

Allied health: credentialling, competency and capability framework (revised edition)

Driving effective workforce practice in a changing health environment



Western Health

MonashHealth



Health
and Human
Services

Allied health: credentialling, competency and capability framework (revised edition)

Driving effective workforce practice in a changing health environment



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(Second Edition)

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Foreword

I am delighted to present the second edition of the *Allied health: credentialling, competency and capability framework*.

The framework supports allied health practitioners to provide safe, effective, high-quality care in a patient- and family-centred way, working as an integral part of multidisciplinary healthcare teams.

In Victoria, allied health is categorised as either an 'allied health: therapy' or an 'allied health: science' profession based on core practices and educational pathways. The *Allied health: credentialling, competency and capability framework* was initially developed for allied health: therapy professions in 2014, with the intention of adapting and contextualising the framework for use in the allied health: science professions in the future.

In 2015, consultation began with the allied health: science professions to contextualise and customise the framework for use by both allied health: therapy and allied health: science professions.

The new framework provides targeted guidance to both allied health: therapy and allied health: science managers and clinicians to assist with developing structures and processes needed to build and sustain an effective workforce through appropriate selection, recruitment and training of staff, maintenance of professional standards, and monitoring scope of practice. In addition, the framework provides a platform to ensure the safe introduction of new models, therapies, procedures and roles.

Combining credentialling, competency and capability into a single framework brings together the key elements of thinking required by allied health managers and clinicians when reviewing workforce planning, service change and changing roles in order to respond dynamically to the changing and increasing demands, advancing technologies, challenges and opportunities for the allied health workforce.

Adopting a standardised and consistent approach across organisations in Victoria will allow new and effective workforce developments to be readily transferred between health services, reducing the need for organisations to 'reinvent the wheel' and supporting the development of clear career pathways in allied health.

This document will guide health services in implementing this framework or to review and further develop existing frameworks. The intention is that health services will adapt the framework to meet local practices and organisational structures.

The framework was initially developed under the leadership of Monash Health, with contributions from allied health practitioners and stakeholders across Victoria. Contextualisation and customisation of the framework for allied health: science professions has been led by Western Health, with contributions from Monash Health and allied health: science practitioners and stakeholders. I would like to thank the many people who contributed their time, expertise, support and ideas to the development of this framework through its extensive consultation and feedback stages.

I would also like to acknowledge the enthusiasm and leadership of the allied health sector in adopting a consistent statewide approach to the governance of professional practices in allied health.



Kathleen Philip

Chief Allied Health Advisor of Victoria
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Introduction

All staff within the Victorian health system should have a fundamental understanding of governance, quality and safety and the appropriate skills and knowledge required to fulfil their role and responsibilities. Health services across Victoria are well invested in quality and safety systems to support this and meet regulatory requirements. However, the changing context and increasing role of allied health in healthcare teams calls for a comprehensive approach to support high-quality care and professional practices across allied health.

Allied health encompasses a diverse range of professions with different technical skills, knowledge and practices. It comprises nationally registered professions (under the National Registration and Accreditation Scheme) and non-registered or self-regulated allied health professions. It includes both professionals and assistants.

Allied health professionals are autonomous health practitioners and are responsible and accountable for the management and care they provide and for the effective clinical supervision of allied health assistants who provide care as part of an interdisciplinary team.

The *Allied health: credentialling, competency and capability framework* builds on the strengths of the existing sound governance mechanisms and practices in allied health in Victoria to present a consistent statewide approach to drive dynamic and effective workforce practice in a changing health environment.

Background and context

Allied health practitioners deliver services to patients and consumers across a diverse range of sectors, contexts and settings in Victoria. All allied health practitioners (including professionals and assistants) are responsible for providing safe, high-quality care in a patient- and family-centred way as part of the healthcare team.

The breadth of service delivery contexts and settings in which allied health services are provided have necessitated the development of flexible and robust clinical governance systems and processes to underpin allied health services. The strength and quality of existing allied health clinical governance systems is widely acknowledged in the health sector. However, Victoria's devolved system of health governance and decentralised approach to health service delivery encourages localised service and governance models that reflect the requirements, issues and pressures inherent in local organisational contexts and settings.

The resultant variation in clinical governance models and authorisation processes for allied health across health services has presented challenges to the broader sectoral understanding of the rigour of allied health clinical governance in Victoria. In turn, this has limited both the ease of development of new roles and the transferability of advanced allied health roles or amended scopes of practice between health services.

Increasingly, as new service and workforce models evolve and care is provided through multidisciplinary healthcare teams with varying skill mix and composition and in different settings, there is a need to ensure the appropriate processes and clinical governance structures are clearly outlined so that safe and effective high-quality care is provided. This will limit use of inappropriate models such as an allied health assistant working without clinical supervision from an allied health professional, or an allied health professional undertaking an advanced practice role without the demonstrated

competency and capability to do so safely and effectively. It will also support organisational understanding of expected performance levels and how this relates to decision making regarding grade classification for positions.

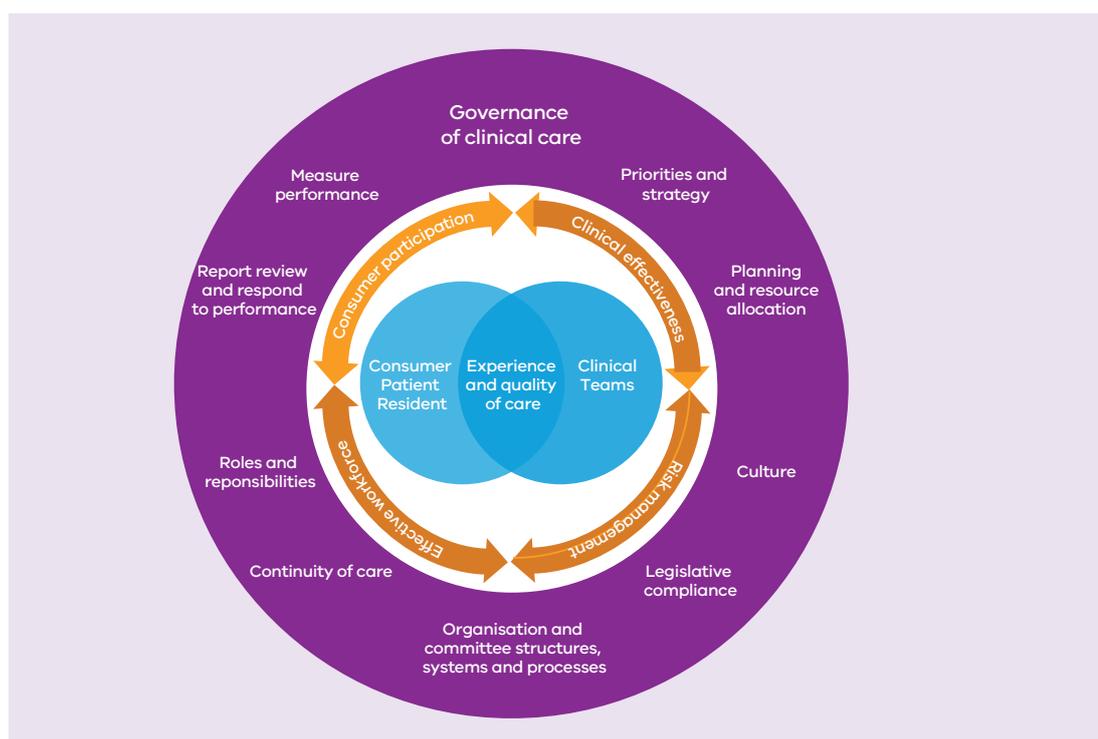
By adopting a standardised and consistent approach to credentialling, scope of practice, competency and capability across Victoria, the allied health workforce will be better equipped to grow capabilities, create and share learning cultures, and more effectively develop new roles and expand advanced and extended scopes of practices, including transferring these across organisations, sectors and professions.

The Australian Health Service Safety and Quality Accreditation (AHSSQA) Scheme has been in place since 2013. Within this scheme it is mandatory for health services to be accredited against the 10 *National safety and quality health services standards* (NSQHS standards). Standard 1: *Governance for safety and quality in health service organisations* describes the quality framework required for health service organisations to implement safe systems and outlines the criteria and actions specific to credentialling and scope of clinical practice required under this standard (ACSQHC 2012).

In Victoria, there is an additional expectation that all health services will have a formal and effective clinical governance framework in operation. The *Victorian clinical governance policy framework* (Department of Human Services 2009b) provides four domains of quality and safety – consumer participation, clinical effectiveness, effective workforce and risk management – as a construct for strategies to enhance the delivery of clinical care. Within each domain there are a number of quality and safety management functions that require direction and oversight by governing bodies.

Figure 1 shows the components of the *Victorian clinical governance policy framework*.

