

Novel Coronavirus: Allied health skill sharing and shared practice

Purpose

Hospital and health services (HHSs) preparing for and responding to the novel coronavirus (COVID-19) pandemic will seek to increase the availability and flexibility of the allied health workforce to support critical service delivery. This may include the implementation of skill sharing, and formalisation and expansion of shared practice in the service model.

The purpose of this document is to support HHSs to implement or expand skill sharing and shared practice in their services during the novel coronavirus demand surge. The recommendations may be applied at the discretion of HHSs and should be based on individual HHS requirements and analysis of associated risks.

Principles

1. The primary motivation for skill sharing is to serve the best interests of clients.
2. Hospital and health services are responsible for delivering safe, high quality clinical care to consumers. Allied health professionals, support staff, managers and leaders share this responsibility.
3. Effective implementation of skill sharing and shared practice can increase the range of clinical tasks delivered by individual health professionals to:
 - fully utilise the scope of clinicians' knowledge and skills,
 - enhance workforce flexibility,
 - improve service access for clients and
 - potentially reduce the number of client-clinician interactions required to provide care.
4. Skill sharing and shared practice can only be implemented if a team has adequate clinical governance to support this model including the supervision and support of allied health professionals with expertise in the shared tasks.

Definitions and concepts

Skill sharing

Skill sharing in a service model refers to two or more health professionals sharing knowledge, skills and responsibilities across professional boundaries in assessment, diagnosis, planning and/or implementation¹. It involves a health professional safely and effectively delivering a clinical task that would traditionally be provided by another profession, or that is not explicitly aligned to the health professional's own entry-level standards. Examples of skill sharing include a dietitian trained to deliver dysphagia screening or an occupational therapist trained to undertake basic foot assessment for clients with diabetes.

Skill sharing and scope of practice

Once training is complete and a health professional has been assessed as competent in the performance of a skill shared task, they assume accountability and responsibility for their decisions and actions. That is, the health professional performs the skill-shared task as part of their independent scope of practice¹. The skill share-trained health professional will use their knowledge and clinical reasoning to determine if the task is indicated, safe and appropriate to implement in a given clinical situation, monitor the performance and outcomes of the task and integrate findings into the client's care plan. Consistent with usual practice, the health professional will continually assess the needs of the client against their own scope of practice competency and skills, and implement collaboration / consultation or referral to other members of the multi-professional team if required.

Safety and quality

Training, competency assessment and clinical governance processes are required to support skill sharing. These are minimum requirements to ensure the safety and quality of clinical services are maintained². The [Framework for Local Implementation and Support of Skill-sharing and Delegation Practice for Allied Health Services in the Queensland Public Health System](#)³ provides more information on these requirements.

A skill share-trained practitioner must have easy access to advice and support of a health professional with expertise in the task. Contact may be face-to-face or through telehealth.

Skill sharing may not be appropriate for clients with complex needs. Direct referral to a health professional with expertise in the task needs to be available to support clinical governance and to allow the skill share-trained health professional to practice within their scope and exercise their professional accountabilities.

Shared practice

Shared practice refers to two or more professions, within their accepted scope of practice, possessing the knowledge, skills and competencies to deliver substantially similar clinical tasks and functions. Shared practice is underpinned by clinical knowledge and skills that are common to multiple professions. Examples of shared practice include physiotherapists and occupational therapists assessing functional mobility or providing upper limb therapy, social workers and psychologists assessing and providing supportive interventions for carers experiencing distress, or podiatrists and medical practitioners ordering and reviewing lower limb X-rays to inform diagnosis.

Safety and quality

Although shared practice encompasses clinical tasks and functions within the accepted scope of a profession, an individual health professional may not possess the relevant experience and competencies to deliver specific tasks. Workplace culture and historical practice can result in shared clinical tasks being "adopted" by one profession (or professional) in a work unit, with resultant de-skilling of other team members³. Shared practice is formalised in a service model through ensuring all relevant team members can safely and effectively deliver the tasks as part of usual practice. This may include competency mapping, workplace-based training and changes to operational processes such as client allocation.

Implementation

Task identification for skill sharing or shared practice in the service model

Tasks to be skill shared between professions or formalised as shared practice in the service model, should be identified and agreed by the team and approved by the service delegate.

