowed for the very near future.

In nursing, for quite some time now, nurses have been working in teams to deliver nursing care, and these teams involve patient care assistants. This is particularly predominant in the aged-care sector, with registered nurses in leadership roles within the team.

In pharmacy, pharmacy assistants work in community pharmacy and pharmacy technologists within the dispensing environment of both community and hospital pharmacy services. Again, in the context where the team always includes a registered, responsible pharmacist.

In the therapies, these models are perhaps a little newer. Allied health assistants have been explored in Australia and other countries, along with community rehabilitation assistants and dietitians working with dietary aides.

Indeed there are no professionals who
are not, at least potentially, engaged in working in health care teams, with assistants or para-professionals as members of the team – again, though, with a registered practitioner in a responsible supervisory role.

Even in medicine, though these models are late coming in Australia, there are assistant roles. In Australia medical assistants now have a formal qualification and are working in primary care. Physician assistants are a particular model of delegated practice within the medical model, which is now taking off in developing and western countries, and this has its origins in the US in the early 1960’s.

What these models all have in common is that there is a registered health professional delegating the care to an appropriately qualified assistant.

This is a particular form of teamwork where the delegating professional remains responsible for the care provided. You will note that this is distinct from multi-disciplinary teams of registered professionals where each is responsible for the care they provide.
In all these examples where delegated practice models are operating, the members of the team (health professional and assistant) share the care, but ultimately a registered, accredited or otherwise formally recognised professional health practitioner is involved in clinical leadership in the team.

So let's just have a look at the fundamentals of delegated practice models, and how they relate to clinical supervision.

The first point to make is that this is a system of care – it doesn't just involve individuals working together in teams, relying on their mutual respect and local collaboration. It requires policies and processes in other parts of the system.

This is one of the fundamental underpinnings of delegated practice models - structural delegation - and we'll go into this in more detail later. But briefly, structural delegation is ultimately about the organisational scaffolding for delegated practice models, and it provides supervising health professional...
and assistants with a framework in which they operate.

We’ll also explore later the close relationship between the delegated practice worker or assistant and the delegating health professional or clinical supervisor.

This is a key part of making these care systems work, and a key part of the job satisfaction for both clinical supervisors and assistants. Also, one of the fundamental benefits of a productive, close and effective relationship between a clinical supervisor and the other members of the team, is that a fair degree of local adaptability can then be incorporated into the model of care. So that within the structure and scaffolding for the delegated practice model, you can have quite a lot of locally negotiated extended roles for individuals within their competence and training.

The clinical supervisor’s performance as a supervisor, and the relationship that the assistant and the supervisor can develop, is key to actually getting the best teamwork going, and the most productive use of the skills and the time.
In looking at delegated practice, we must tease out the issues of responsibility and accountability.

Within the western health care system, responsibility for the patient care overall, and for the outcomes of that, generally are at an individual level, held by registered health professionals. This is the traditional model.

The nature of professionalism is that ultimately the buck will always stop with the registered health professional, and responsibility for the outcomes and the processes of care, can never be wholly delegated away from you, if you’re the registered health professional.

However, parts of the scope of traditional health professional practice are being quite logically moved into extended roles of other members of the health care team, particularly those who are not themselves actually registered health professionals, but who are trained health workers of other varieties.

So while responsibility cannot be wholly
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<td>delegated, the performance of tasks, the authority to perform tasks, can be wholly delegated. And with the transfer of authority to undertake a task, either simple or quite complicated, or a complex set of tasks, with the delegation of this comes accountability. And accountability certainly can be transferred from one member of the team to another, or shared amongst the team. So the authority to undertake tasks or functions is delegated, and with that comes accountability for the performance of those tasks or functions within the team.</td>
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<td>If you want to understand this in a simpler form, just think about legal responsibility or legal liability. The legal liability for the care of a patient, for example, can never be transferred completely from the medical practitioner responsible for the care to, for example, a medical assistant or a physician assistant who might be engaged as part of the care team.</td>
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<td>Similarly, the legal liability for care can never be shifted completely from a registered nurse to perhaps a patient care assistant, or from a registered</td>
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<td>physiotherapist to an allied health assistant. This doesn't mean to say that members of a team aren’t co-accountable for the quality and outcomes of care, or that individuals are not accountable for their own performance within their roles and functions, having undertaken those roles and functions within a team.</td>
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<td>This is where the clinical supervision role comes in - delegated practice and clinical supervision are intimately linked. One cannot operate a delegated practice model of care in a team, without there being a formal notion of clinical supervision co-existent with that.</td>
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<td><img src="slide.png" alt="Clinical supervision" /></td>
<td>So let's have a look at clinical supervision then as a concept. Clinical supervision can be a fairly loosely defined term. It can cover a multitude of sins. It's used to describe the teaching of students in clinical settings, also mentoring younger colleagues or trainees, particularly in vocational training programmes or in pre-registration programmes. But in this context, we are talking about supervision as, of a para-professional or assistant working in a team of people responsible for delivering care.</td>
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Adequate supervision