Figure 1: Components of the Victorian clinical governance policy framework



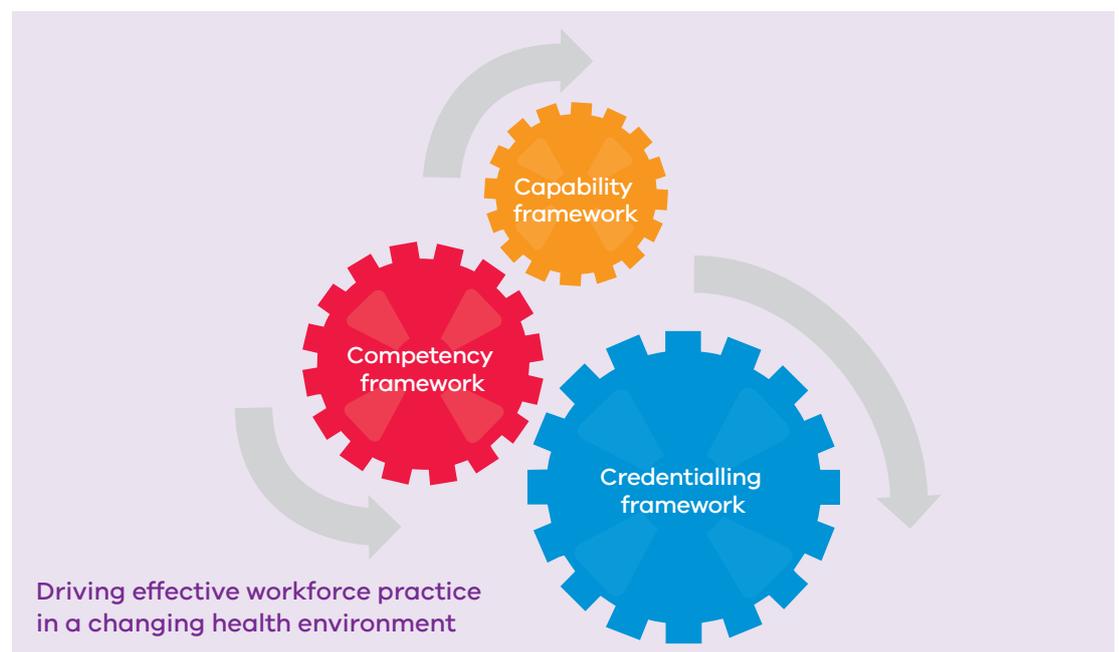
For an effective workforce, as described in the *Victorian clinical governance policy framework*:

... all staff employed within health services must have the appropriate skills and knowledge required to fulfil their role and responsibilities within the organisation. Support is required to ensure clinicians and managers have the skills, knowledge and training to perform the tasks that are required of them and that they understand the concept of governance. Processes should be in place to support the appropriate: selection and recruitment of staff; credentialling of clinical staff including annual review of practice; maintenance of professional standards; and control of the safe introduction of new therapies or procedures. (Department of Human Services 2009b, p. 5)

The credentialling framework clearly supports this requirement of the *Victorian clinical governance policy framework* for allied health, recognising the diversity of registered and unregistered professions. The competency and capability frameworks give additional support to the quality and safety domain of 'Effective workforce' by providing a robust platform for workforce adaptability and productivity across the allied health workforce.

Together, the three component frameworks that make up the *Allied health: credentialling, competency and capability framework* (**Figure 2**) aim to: support the allied health workforce across Victoria by providing a consistent approach to meeting credentialling and scope of practice (CSOP) requirements; support competency and capability development and expansion; and increase the overall effectiveness and efficiency of the workforce in achieving optimal patient- and family-centred outcomes. Working together, the components enable a dynamic and proactive response to changing health service delivery contexts and demands. **Figure 2** shows the three interlinking components of the framework.

Figure 2: Components of the framework



Clinical supervision and performance review is a fundamental part of ensuring safe, high-quality care and an effective workforce and is specifically referred to as core actions in standard 1.11 of the NSQHS standards (ACSQHC 2012). Appropriate and effective clinical supervision and performance review are already an integral and well-established part of clinical governance and performance development procedures in the allied health workforce across Victoria within most healthcare organisations.

Clinical supervision

'The oversight (direct or indirect) by a clinical supervisor of professional procedures and processes performed by a supervisee within a clinical setting for the purpose of guiding, providing feedback on, and assessing personal, professional and educational development in the context of each supervisee's experience of providing safe, appropriate and high-quality patient care' (Health Workforce Australia 2013a, p. 22).

Performance review

Performance enhancement or review is an ongoing process where a staff member's performance and development is discussed and reviewed against an agreed plan.

The individual processes, minimum standards and requirements stipulated by healthcare organisations vary considerably in this space, reflecting differing local requirements, issues and resources. Significant and comprehensive resources have already been developed to support clinical supervision and performance review for the allied health workforce including:

- organisational procedure(s) for clinical supervision and performance review
- policy frameworks such as the *Victorian clinical governance policy framework* (Department of Human Services 2009b)
- *Supervision and delegation framework for allied health assistants* (Department of Health 2012)
- *National clinical supervision support framework* (Health Workforce Australia 2011)
- *National clinical supervision competency resource* (Health Workforce Australia 2013a).

For this reason, while the critical importance of effective clinical supervision and performance review in achieving a high-performing and effective workforce is acknowledged, this framework has not incorporated additional material on these core areas. Rather, the reader is directed to the resources listed above.



Framework principles

The development of this framework was underpinned by the following principles as a basis for supporting consistent best practice and good governance of clinical care in allied health.

Principle 1: Patient- and family-centred

The framework is patient- and family-centred and supports appropriately qualified allied health practitioners to communicate and work with patients and their families respectfully to consistently provide high-quality care.

Principle 2: Flexible

The framework supports allied health practitioners of all levels to work safely and effectively in diverse settings.

Principle 3: Contemporary

The framework is forward-thinking to support the allied health workforce to respond dynamically and capably to the demands and opportunities presented in a changing health environment.

Principle 4: Evidence-based

The framework is evidence-based and draws on best practice local, national and international standards and examples.

Principle 5: Robust

The framework is rigorous and thorough, with precise explanation and application to support implementation of sound practices for credentialling, competency and capability across the allied health workforce.

Principle 6: Comprehensible

The framework is clearly written and easy to navigate, with tools, samples and case studies to make it easy to understand and apply.

Principle 7: User-friendly

The framework is logical and easy to understand to enable simple practical application.

Why was it developed?

The population is ageing and so too the burden of disease has shifted. Increasingly chronic and complex comorbidities, combined with technological advances and increasing consumer expectations, are presenting significant challenges to our health system and the health workforce in meeting the community's need for safe, effective and high-quality healthcare.

The framework builds on the strengths of the existing governance mechanisms and practices in allied health to present a consistent statewide approach to drive dynamic and effective workforce practice in a changing health environment.

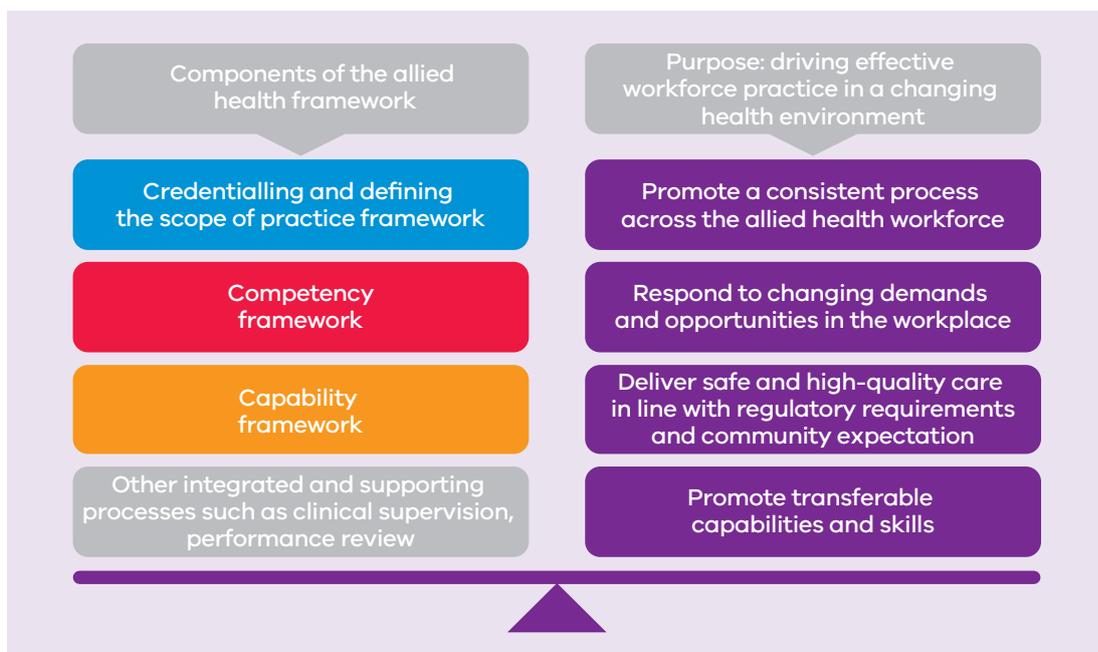
The framework brings together the criteria and actions specific to credentialling and scope of clinical practice required under Standard 1 of the NSQHS standards with a standardised competency framework and capability framework. This promotes an effective workforce as required in the *Victorian clinical governance policy framework*, which provides the key components, elements and tools needed to respond to changing demands on the allied health workforce in a coherent and considered way. By adopting a standardised and consistent approach across organisations, new and effective workforce developments can be rapidly transferred between health services, preventing the need for organisations to 'reinvent the wheel' and supporting the development of clear career pathways in allied health.

The key purpose of the framework is to support the allied health workforce to respond dynamically and effectively to the demands and opportunities presented in a changing health environment to achieve optimal patient-centred care. It aims to:

- promote a consistent approach across the Victorian allied health workforce
- promote the development and transferability of capabilities and skills for the allied health workforce across diverse settings and occupational groups
- assist health service organisations to develop and implement processes focusing on credentialling (and defining the scope of practice), capabilities and competencies in support of workforce reform, changing scope of practice and to deliver safe and high-quality care in line with regulatory requirements such as national standards
- assist health service organisations to develop and implement processes that support the department's policy on clinical governance, with particular reference to the effective workforce domain (Department of Human Services 2009b)
- allow for knowledge and resource sharing between health services.

The key components and purpose of the framework are depicted in **Figure 3**.

Figure 3: Key components and purpose of the framework



How was it developed?

To ensure the strengths of existing local governance models were carried forward into the framework, broad consultation formed a key component in the framework's development phase.

A steering committee comprising representatives from the then Department of Health (now Department of Health and Human Services (the department) and Monash Health was established to undertake an extensive statewide consultation.