Efficient implementation will favour tasks that:

- are high frequency or high priority for the service,
- involve a limited expansion of team members' existing knowledge and skills,
- have training resources available, and
- align with usual workflow and client allocation for the service.³

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 service manager or Director of Allied Health and endorsed by the relevant profession delegates¹. The profession delegates include the director (or equivalent senior HHS profession lead) for the clinician to be trained and the clinician providing the training.

Risks to be considered when examining a task for skill sharing or formalisation of shared practice include³:

- task complexity including the number and duration of steps in the task procedure, whether task steps are in a clear linear sequence or require continuous, complex decision making and alterations to approach,
- clinical knowledge and clinical reasoning demands,
- the technical skills required,
- the likelihood and consequence of error, and the extent to which the risk of error can be mitigated through training and supervision, protocols/procedures, and client inclusion/exclusion criteria for skill sharing,
- context factors such as physical setting hazards, access to assistance from other members of the team, client group clinical risk profile, and
- the feasibility of maintaining competence given the extent of the training requirements for the health professional and the frequency of task implementation.

Examples of tasks that may be appropriate for skill sharing and formalisation of shared practice are shown in Attachment 1.

Training and competency assessment of allied health professionals

Skill sharing

Skill sharing will require a program of training to be implemented in the workplace, to be facilitated by a "lead clinician" who has with expertise in the task. Competence in the task must be assessed by an occupationally competent assessor i.e. a person qualified in the profession with the task in accepted scope of practice¹. Workplace training and assessment qualifications are advantageous for the competency assessor but not mandatory. Observation of task performance in the usual practice environment should be included in the competency

assessment process, but other methods can augment observation including case reviews and simulated practice of technical skills. Refer to the [Guideline for skill-sharing between allied health professionals](#)¹ for further information on training and assessment.

A list of training resources for skill shared tasks is provided in Attachment 1. Queensland Health CTIs can be used to support clinical governance, define training requirements and complete competency assessment using the assessment matrix and clinical reasoning record.

Training and competency assessment should be documented. Records kept by the work unit should at a minimum, list the skill share competencies each team member has completed. Examples of skill sharing training records are shown in the Queensland Health [Guideline for skill-sharing between allied health professionals](#)¹ and published with skill sharing resources on the [AHPOQ website](#).

Shared practice

For shared practice tasks an individual health professional may require workplace-based training to refresh knowledge and skills or to align their profession-specific approach to the team's agreed, best practice procedure for a clinical task. The skill sharing resources in Attachment 1 may be useful for training. Formal competency assessment is unlikely to be required.

Supervision and monitoring

Skill sharing

Allied health professionals performing clinical tasks across professional boundaries require supervision or mentoring from a suitably qualified and experienced health professional who is competent in the relevant task⁵. This "lead clinician" for the skill shared task will provide more intensive, direct clinical supervision and monitoring (i.e. task supervision) during the training phase, including reviewing and discussing the health professional's clinical reasoning log (or similar)¹. Following successful competency assessment, a process for regular review of competence in the shared task by the lead clinician can be incorporated into the skill shared practice model e.g. monthly discussion of cases, quarterly case review. The frequency and format of the review will be influenced by the risk profile of the task, skills and experience of the trained health professional and frequency of the task implementation.

Shared practice

Shared practice should be integrated into regular profession-specific supervision arrangements as defined by the [Guideline for Credentialing, Defining the Scope of Clinical Practice and Professional Support for Allied Health Professionals](#)⁶.

Credentialing and defining scope of clinical practice

Refer to AH002335 Guidance Note: Allied health workforce flexibility and clinical governance.