- Adequately guards the consumer and public interests in quality maintenance
- Protects the employer from legal risk
- Permits the ‘assistant’ to grow in competence
- Avoids waste of scarce resources by under-delegation or over-supervision

So, looking at what we mean in more detail about this type of clinical supervision. What are the objectives or the standards for clinical supervision?

It can be briefly summarised like this:

Adequate clinical supervision when working in teams, which include assistants, is always such that -

1. it adequately guards the consumer and the public interest in the maintenance of quality
2. it certainly protects the employer or the organisation from legal risk
3. but it importantly permits the assistant to grow in competence - so there’s definitely a developmental role for a clinical supervisor.
4. and, ultimately we want to avoid the waste of scarce resources, by not falling into the trap of under-delegation, in other words where too much of what could usefully be done by other members of the team, is still left within the province of the
At the same time we don’t want to create a huge impost in terms of the clinical supervision load. So there’s a balancing act going on here, between the requirements for adequate maintenance of quality and safety, or the guarantee of that, and scope for local development and negotiation to optimise the job satisfaction and the effectiveness of all the members of the team.
This little diagram might help show that balancing act a little more clearly. There’s a very significant overlap in the nature of clinical supervision of assistants in a delegated practice model with that which is generally described when talking about clinical teachers and students in a clinical environment.

In the latter, there is perhaps a more heavier emphasis on professional development. But in all forms of clinical supervision, there is, at least, a balancing act between professional development and the commitment of the clinical supervisor and the assistant to providing safe and quality care, which involves other responsibilities on both parts.

The balance should be a subject of discussion in clinical teams to ensure the optimal use of resources in the short and the long term, while maintaining a high level of safety and quality of care for patients.
So let's sum up. We've looked at the way delegated practice contributes to modern health care delivery.

We've unpacked the critical concepts of accountability, which all members of the health care team have for their actions, and responsibility which is shared always with the supervising registered health professional.

And we have seen how this places the role of the clinical supervisor as central to the success of this model of care.

And this is the reason why clinical supervisors and assistants need to work together to make this relationship effective for both supervisor and assistant and effective for the patient.
Learning Goals
Have you met these Learning Goals?

• Understand delegated practice in the context of a model of care as opposed to the delegation of individual tasks
The value of clinical supervision and delegated practice

Group learning

Table of contents

1.0 Improving clinical supervision and delegated practice
2.0 Meeting the objectives of clinical supervision

Learning Goals

- Describe the scope, roles and responsibilities of the allied health professional and the allied health assistant in a delegation relationship

Reflection

If your team is working progressively through the materials in this workshop over a period of weeks, take a moment to quickly refresh your memory of what you have previously covered in this workshop before continuing on with this new topic.
1.0 Improving clinical supervision and delegated practice

**Group discussion questions**

1. Describe the issues that currently face your team in relation to clinical supervision and the role of the supervisor in ensuring patient outcomes, quality and safety.

2. Discuss the role of the allied health assistant in ensuring patient outcomes, quality and safety.
2.0 Meeting the objectives of clinical supervision

This slide is taken from Professor Lynn Robinson's presentation ‘Delegated practice: basic concepts’. It shows the 4 objectives or standards of adequate clinical supervision.

Instructions

Which of the listed objectives is your team currently addressing effectively in terms of your clinical supervision processes? List the processes that you have in place to ensure this.

Objective(s) currently being effectively addressed:

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Processes currently in place:
Instructions

Which of the listed objectives does your team need to focus on improving? Describe the steps or processes that your team should put in place to address this objective/these objectives.

Objective(s) to be addressed:

Steps or processes to be implemented:
Learning Goals

Have you met these Learning Goals?

- Describe the scope, roles and responsibilities of the allied health professional and the allied health assistant in a delegation relationship.

Authority

This training program has been developed by The University of Queensland’s Centre for Innovation in Professional Learning for use by the Department of Health and Hospital and Health Services established under the Hospital and Health Boards Act 2011 (Qld).