A series of forums were held across metropolitan and regional Victoria in 2013 to garner input from key stakeholders including professional associations, metropolitan/rural healthcare networks, Medicare Locals, private healthcare providers and representatives from the community sector. More than 60 Victorian health services and organisations were represented. Additional information and written feedback was sought during and after the forums and has informed the development and review of the framework. Case studies and sample documents from a range of health services and organisations have been included to demonstrate and clarify key aspects of the framework.

For a full list of the steering committee, forum participants and contributors to the framework, please refer to the appendix at the back of this document.

Who does it apply to?

Allied health professionals are qualified to support and enable diagnosis of health conditions. They provide treatment to maintain and optimise physical, social and mental health and function across the continuum of care, and promote healthy living. Allied health assistants provide therapeutic and program-related support to allied health professionals under the guidance and supervision of an allied health professional.

In Victoria a diverse group of professions and practitioners comprise the allied health workforce including both allied health: therapy and allied health: science professions. The professions include nationally registered and non-registered or self-regulated allied health professionals and allied health assistants. The framework provides targeted guidance to both allied health: therapy and allied health: science managers and clinicians to assist with developing structures and processes needed to build and sustain an effective workforce.

Private allied health practitioners, non-allied health professionals, peak bodies or regulators might view and use the guide and adapt it to meet their own needs.

Framework structure

The framework is divided into three main sections and is complemented by a resource kit for each section. These are colour-coded for easy reference. Together the framework and the resource kits comprehensively outline the framework development as well as including explanatory content, supporting evidence and resources to assist from scoping to implementation. These can be accessed at www2.health.vic.gov.au.

Allied health: credentialling, competency and capability framework

- 1 Credentialling and defining the scope of practice framework
- 2 Competency framework
- 3 Capability framework

Allied health: credentialling, competency and capability resource

- 1 Credentialling and defining the scope of practice resource kit
 - 2 Competency resource kit
 - 3 Capability resource kit
-



How can I use the framework?

The department strongly encourages health service organisations to actively apply the framework or review and further develop existing frameworks. The application of the framework or parts thereof can be used to: supplement established organisational structures; improve the quality of care provided; increase workforce competency and adaptability; create learning cultures; assist with the development of leadership capability; and provide a platform for transferability of new roles and advancing practice.

We recommend using the self-assessment tool for each section before you progress through the framework. The self-assessment tool can be used to identify areas for targeted action. If you have identified an area of need, please refer to the contents page of the framework – this provides a quick reference for finding parts of the framework. Alternatively you can refer to the resources table in each section of the framework to seek out the most relevant resource for your use. These resources can then be accessed in the corresponding resource kit.

Case studies that demonstrate how parts of the framework and resources can be practically applied are available under the 'Practically applying the allied health credentialing, competency and capability framework' heading.



Section 1: Credentiailling and defining the scope of practice framework



Aim

Credentiailling and defining scope of practice aim to protect the public and health service provider by ensuring practitioners have the appropriate qualifications, level of experience and professional standing to carry out the role they are employed to do within the needs and capability of the organisation (ACSQHC 2004).

A robust process of credentiailling and defining the scope of clinical practice is essential to:

- provide services that are safe and of high quality
- sustain the confidence of the public and healthcare professions
- support and embed good practice.

Health services have a responsibility to ensure that all services provided to patients are safe, appropriate and within the capability and role of the service; this is integral to the clinical governance of the allied health workforce.

This section provides a framework for developing or enhancing credentiailling and defining the scope of practice for allied health profession groups and individuals within your health service organisation. It can be used to support achieving and maintaining mandatory accreditation standards, as well as improving the governance and quality and safety systems within your organisation.

What is credentiailling?

Credentiailling refers to *'the formal process used to verify qualifications, experience, professional standing and other professional attributes for the purpose of forming a view about their competence, performance and professional suitability to provide safe, high-quality healthcare services within specific organisational environments'* (ACSQHC 2004, p. 3).

Traditionally within healthcare organisations credentiailling has been a process that has been applied on recruitment into an organisation and, depending on the size of the organisation, may take place some distance from the area/unit into which the practitioner will be employed.

In many organisations credentiailling is considered at the 'threshold' level. The threshold level refers to the minimum qualification necessary for a practitioner to work within the organisation and call themselves, for example, an occupational therapist.

As credentiailling frameworks become more sophisticated in organisations there is a growing need to consider 'credentiailling' beyond the threshold and consider how credentiailling, together with defining clinical practice, may drive change in clinical practice.

Credentiailling may occur at multiple levels (national, regional or organisational) and has been suggested to be an alternative to registrations (Productivity Commission 2005).

What is defining the scope of practice?

The Australian Council for Safety and Quality in Health Care's (2004) definition of defining scope of practice (stated below) highlights the complementary nature of credentialling and defining scope of practice.

Defining the scope of practice *'follows on from credentialling and involves delineating the extent of an individual (allied health practitioner's) clinical practice within a particular organisation based on the individual's credentials, competence, performance and professional suitability, and the needs and capability of the organisation to support the practitioner's scope of clinical practice'* (ACSQHC 2004, p. 4).

Various terms may be used interchangeably for defining scope of practice. 'Clinical privileging' is a term used widely in health services documentation, including organisational by-laws, to describe the process of granting 'a specific practitioner the authorisation to provide specific patient care services ... in accordance with the standard of care of the facility granting the privilege' (Galt 2004, p. 661). The term 'defining the scope of clinical practice' is the term consistent with the national standard.

Credentialling and defining the scope of practice are two distinct but complementary processes. These processes are the key form of regulation exerted by a healthcare organisation on an individual practitioner or group of practitioners.

The Nursing and Midwifery Board of Australia (2007) provides a useful definition for both the scope of practice for an individual and for a professional group or profession (see box).

A profession's scope of practice *is 'the full spectrum of roles, functions, responsibilities, activities and decision making capacity that individuals within that profession are educated, competent and authorised to perform. Some functions within the scope of practice of any profession may be shared with other professions or other individuals or groups. The scope of practice of all health professions is influenced by the wider environment, the specific setting, legislation, policy, education, standards and the health needs of the population'* (Nursing and Midwifery Board of Australia 2007, p. 1).

The scope of practice of an individual *is 'that which the individual is educated, authorised and competent to perform. The scope of practice of an individual nurse or midwife may be more specifically defined than the scope of practice of their profession. To practise within the full scope of practice of the profession may require individuals to update or increase their knowledge, skills or competence'* (Nursing and Midwifery Board of Australia 2007, p. 2).

Background

Accreditation standards

Accreditation is recognised as an important driver for safety and quality improvement. The NSQHS standards are a critical component of the AHSSQA Scheme as they determine how and against what an organisation's performance will be assessed. Core actions of the national standards are considered fundamental to safe practice and are mandatory requirements.

Core actions linked to Standard 1 (*Governance for safety and quality in health service organisations*) include 'Implementing a system that determines and regularly reviews the roles, responsibilities, accountabilities and scope of practice for the clinical workforce' and 'Implementing a governance system that sets out the policies, procedures and/or protocols for establishing and maintaining a clinical governance framework'.

The Victorian Home and Community Care (HACC) program manual outlines the expected standards for funded professions (Department of Health 2013b).

The most relevant parts of the NSQHS standards and other accreditation standards relating to allied health CSOP processes are listed in the credentialling Appendix 11.

Registered professions

The allied health workforce includes both nationally registered and non-registered or self-regulated allied health professionals and allied health assistants.

In 2010 the National Registration and Accreditation Scheme ('the national scheme') began by regulating 10 professions (chiropractors, dental practitioners, medical practitioners, nurses and midwives, optometrists, osteopaths, pharmacists, physiotherapists, podiatrists and psychologists). In 2012 four other professions joined the national scheme (Aboriginal and Torres Strait Islander health practitioners, Chinese medicine practitioners, medical radiation practitioners and occupational therapists). The national scheme was established under state legislation (*Health Practitioner Regulation National Law Act 2009* (Vic) ('the national law')). The national scheme is supported and administered by the Australian Health Practitioner Regulation Agency (AHPRA).

Registered professions under the national scheme have clear registration standards. For these professions, 'threshold' credentialling is completed at the point of registration or re-registration. During initial registration, practitioners provide evidence of qualification and/or experience that is then verified by AHPRA. On re-registration, practitioners declare that they continue to meet the standards as set by the appropriate national board. After registration, verification of credentials is conducted as required or through routine auditing.



The national scheme recognises several types of registration – student registration, general registration, specialist registration, non-practising registration and limited registration. There are four subtypes to limited registration – postgraduate or supervised practice, area of need, teaching or research and public interest. Not all forms of registration are available for each of the registered professions. Each type of registration has a standard that is developed by the appropriate registration board.

The formal process of registration does not grant scope of practice (as being the range of services the practitioner is able to practise within a defined environment), verify the quality of a practitioner’s work or verify the organisation’s capability to support practice (Health Quality and Complaints Commission 2012).

Protected titles and practices

Legislation that establishes the national scheme protects the titles and certain practices of registered professions. The protected titles and practices under the national law are outlined in Appendix 1.2.

In addition to protecting certain titles there is a restriction on the use of specialist titles where there is a recognised specialty and an individual is not registered in that specialty.

Best practice regulation

The Council for Healthcare Regulatory Excellence (CHRE) (2010) has defined the concept of ‘right- touch regulation’ as ‘based on a proper evaluation of risk, is proportionate and outcome focused; it creates a framework in which professionalism can flourish and organisations can be excellent’ (CHRE 2010).

The features of right-touch regulation are:

- effectiveness
- proportionality
- flexibility
- transparency
- consistency and predictability
- cooperation
- accountability
- subject to appeal.

The Victorian Government has identified key characteristics of good regulatory systems. In the *Victorian guide to regulation* (Department of Treasury and Finance 2011) the government advocates government intervention where a problem exists, where government action is justified and where regulation is the best option. While this expressly refers to government action, the same characteristics of principles can be applied to local regulatory activities such as credentialling and defining scope of practice.