Reference documents

1. Queensland Health, 2013. Guideline for Skill-Sharing Between Allied Health Professionals at https://www.health.qld.gov.au/__data/assets/pdf_file/0020/155513/wpi-three.pdf
2. Greater Northern Australia Regional Training Network, 2013. Project Report: Rural and Remote Generalist - Allied Health Project at https://www.health.qld.gov.au/__data/assets/pdf_file/0025/656035/GNARTN-project-report.pdf.
3. Queensland Health, 2013. A Framework for Local Implementation and Support of Skill-sharing and Delegation Practice for Allied Health Services in the Queensland Public Health System at https://www.health.qld.gov.au/__data/assets/pdf_file/0029/156872/ssdp-framework.pdf.
4. Queensland Health, 2019. Skill sharing training plan template at https://www.health.qld.gov.au/__data/assets/word_doc/0035/706598/ss-training-plan.doc.
5. Queensland Health, 2018. Allied Health Clinical Governance Framework at https://www.health.qld.gov.au/__data/assets/pdf_file/0030/143895/clingovframe.pdf.
6. Queensland Health, 2015. Guideline for Credentialing, Defining the Scope of Clinical Practice and Professional Support for Allied Health Professionals (#QH-HSCGDL-034-2:2015), 2015 at https://www.health.qld.gov.au/__data/assets/pdf_file/0021/155505/qh-hsdgdl-034-1.pdf.
7. Queensland Health, 2019. Domain 4: Skill Sharing in Allied Health Rural Generalist Education Framework at https://www.health.qld.gov.au/__data/assets/pdf_file/0032/695390/ahrg-education-framework.pdf.

Attachment 1

Training resources

- Queensland Health [clinical task instructions](#) (CTIs) describe the best practice process for undertaking skill shared tasks. The CTIs have been reviewed by relevant statewide profession groups. CTIs are available in a range of clinical areas including activities of daily living and function, mobility and transfers, and foot care.
- The Metro North Hospital and Health Service [Dysphagia e-Learning Resource](#) assists health professionals to develop skills in screening swallowing problems.
- The Queensland Health (AHPOQ-C) [Compression Garment Education Package](#) assists occupational therapists, physiotherapists and podiatrists to develop competency in compression garment selection, fitting and monitoring.
- Hospital and health service clinical procedures e.g. wound care, clinical observations.
- Statewide Clinical Network resources including clinical guides and training materials e.g. [Respiratory Network resources](#), [Diabetes Network resources](#) and [Dementia Network resources](#).
- Other Queensland Health and external clinical training resources such as [insight](#) (AODS), [Prevention Division](#) (healthy weight/eating), [Centre for Palliative Care Research and Education](#), [Queensland Centre for Mental Health Learning](#), and [Clinical Skills Development Centre](#) (online courses).

Potential skills sharing / shared practice tasks

Table 1 provides examples of clinical tasks that may be appropriate for skill sharing / shared practice. The tasks have been identified in previous AHPOQ-supported projects⁷. A task can be implemented as skill sharing or shared practice depending on the profession delivering it. For example, delivering a knee/hip replacement rehabilitation program could be performed by an exercise physiologist as shared practice, drawing on underpinning knowledge of functional anatomy, movement analysis and exercise prescription, and with some workplace-based upskilling. The same task would be considered skill sharing for a pharmacist or psychologist as the task deviates substantially from accepted scope of practice, standards and training for these professions.

Table 1: Potential skills shared / shared practice tasks

Clinical Function	Tasks
Activities of daily living (ADL) and function	<p>Assessment</p> <p>Administer / conduct, interpret and implement actions from screening and basic assessments:</p> <p>Personal ADLs e.g. grooming, dressing, toileting, showering / bathing, basic meal preparation.</p> <p>Home environment assessment.</p> <p>Intervention</p>