Finding the ‘right touch’ is important in any organisation to balance the needs of all stakeholders while ensuring quality and safety.

Self-regulated professions

Professions not registered under the national scheme are largely subject to self-regulation or co-regulation. A peak body (association) will usually define the threshold qualifications/experience required for a practitioner to hold out as that profession. There is no legislative protection of titles for professions that are not registered.

Regulatory failure

Examples:

Dr Raad's medical registration was fast tracked when he began working for a private medical company. Dr Raad's registration had been suspended in South Africa on two occasions before his licence was finally revoked. Dr Raad was found to have lied on his application for registration with the Tasmanian Medical Council and was forced to leave after a number of complaints about his medical competence. Dr Raad then moved to the United Kingdom where concerns were again raised about his competence and health authorities' failure to adequately check the credentials of overseas medical staff.

Dr Jayant Patel is perhaps a more readily recognisable failure of credentialling standards. Dr Patel was employed at Bundaberg Hospital first as a staff surgical officer and then promoted to the director of surgery. A later internet search of Dr Patel revealed that his practice had been restricted in Oregon and New York, and that his licence had been revoked.

Fortunately, there have been few high-profile regulatory failures relating to allied health practitioners where credentials have not been appropriately verified or where practitioners have been found to be practising outside of their scope of practice. In general, registered complaints about allied health practitioners are low. Very few are escalated for decisions by the national board or adjudication bodies; even fewer result in a determination of professional misconduct, imposed conditions on a practitioner's registration or result in a practitioner's registration being cancelled under the national law. Access to published records of such matters for registered professions has improved since the national scheme was introduced in 2010. CSOP issues relating to allied health practitioners are usually dealt with at the local level.



Local challenges to credentialling and scope of practice

Within allied health, breaches to CSOP procedure are more likely to reflect immature CSOP processes or poor compliance with established processes.

The challenges for allied health are commonly related to the diversity of the workforce represented and the changing health environment in which they work. **Resource 1.14** outlines short scenarios that represent common allied health CSOP questions and how they might be resolved. These are intended to be a guide only. Actions taken between health services may vary.

Summary points

Core actions of the national standards are considered fundamental to safe practice; some relate to CSOP.

For registered professions, registration standards set by AHPRA play a key role in the 'threshold credentialling' of clinicians. Legislation also protects the titles and certain practices of registered professions.

For unregistered professions, a peak body (association) will usually define the threshold qualifications required for a practitioner to hold out as that profession. There is no legislative protection of titles for unregistered professions. Funding bodies may require that certain standards be met by health practitioners.

Regulatory failure is not common in the allied health professions, with very few escalations to adjudication bodies.

In general, CSOP issues relating to allied health practitioners are dealt with at the local level.

Credentiailling and defining scope of practice resources table

A summary of the CSOP tools, samples and appendices are included below. All the resources can be accessed electronically in the CSOP resource kit available on the Department of Health and Human Services website (www2.health.vic.gov.au).

CSOP resource name	Description or purpose
Tools	
1.1 Self-assessment tool: credentialling and scope of practice	Use this self-assessment tool to identify areas for targeted action by your health service. If you have identified an area of need please refer to the CSOP methodology section or access the other samples and tools to assist you in this process.
1.2 Decision tool: Is it standard clinical practice?	Use this tool to assist to determine which skills are considered 'standard' for your organisation. This will help guide decisions in situations where a hierarchy of skills is established to support CSOP processes.
Samples	
1.3 Sample: CSOP framework	This sample from Western Health represents a mature and broad framework for clinical governance and includes CSOP processes.
1.4 Sample: New appointment, re-appointment, change of scope of practice for individual allied health professionals	This sample form from Barwon Health provides a record of initial credentialling for new or (re)appointment purposes, including commonly applied parameters for this purpose. It is also adaptable for use when an individual applies to change their scope of practice.
1.5 Sample: Allied health CSOP procedure	This sample from Peninsula Health is a procedure related to allied health CSOP.
1.6 Sample: Credentialling and professional practice standards for allied health staff procedure	This sample from Bendigo Health outlines the credentials and professional practice standards required by allied health practitioners for employment.
1.7 Sample: Allied health: CSOP committee terms of reference	These samples from Western Health outlines the terms of reference for a committee with delegated roles and responsibilities for allied health CSOP.
1.8 Sample: Allied health: CSOP committee terms of reference	These samples from Monash Health outline the terms of reference for a committee with delegated roles and responsibilities for allied health CSOP.
1.9 Sample: Registration and credentialling procedure	This sample from Austin Health outlines a procedure related to allied health registration and credentialling.

CSOP resource name	Description or purpose
Samples (cont.)	
1.10 Sample: Application form for a change to scope of practice, credentials or the use of a new technology or clinical practice for professions	This sample from Monash Health is an application form that is used for professions to apply for a change to scope of practice or for the use of a new technology/ clinical process.
1.11 Sample: Application form for changes to individual scope of practice (allied health)	This sample from Monash Health is an application form that is used for individuals to apply for a change to scope of practice.
1.12 Sample: Scope of practice documentation (podiatry)	This sample from Monash Health is used to define the scope of practice for a profession group or an individual.
1.13 Generic allied health CSOP process diagram	This diagram shows the CSOP cycle for an individual within an organisation.
1.14 CSOP learnings from the workplace	These examples pose CSOP scenarios with proposed solutions to common issues.
1.15 Sample: Allied health advanced practice skills list	This list is an example of advanced practice skills, categorised by a health service using Resource 1.2 .

Case studies based on using Resource 1.2: Decision tool: 'Is it standard clinical practice?'	
1.	Dietitians Association of Australia: Gastrostomy feeding including tube replacement
2.	Gippsland Lakes Community Health: Dry needling by physiotherapists
3.	A metropolitan community health service: Interpretation of blood glucose readings and administration of appropriate actions in the event of hypoglycaemia or hyperglycaemia in diabetes mellitus clients for exercise physiologists
4.	Western Health: Intravenous (IV) cannulation by radiographers
5.	Western Health: Intradermal injections for lymphoscintigraphy
6.	A large metropolitan hospital: Pharmacist charting in the preadmission clinic

Resource 1.1: Self-assessment tool

Use this self-assessment tool before you progress through the rest of the CSOP section. It can be used to identify areas for targeted action. If you have identified an area of need please refer to the methodology section below to access information, samples and tools to assist you in this process.

CSOP criteria	Planned	Partly implemented	Established	Not applicable	Review date
1. Do you have defined roles and responsibilities for credentialling and defining a scope of practice?					/ /
2. Do you have a documented scope of practice for all identified professions?					/ /
3. Do you have documented processes for initial credentialling of an individual?					/ /
4. Do you have documented processes for initial defining of an individual's scope of practice ?					/ /
5. Do you have documented processes for re-credentialling individuals?					/ /
6. Do you have documented processes for reviewing an individual's scope of practice ?					/ /
7. Do you have documented processes for credentialling and defining the scope of practice of temporary appointments?					/ /
8. Do you have documented processes for credentialling and defining the scope of practice for brokered services ?					/ /
9. Do you have documented processes for introducing new technologies and clinical practice ?					/ /
10. Do you have documented processes for unplanned reviews ?					/ /
11. Do you have documented processes for appealing decisions regarding scope of practice?					/ /
12. Do you have documented terms of reference for all committees?					/ /

CSOP criteria	Planned	Partly implemented	Established	Not applicable	Review date
13. Do you have a documented process that articulates how committees work together?					/ /
14. Do you have templates for position descriptions?					/ /
15. Do you have a template for reference checks (verification of experience)?					/ /
16. Do you have a template for an annual performance review?					/ /
17. Do you have performance review documentation that includes a review of credentials and scope of practice?					/ /
18. Do you have a documented process in place to check data against a register of registered health practitioners?					/ /
19. Do you have a documented system for recording the scope of practice of individuals?					/ /
20. Do you have a documented system for recording the credentials of individuals?					/ /
21. Do you have a documented process to apply for expanded scope of practice?					/ /
22. Do you have a documented process for reviewing CSOP standards?					/ /
23. Do you have a documented process for responding to concerns regarding the conduct, health or performance of a registered health practitioner (notifiable conduct)?					/ /
24. Do you have a documented process for responding to concerns regarding the conduct, health or performance of a self-regulated or non-registered health practitioner?					/ /

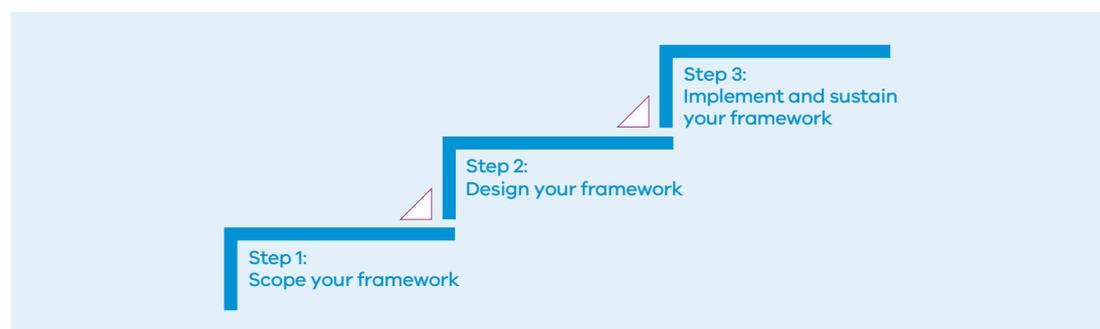
Methodology: How to implement a credentialling and defining scope of practice framework in your workplace

Reflective questions

- Why do you need a credentialling and defining scope of practice framework?
 - What problems are you trying to address?
 - Who do you consider to be the end user of the framework? Are there ways of engaging with them to assist you in understanding their needs?
 - Are there already complete or partial solutions available to you?
 - Who are your partners in developing the framework?
 - Who is in scope for the framework? (Consider individuals, third parties, profession groups, registered professions, non-registered professions, third parties, employees, students and volunteers.)
-

There are three steps in designing and implementing a credentialling and defining scope of practice framework for your organisation. These steps are outlined in **Figure 1.1**.

Figure 1.1: Designing and implementing a credentialling and defining the scope of clinical practice framework



Step 1: Scope your framework

Understand your needs

Before undertaking the task of developing a framework it is important to understand why you are doing it. Having a clearly articulated aim will assist in developing a framework that will truly benefit your organisation. A CSOP framework can help to stimulate culture changes within the workplace.

Building a framework for allied health is very different from building one for nursing or medicine because of the complexities of the workforce and the diverse range of regulatory actors in the regulatory space of allied health.

Depending on the work environment (private practice, private health networks, public health), how the workforce is regulated will be different given the different funding and revenue models, the types of allied health practitioners employed, the way in which health practitioners are employed and the range of services provided.

Credentiailling, as a workforce tool, may be used to restrict or expand the clinical practice of allied health practitioners. In the research report *Australia's health workforce*, released in 2005, the Productivity Commission highlighted that credentialling systems that involved the verification of qualifications, experience, professional standing and other professional attributes could be a better way of tailoring scopes of practice to a work environment and lead to the better utilisation of workforce competencies.

The NSQHS standards contain a criterion (1.10) and actions that are specific to credentialling and defining scope of practice.

Credentialling standards that are very specific to the single work environment may be an inhibitor to delegation or portability across work contexts, even within the same organisation.

Identify partners

It is most likely that your framework will need to satisfy a range of internal and external partners. Deciding who the likely end users are will help to focus who you need to partner with in designing the framework.

Most organisations will apply the framework to existing and future employees of the organisation. For an organisation that provides brokered services via a third party (individual or company), the framework may need to extend to how third parties are credentialled and how their scope of practice is defined and monitored.

Consideration should be given to how students and volunteers are credentialled within the organisation, as well as other aspects of on-boarding such as citing Working with Children Checks and vaccination status.

Human resources

Where the framework is being applied directly to employees, human resources (HR) departments have a wealth of experience in setting and measuring standards. HR departments have played a very traditional role in credentialling and defining scope of practice. HR tools such as position descriptions and advertisements often define the credentials and scope of practice required for a position. If your organisation has a defined HR department, it is important to consult with them and look at the range of tools and checks that are in place across the organisation.

Orthotics and prosthetics is a non-registered allied health science profession. The Australian Orthotic Prosthetic Association has published competency standards (2014) for entry into practice.

Speech pathology is another non-registered allied health profession. Speech Pathology Australia publishes guidelines and statements to guide members and organisations in making decisions about credentialling and scope of practice for the profession.

Corporate counsel

Where the framework is being applied to third parties, legal counsel or procurement will be able to provide information on how this is best done, and what defining and monitoring processes are consistent with the organisation's policy and procedures.

Education providers

The credentialling of students is often done in conjunction with the education provider, and should mirror the requirements of organisational employees. Consideration should be given to how student credentials will be recorded for organisational reference.

Health organisations

In both rural and metropolitan settings the processes of credentialling and defining scope of practice could be undertaken using a regional approach where there are agreed standards and joint committees or processes between healthcare organisations.

Step 1: Summary action

- Outline the aim of your framework.
- Outline the needs of the end user. (What will help them to use the framework to the fullest extent possible?)
- Outline the scope of your framework; list all the profession groups to be covered. (Will it include volunteers and students?)
- Gather information regarding the existing frameworks within and outside your organisation. (How do they work together? How can they be used to help design your framework?)
- Outline the any internal or external standards that need to be applied to you – quality, funding.



**MOVE
TO STEP 2**

A sample of a well-developed clinical governance framework that includes CSOP is included in **Resource 1.3**.

Step 2: Design your framework

Reflective questions

- What are the expectations of your organisation and your allied health practitioners regarding the framework?
 - What expectations of the framework do you think the community may have?
 - How will your organisation deal with dual qualifications?
 - Will practitioners be given a scope of practice or will they have to apply for their scope of practice?
 - What regulatory bodies have the most influence? (Consider funding bodies, AHPRA, associations and the public.)
 - Where can you look for existing standards?
 - How will you determine what standards to set or use?
 - When should individuals be credentialled (have their scope of practice defined)?
 - At what points of a practitioner's length of service will credentialling and defining the scope of practice be applied?
 - How will temporary appointments be considered under your framework?
 - At what point will students be credentialled and have their scope of practice defined?
-

Determine what standards to apply

Section 3(2) of the national law sets out the objectives of the national scheme:

- for the protection of the public by ensuring that only health practitioners who are suitably trained and qualified to practise in a competent and ethical manner are registered
- to facilitate workforce mobility
- to facilitate the provision of high-quality education and training of health practitioners
- to facilitate the assessment of overseas-trained health practitioners
- to facilitate access to services provided by health practitioners in accordance with the public interest
- to enable the continuous development of a flexible, responsive and sustainable Australian health workforce and to enable innovation in the education of, and service delivery by, health practitioners.

These objectives may be summarised in the three domains demonstrated in **Figure 1.2**. Defining the scope of practice is a fine balance between the needs, expectations and capabilities of the community, practitioners (as individuals and profession groups) and the organisation. These expectations and capabilities are further explored below and should be considered when developing the framework for your organisation, and in decision making. The needs, capabilities and expectations of each domain will vary depending on the context and environment in which the allied health practitioner practises.

Figure 1.2: Determining scope of practice



Needs, expectations and capabilities

Community

In all healthcare contexts (including private and public) there is an expectation that allied health practitioners have the training and qualifications required to practise in a competent and ethical manner, and that there is reasonable access to health services.

Organisational

Organisations expect that practitioners' training and qualifications to deliver services in a competent and ethical manner are in line with the clinical needs and capabilities of the organisation. Organisations may also reasonably expect that new procedures or technologies are introduced following consideration of their financial, safety, cost-benefit and operational impact, ensuring that the practice is based on best available evidence.

Practitioner

Practitioners often express a desire to practise to the fullest extent of their qualification, experience and capability and to develop their personal and profession potential. This is assisted when there are clear pathways articulated to support personal and professional development. Increasingly, practitioners want their acknowledged experience, capabilities and competence to move with them from one context to another without unreasonable limitation.

Approaches to credentialling

In many cases the threshold credential, or the qualification and/or experience required for a particular role, is well defined. This is the experience with most registered professions where requirements for registration are well articulated. This becomes less clear for non-registered professions, or when new technologies or procedures are being introduced to an organisation.

A range of standards are available for registered and non-registered professions. These standards are articulated by regulators within the allied health regulatory space. A list of regulators and examples of the instruments they use relevant to allied health practitioners or health organisations are outlined in **Table 1.1**. The formal and informal standards articulated by these regulators may be used as the basis for determining and articulating clear credentialling standards for your organisation.

Table 1.1: Regulators of allied health professions and services

	Regulators	How they regulate
Registered	<ul style="list-style-type: none"> • National registration boards • Associations • Private health insurers • Medicare • Funding bodies • Legislation • Insurers • Health Complaints Commissioner • Australian Competition and Consumer Commission • Therapeutic Goods Administration • Accreditation standards • Trade practices legislation • Pharmaceutical Benefits Scheme 	<ul style="list-style-type: none"> • Registration • Membership • Insurance • Contracts • Funding agreements • Accreditation and certification such as ACHS, NATA and DIAS accreditation • Code of conduct • Payment • Sanctions • Prosecution • Licensing such as through the Poisons Act and radiation use license
Non-registered	<ul style="list-style-type: none"> • Associations • Private health insurers • Medicare • Funding bodies • Legislation • Insurers • Health Complaints Commissioner • Therapeutic Goods Administration • Accreditation bodies • Trade practices legislation 	<ul style="list-style-type: none"> • Membership • Insurance • Contracts • Funding agreements • Accreditation and certification • Code of conduct • Payment • Sanctions • Prosecution

ACHS = Australian Council of Healthcare Standards; DIAS = Diagnostic Imaging Accreditation Scheme; NATA = National Association of Testing Authorities

Approaches to defining scope of practice

The *Standard for credentialing and defining the scope of clinical practice* (ACSQHC 2004) outlines a number of approaches to credentialling. These approaches are summarised in **Table 1.2**.

Organisations may choose to use the 'combination' approach, using either lists, categorisations or descriptions for various profession groups. For example, a highly procedural profession such as podiatry may be best suited to a checklist approach where each individual procedure or skill could be listed. **Resource 1.12** is a sample of scope of practice documentation (podiatry) in a checklist format. This sample is used to define the scope of practice for a profession group as well as an individual. In contrast a profession such as social work may lend itself more to a categorisation approach. A combination may also be used in designing the tools you will use during the credentialling process such as application forms and position descriptions.

Table 1.2: Approaches to defining scope of practice

Approach	Description	Use
Checklist	Lists of: <ul style="list-style-type: none">• services• procedures or other interventions• conditions	Procedural professions
Categorisation	Well-defined categories/levels of scope of clinical practice Identify major clinical services and interventions classified on the degree of complexity of the procedure or illness to be treated	Non-procedural professions or areas of practice
Descriptive	Narrative description of scope of practice	
Combination	A combination of any checklist, categorisation or description	

Source: ACSQHC 2004

Using the definitions of individual and profession scopes of practice provided earlier, we can see that an individual scope of practice is drawn from the profession scope of practice.

A shared understanding of the approach to be undertaken to document the scope of practice and how the scope of practice for the profession will shape the scope of practice for an individual is needed. This becomes a challenge when the individual's qualifications and experience are larger than the profession. This is depicted in **Figure 1.3**.

Figure 1.3: Relationship between individual and profession scopes of practice



Defining scope of practice is a dynamic exercise because healthcare, education, technology and community expectations are continually changing. The dynamic nature of clinical practice should be captured in the capacity of the framework to absorb and adapt to changes.