Clinical Function	Tasks
	Provide bridging / basic intervention tasks (rehabilitation and re-training) as indicated by assessment (or reassessment / review): personal ADLs, home modifications, equipment / assistive technology.
Mobility and transfers	<p>Assessment</p> <p>Administer / conduct, interpret and implement actions from screening and basic assessments: mobility with and without usual aid, mobility on stairs, transfers, bed mobility, falls and balance assessment (e.g. Berg Balance Scale, FROP-Com), timed up and go.</p> <p>Intervention</p> <p>Provide bridging / basic intervention tasks as indicated by assessment (or reassessment / review): mobility aids, basic wheel chair for short term use, falls risk minimisation, mobility and transfer re-training / practice.</p>
Cognition, Perception and Memory	<p>Assessment</p> <p>Administer / conduct, interpret and implement actions from screening and basic assessments: Perception screening using standardised tools, cognition screening using standardised tools.</p> <p>Intervention</p> <p>Provide bridging / basic intervention tasks as indicated by assessment (or reassessment / review): Standard education for client and carer / family - behaviour management strategies, compensatory memory and perception strategies.</p>
Developmental and Child Health	<p>Assessment</p> <p>Administer / conduct, interpret and implement actions from screening and basic assessments: Developmental assessment including protocol-supported subjective assessment and screening tool/s (e.g. Ages and Stages Questionnaire).</p> <p>Intervention</p> <p>Provide bridging / basic intervention tasks as indicated by assessment: Standard education to promote physical function including positions / postures, principles for maximising engagement in functional activities, basic environmental modifications and compensatory strategies.</p> <p>Review and progress prescribed therapy program: Language development (including receptive and expressive language), fine motor therapy program, gross motor therapy program.</p>
Diet and Nutrition	<p>Assessment</p> <p>Administer / conduct, interpret and implement actions from screening and basic assessments: Subjective assessment including diet history / nutritional intake, height, weight, BMI (or Height, weight, BMI and waist circumference), Malnutrition Screening Tool (also in core skill sharing skill set), Subjective Global Assessment.</p> <p>Intervention</p> <p>Provide bridging / basic intervention tasks as indicated by assessment (or reassessment / review): Nutrition education supported by standard client information resources and advice on food strategies relevant to local setting (e.g. high protein high energy).</p>

Clinical Function	Tasks
Musculoskeletal	<p>Assessment</p> <p>Administer / conduct, interpret and implement actions from screening and basic assessments: Subjective assessment (post-orthopaedic surgery review), objective assessment (post-knee/hip replacement) observation, goniometry, manual muscle testing.</p> <p>Intervention</p> <p>Review and progress prescribed rehabilitation program: knee/hip replacement rehabilitation program, lower limb home exercise program (non-operative, pre-operative).</p>
Foot care (high risk groups)	<p>Assessment</p> <p>Administer / conduct, interpret and implement actions from screening and basic assessments: Subjective screening assessment including high risk foot screen, basic vascular assessment including Ankle-Brachial Pressure Index (ABPI), neurological Screen Foot & Lower Leg including monofilament testing, basic wound assessment/review including photography.</p> <p>Intervention</p> <p>Provide bridging / basic intervention tasks as indicated by assessment (or reassessment / review): Education - foot self-care for clients at risk of foot ulcers; diabetes complications impact/risk for lower limb, basic offloading.</p>
Pressure care, scars and wounds	<p>Assessment</p> <p>Administer / conduct, interpret and implement actions from screening and basic assessments: subjective screening assessment of pressure area risk including Waterlow (pressure risk screen), basic wound assessment / review including photography.</p> <p>Intervention</p> <p>Provide bridging / basic intervention tasks as indicated by assessment (or reassessment / review): pressure care education for clients and carers, basic pressure relieving equipment (heel protectors, low pressure relief products).</p> <p>Review and progress prescribed rehabilitation program: wounds and scars ongoing self-management program including scar massage, moisturisers, exercise program, positioning.</p>
Psycho-social	<p>Assessment</p> <p>Administer / conduct, interpret and implement actions from screening and basic assessments: Geriatric Depression Scale - Short Form, psycho-social screening, carer strain index.</p> <p>Intervention</p> <p>Provide bridging / basic intervention tasks as indicated by assessment (or reassessment / review): mental health first aid (Note: formal training program, not a CTI).</p>
Communication	<p>Assessment</p> <p>Screening assessment of communication for adults.</p> <p>Intervention</p> <p>Provide bridging / basic intervention tasks as indicated by assessment (or reassessment / review): Deliver standard education to support implementation of management plan recommended by Speech Pathologist.</p>

Clinical Function	Tasks
Swallowing	<p>Assessment</p> <p>Administer / conduct, interpret and implement actions from screening and basic assessments: subjective screening assessment for dysphagia.</p> <p>Provide telehealth supported assessment: Client-end support for speech pathologist telehealth-delivered dysphagia assessment.</p> <p>Intervention</p> <p>Provide bridging / basic intervention tasks as indicated by assessment (or reassessment / review): deliver standard education on swallowing risk minimisation and oral hygiene.</p> <p>Provide telehealth supported intervention tasks as indicated by assessment (or reassessment / review): deliver standard education to support implementation of management plan recommended by Speech Pathologist, (supporting speech pathologist real-time prescription via telehealth or prescription previously provided).</p>