Establishing a reference group to periodically examine, challenge and determine the normative standards for the profession group is one way of capturing and reflecting the dynamic nature of change in healthcare.

In describing scope of practice a large variety of terms have been applied. Consistency and shared understanding is difficult.

The terms advanced and extended practice are commonly used by organisations and professions, often interchangeably. Organisations have used this terminology as a mechanism to define practice and guide decisions for organisational credentialling and recording purposes. Equally, organisations could use another term to describe elements of practice or clinical practice roles that will be restricted until an individual is authorised within an organisation. This restriction until authorised could reflect elements of practice considered as a vertical substitution, such as a specialised skill customarily performed by a doctor; or perhaps a horizontal substitution, with the usual scope of practice supplemented by translation of selected skills across occupational groups.

The Physiotherapy Association of Australia has adopted a definition of advanced practice that includes the notion of an advanced practice being within scope for the profession but notionally being seen as a substitution role (APA 2009). This definition appears to have been adopted by various registration boards under the national scheme.



The South Australian Department of Health (2013) policy document *The governance framework for advanced scope of practice and extended scope of practice roles in SA Health policy directive* defines advanced and extended practice in the following way:

Advanced scope of practice is a level of practice characterised by an increase in clinical skills, reasoning, critical thinking, knowledge and experience so that the practitioner is an expert working within the scope of established contemporary practice (The governance framework for advanced scope of practice and extended scope of practice roles in SA Health policy directive 2013, p. 4).

Extended scope of practice is a level of practice which incorporates practice beyond the established, contemporary scope of practice (The governance framework for advanced scope of practice and extended scope of practice roles in SA Health policy directive 2013, p. 5).

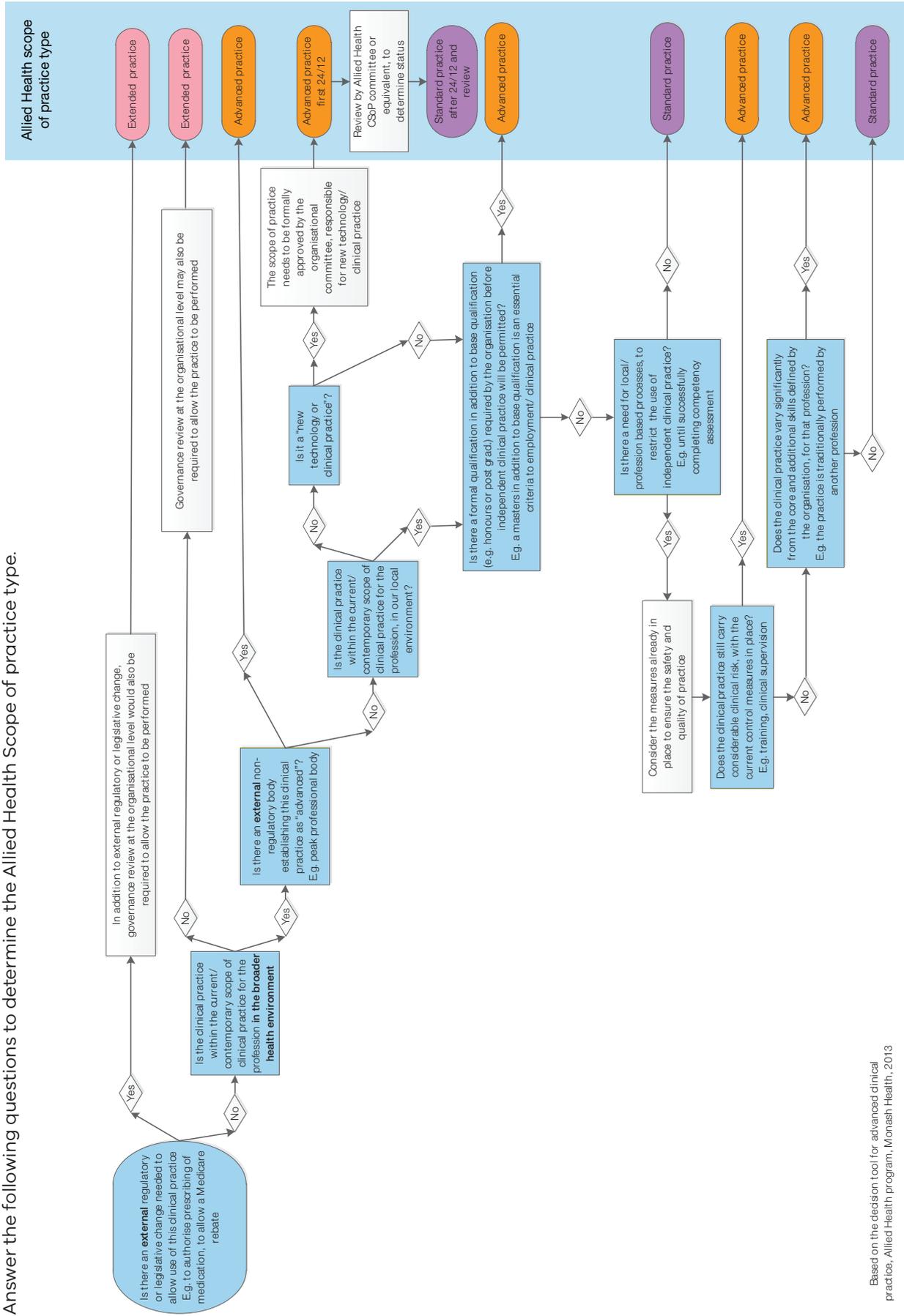
If the term advanced is used to describe/categorise clinical practice, then it is important to distinguish between advanced practice roles and advanced practice skills. Is it the advanced practice role or is it the advanced practice skill/task as part of a role that is to be credentialled, or is it both? Advanced skills or tasks that require credentialling may be applied more broadly within an organisation than just within the function of a role for example: the technique of fiberoptic endoscopic evaluation of swallowing (FEES) by speech pathologists is considered an advanced practice skill by Speech Pathology Australia and requires workplace credentialling. FEES could be applied by a speech pathologist working in an advanced practice role in a clinic setting, or it could be applied as a separate skill by a suitably credentialled clinician as part of everyday clinical practice on an inpatient ward. An advanced practice role is more than a particular skill or competency; it encompasses the underpinning knowledge, capability and technical expertise across an area or dimension of practice that provides the basis for independent clinical reasoning, diagnostic ability and professional judgment.

Determining what is standard practice, advanced practice and extended practice for any profession may be the subject of much debate where there is no clear assistance delivered through legislation or professional positions or standards. *Resource 1.2: Decision tool: Is it standard clinical practice?* was developed as one method to assist organisations in determining if a skill or role is standard, advanced or extended practice and can be used as a guide throughout the CSOP cycle. Organisations can then determine the implications of this categorisation within their credentialling and scope of practice framework.

This tool takes a risk-based approach to defining scope of practice, and notionally determines whether a practice is extended, advanced or standard. The tool guides the user through external and internal regulatory requirements, the existing scope of practice for a profession and whether or not the practice may be considered a new technology or clinical practice. It is reproduced here as well as in the resource kit for section 1.

Resource 1.2: Decision tool: Is it standard clinical practice?

Answer the following questions to determine the Allied Health Scope of practice type.



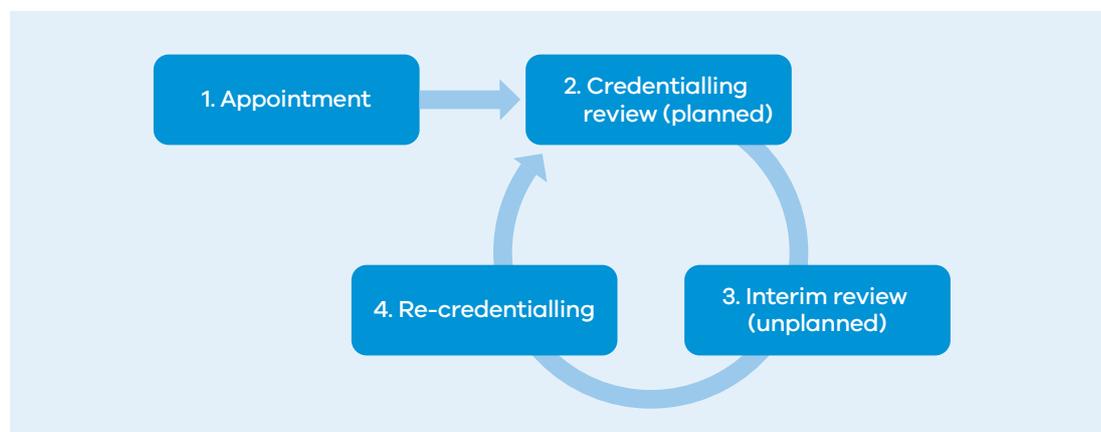
Based on the decision tool for advanced clinical practice, Allied Health program, Monash Health, 2013

Steps in the credentialling and defining scope of practice cycle

Credentialling and defining scope of practice is an ongoing process that begins prior to an allied health practitioner being employed with an organisation, and ends with their exit from the organisation. These processes are commonly set out in organisational frameworks and procedural documents. **Resource 1.5** and **Resource 1.6** are sample documents related to CSOP procedure.

The credentialling cycle is summarised in **Figure 1.4** and consists of four steps.

Figure 1.4: Credentialling and defining scope of practice cycle



1. Appointment

The processes of credentialling and defining scope of practice begins prior to the appointment of a suitable candidate.

Defining the credentials and scope of practice required

The process of appointment begins with reviewing the needs of the position and developing the position description to determine the parameters of the position being recruited to. Consideration should be given to the needs of the vacant position in relation to the requirements of the organisation.

As one of the tools available, the position description should reflect the CSOP requirements of the position being recruited to.

As part of the employment process applicants should be invited to provide their credentials and apply for a scope of practice.

Interviewing and appointing

The process of recruitment (including the interview, checking of references, sighting of qualifications, national police checks and Working with Children Checks) helps verify that the individual has appropriate credentials to fill the scope of practice. **Resource 1.4** is a sample form for initial credentialling. In the Victorian allied health workforce, initial credentialling commonly encompasses verification of the components listed in **Table 1.3**.

Table 1.3: Possible components of initial credentialling

Possible components
<input type="checkbox"/> Proof of identity (100-point test)
<input type="checkbox"/> Primary allied health qualification
<input type="checkbox"/> National registration check (registered professions) including currency and any conditions on registration
<input type="checkbox"/> Professional standards
<input type="checkbox"/> Professional association membership or eligibility for membership
<input type="checkbox"/> National police record check
<input type="checkbox"/> Current Working with Children Check (if applicable)
<input type="checkbox"/> Review of curriculum vitae, in particular relevant clinical experience and training for the role
<input type="checkbox"/> Referee check (current referees capable of giving a considered opinion regarding the applicant's clinical skills, competence and suitability for the position)
<input type="checkbox"/> Other documentation specific to the role such as a postgraduate qualification to support proposed advanced scope of practice and/or a current driver's licence
<input type="checkbox"/> Copy of current medical indemnity certificate (if applicable)
<input type="checkbox"/> Work visa (if applicable)
<input type="checkbox"/> Profession re-entry requirements (if applicable)
<input type="checkbox"/> Radiation Use Licence (if applicable)
<input type="checkbox"/> Satisfy specific requirements for the role

Where there is not an exact match, the individual's scope of practice may be 'restricted' to match their credentials and experience. The practitioner would then be supported to undertake independent practice in the required areas. This may also apply where there are any restrictions or limitations on an individual's registration.

Registration boards may place conditions on registrations when a registration is new, or if there has been a prolonged period of absence from working within the profession. This may require a period of supervised practice before the condition is removed from registration.

Urgent appointments

Appointing staff at short notice (such as locums) may require a shortened credentialling process, with a temporary scope of practice involving the minimum requirements of the role granted. The basic credentialling elements of verifying qualifications and/or experience remain consistent with a permanent member of staff.



Observational placements

Observational placements are often short-term and do not involve direct patient contact. As part of the initial 'credentialling' process the insurance status of an individual seeking placement may be required. This might be in addition to other placement requirements such as a Working with Children Check, confidentiality statements and confirmation of identity.

Brokerage and third-party contractors

Where services are provided by third parties that are not under the direct control of the purchasing organisation, consideration should be given to what standards the providers will be held to, and how the credentials of the providers will be verified and recorded.

When constructing the tender specifications and/or contract, these elements, as well as the intended scope of practice and how these will be monitored and verified through the life of the agreement, should be included in the terms of the agreement.

Third-party providers may be sole practitioners or large multi-practitioner or multi-modality providers. Consideration should be given to whether each employee or subcontractor to the third party is required to be credentialled by the provider organisation, or if a declaration of compliance from the third-party provider is adequate.

If you are a purchasing organisation, talking with your procurement and/or corporate counsel will assist you in developing an approach to credentialling and defining scope of practice.

If you are a third-party provider, ensuring you have a thorough understanding of the needs and requirements of the purchasing organisation and their accreditation standards is vital to providing a quality service.

2. Credentialling review (planned)

A credentialling review is a formal review of a practitioner's credentials and scope of practice to ensure the needs and capabilities of the organisation, community and practitioner are in alignment and that the practitioner has maintained their qualifications and competencies to support their scope of practice.

Many organisations conduct this credentialling review as part of a practitioner's annual performance review. For registered professions, the annual review includes verifying their registration status and identifying any conditions or limitations on registration. For non-registered professions this may include continuing professional development undertaken and therefore their membership or eligibility status for membership of a professional association.

It is not uncommon for a more frequent review of registration status and any registration conditions to be conducted by organisations. This can involve using pre-populated data that is then matched against AHPRA's register of practitioners. It alerts the organisation to a lapse or change in registration status for those practitioners whose continued clinical practice is conditional upon it.

3. Interim review (unplanned)

Interim reviews of scope of practice are conducted as required. An interim review may be required for any one or more of the following reasons:

- an allied health practitioner requests to increase their scope of practice
- there are changes in the organisation's ability to provide support services
 - a change to the credential standards or scope of practice for a profession
 - a new technology or clinical practice is introduced
 - an existing technology or clinical practice is being used in a novel way
- the requirements of the organisation have changed
- there are concerns regarding the practitioner's performance or competence
- the individual has acquired or demonstrates skills beyond standard practice
- there is a change to the clinical supervision available
- there is a change to the job role and the practice skills required – for example, a grade 1 physiotherapist in an acute tertiary hospital changes from a rotation in orthopaedics to one in cardiorespiratory in the intensive care unit.

Where there are specific concerns about the competence of an individual, this should be referred to and dealt with under the organisation's local policy and procedure and within the delegated role of the credentialling and defining scope of practice committee, or other committees. Notification requirements under the national scheme or peak body should also be taken into consideration and acted on as appropriate.

Common triggers for an interim review may require an application to the responsible committee. Sample documents showing application forms that might be used to support these interim reviews are included as **Resource 1.10** and **Resource 1.11**.

4. Re-credentialling

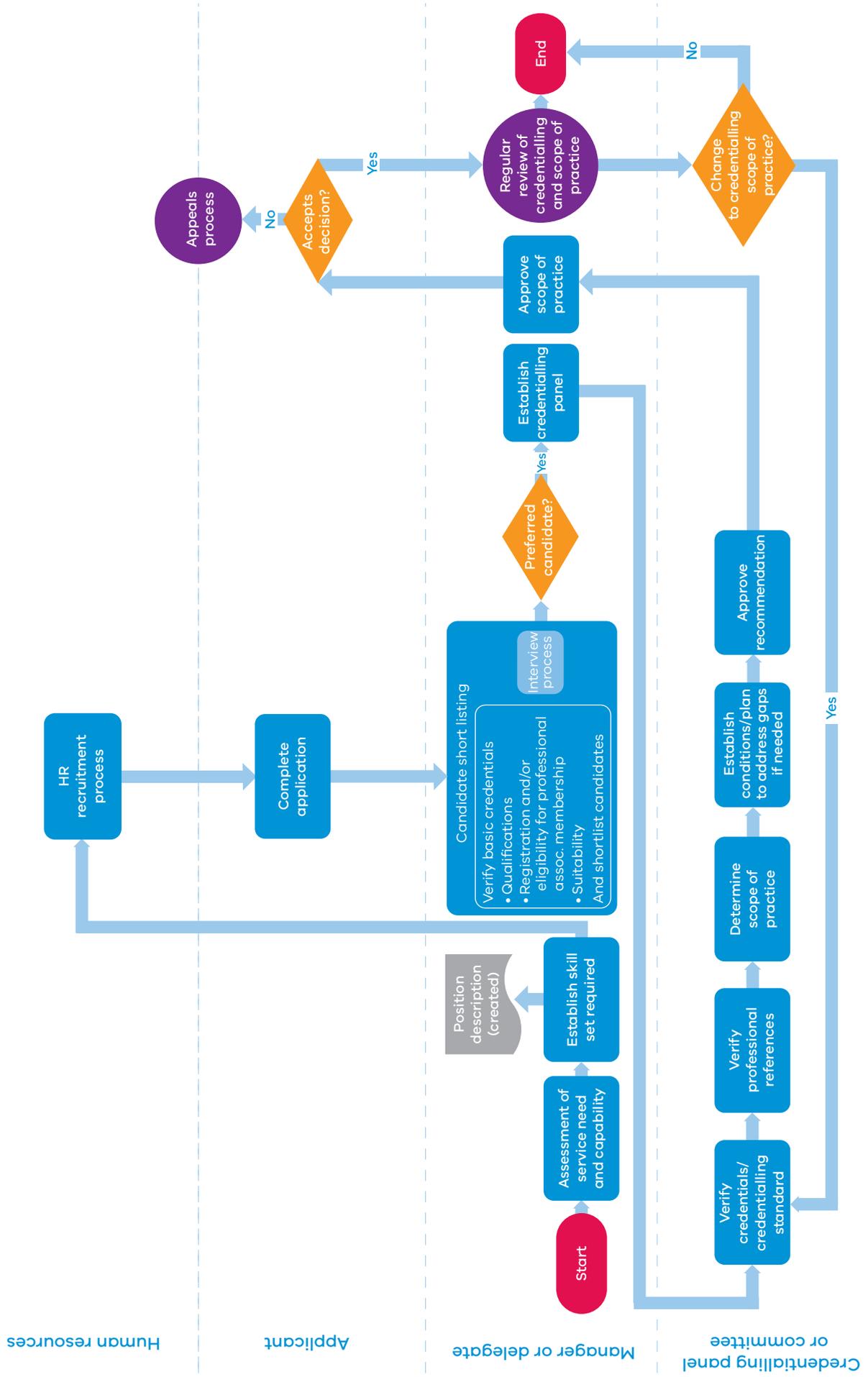
This process confirms the credentials and scope of practice of the individual against the functions of the position and provides an opportunity to review the profession's scope of practice against recognised standards.

This should be completed at least every five years or more frequently as appropriate. The frequency of re-credentialling is largely dependent on the rate of change within a profession, and assists in ensuring that practice remains contemporary.

This process may be superseded if planned or unplanned reviews have already been conducted within the timeframe and cover the parameters of the re-credentialling process. This is particularly relevant for non-registered professions not aligned with any professional association or where a profession's scope of practice is rapidly changing.

There are many parts to this process. A generic allied health process for credentialling and defining the scope of practice for an individual is depicted in **Resource 1.13**.

Resource 1.11: Generic allied health process for credentialling and defining the scope of practice of an individual



Step 2: Summary action

- List the steps in your CSOP cycle. (Are they the same for each of your professions, groups, volunteers and students?)
- Document the standards for each of your discipline groups. Forming reference groups may assist in setting and understanding standards, and how individual scope of practice relates to the scope of practice for a profession.



**MOVE
TO STEP 3**

Step 3: Implement and sustain your framework

Reflective questions

- How will credentials and scope of practice be recorded?
- Who has the overarching governance responsibility for allied health credentialling and scope of practice in your organisation?
- Does the governance of the framework need to be overseen by a committee structure?
- Who are the right people to involve in the ongoing processes?

Recording

There are a number of ways to record CSOP. This may range from the individual's position description to local or online databases. Various proprietary products are available for this task as either online or stand-alone databases. Simple spreadsheets may be adequate for recording the level of data required.

Deciding what to record and how to record it may be a complex task and will be dependent on how you have chosen to approach both credentialling and defining scope of practice, and the tools you have available to you.

One approach to determining what will be recorded is to develop a hierarchy of elements or clinical practices for inclusion in a database. A limited example is provided as **Table 1.4**. This example accepts the standard scope of practice for each profession and only records elements or clinical practices where the individual scope of practice would be absolutely restricted unless an additional layer of verification is undertaken. These practices may require an additional qualification, training or formal demonstration of competency prior to an individual's scope of practice being expanded to include it.

Table 1.4: Hierarchy of skills

Profession	Credentialed practice elements or clinical practices
Physiotherapy	Dry needling
	Acupuncture
Podiatry	Podiatric surgeon
	Endorsed prescriber
Financial counselling	Accredited supervisor
Radiography	Peripheral insertion of central catheter (PICC insertion)
Pharmacy	Partnered Pharmacy Medication Charting

Roles and responsibilities

A number of staff members will be responsible for the ongoing delivery and maintenance of the framework. This will be most effective where there are clear and documented roles and responsibilities for the organisation through every step of the CSOP cycle.

Committee structures and decision making

Committees constituted under the CSOP framework should operate within a sound ethical and legal framework. Committees should operate without conflicts of interest or bias, and according to the principles of natural justice (Department of Health 2011).

Natural justice, or procedural fairness, refers to the right of a fair hearing by an unbiased decision-maker; this is of particular importance in considering matters relating to CSOP as there is potential to adversely affect a person's rights, interests and legitimate expectations.

The principles of procedural fairness ensure an individual has the right to:

- be heard
- receive notice of matters to be dealt with
- representation
- make decisions
- state their case
- have the matter dealt with in a timely manner.

The right to make a decision restricting professional practice may be governed by the organisation's delegation authority.

Like any good framework it will require routine maintenance and ongoing development. Consideration should be given to who and what is responsible for the ongoing development of the framework.

Credentiailling and scope of practice committee

The functions of verifying credentials and defining the scope of practice could take place at multiple points in an organisation or within a region. These functions can be centralised by, for example, using a committee structure, or they can be decentralised by, for example, utilising line managers.

Most organisations that employ medical staff have a formalised CSOP committee that has the responsibility for verifying credentials and defining scope of practice for new starters, as well as staff who would like to expand their scope of practice.

The medical model demonstrates an example of a centralised model. What aspects of this model work or don't work within your organisation?

The nature of the committee will be dependent on the perspective adopted by the organisation, and whether or not scope of practice is determined primarily for the individual or for the individual within a profession group.



The committee may have a decision-making or recommending role. Decisions relating to CSOP should be made on review of the merits of application, balancing organisational needs, resourcing, client benefits and safety and professional needs and capacity. Any decisions about credentialling and defining scope of practice must be in compliance with any laws and must be well documented.

Case study

One large Melbourne metropolitan health service uses a decentralised model for credentialling and defining the scope of practice of its allied health practitioners. The responsibility for aspects of the framework is devolved throughout the organisation.

Line managers have responsibility for making local decisions as to whether an individual demonstrates the appropriate level of qualification or experience to expand their scope of practice within the defined scope for a profession against a defined credentialling standard. Line managers make the decisions regarding appointment and whether applicants are appropriate as defined by the position description.

The CSOP committee considers applications to expand scope of practice for profession groups, including when a clinical practice is to be considered by the New Technology and Clinical Practice Committee. The committee has an advisory role and forms recommendations for the allied health executive.

What could be the strengths or weaknesses of this approach for your environment?

New technology and clinical practice committee

New technology or clinical practice is a therapeutic intervention or diagnostic procedure that is considered by a reasonable body of clinical opinion to be significantly different from existing clinical practice. It includes a procedure that has not been performed within the organisation, as well as any variation to an existing procedure or treatment where a new device or item or equipment is introduced, including situations where new devices are provided by manufacturers without charge. A new technology or clinical practice does not include a situation where a clinician proposes to use a technology or clinical practice that is already being undertaken within the organisation but has not been previously used by that clinician.

Regardless of the context of your organisation, consideration should be given to the risks and cost-benefits of introducing a new technology or clinical practice and the threshold credentials required to introduce the technology or practice safely. The threshold credentials may include ensuring that using the technology or clinical practice is included within the allied health practitioner's indemnity insurance. The scope of practice associated with the new technology may require the scope of practice for an individual or profession to be amended on a temporary or probationary basis while the technology or clinical practice is evaluated against a set of criteria.

Most public health organisations will have a committee that considers the safe introduction of new technologies or clinical practices.

Is there an opportunity for allied health to join an existing committee structure? Or will separate structures need to be established to oversee a new technology or clinical practice?

The requirements for introducing a new technology or clinical practice should be documented in a policy or procedure document.

Review, appeals processes and committees

The review and appeals process, represented in **Figure 1.5**, is activated when an individual is not satisfied with the outcome of an original or reviewed decision. Individuals should be made aware of the appeals process throughout the CSOP process.

Initial review

During the initial (internal) review the practitioner is able to present new information that was not previously provided to the decision-maker for consideration. On review of the information the committee or manager then makes a decision on the merits of the application in the usual way. Applications to have the original decision reviewed are usually made in writing.

Appeal

The appeal, usually in writing, is then escalated to a committee structure to deal specifically with the individual's appeal. The process to appeal a decision should be clearly articulated and, again, the rules of procedural fairness applied.

The appeals committee should act independently of the original decision-maker and be convened in response to a grievance raised by an individual who has had their scope of practice modified or their application to increase their scope of practice rejected.

In making a decision the appeal committee reconsiders the facts and policy aspects of the original decision. The original decision may be affirmed, varied or set aside. Any decisions or recommendations made by the appeals body should be in accordance with the organisation's decision-making delegation.

The practitioner may request representation during an appeals process.

Figure 1.5: Review and appeal process





Step 3: Summary action

- Clearly articulate and document the governance structure for your framework.
- Establish clear terms of reference that outline the roles and responsibilities for each committee.
- Ensure members of committees understand their roles and the requirement to make decisions in a fair and transparent manner without bias.
- Clearly articulate and document the relationship between committees.
- Clearly articulate and document the delegation and decision-making process.
- Document the grievance procedure for staff to appeal a decision made about their individual scope of practice.

Supporting evidence and learnings

Key policy, regulation and law

The published literature and regulation to support the framework has been referred to throughout this document. In addition, current practices in the allied health workplace were captured during the consultation phase of the project to support the framework presented here. Key sources informing the CSOP framework are listed in **Table 1.5**.

Table 1.5: Key sources informing the CSOP framework

Key sources
Australian Commission on Safety and Quality in Health Care (ACSQHC) 2012, <i>National safety and quality health service standards</i> , ACSQHC, Sydney
Australian Council for Safety and Quality in Health Care 2004, <i>National standard for credentialling and defining scope of clinical practice</i> , ACSQHC, Canberra
Australian Health Practitioner Regulation Agency
Department of Health 2011, <i>Credentialling and defining the scope of clinical practice for medical practitioners in Victorian health services – a policy handbook</i> , State Government of Victoria, Melbourne
Department of Health 2012, <i>Supervision and delegation framework for allied health assistants</i> , State Government of Victoria, Melbourne
<i>Health Practitioner Regulation National Law Act 2009 (Vic)</i>
Professional association position statements and policy
Department of Human Services 2008, <i>Victorian clinical governance policy framework</i> , State Government of Victoria, Melbourne
Government of South Australia 2013, <i>Authenticating SA Health allied health professionals' credentials</i> , SA Health, Adelaide
Victorian Healthcare Association 2007, <i>How to guide for credentialling and scope of practice in community health</i> , Victorian Healthcare Association, Melbourne

Decision tool refinement

Resource 1.2: Is it standard clinical practice? was originally developed by the allied health CSOP committee at Monash Health and trialed with multiple profession groups to establish a list of 'advanced' clinical practices that would have specific credentialling standards developed and be included in an e-credentialling system. It is likely that the list of 'advanced' clinical practices established within one organisation will vary from that of another. An example list is available in **Resource 1.13**.

The metropolitan and regional forums within the project also provided feedback on **Resource 1.2**. In the main, the tool was considered useful, with some recommendations made by the group regarding formatting, wording and instructions for use.

Learnings from the workplace

Resource 1.14 outlines short scenarios that represent common allied health CSOP questions and how they might be resolved from learnings in the workplace. These are intended to be a guide only. Actions taken between health services may vary.

Resource 1.14: CSOP learnings from the workplace

CSOP scenario		Identified issue and action taken by the health service organisation
Regulatory compliance		
1.	A clinician from a nationally registered health profession is unaware that the currency of their registration has lapsed. The health service organisation is alerted by a routine monthly check of national registration. The clinician arrives at work.	<p>Issue: The clinician has a responsibility to maintain their registered status and inform their employee if this status changes for any reason.</p> <p>Action: The clinician must be prevented from providing clinical services until their registration is reinstated.</p>
2.	A psychologist applies for a position as a 'neuropsychologist'. They are registered with AHPRA as a psychologist but do not have any endorsement(s) on their registration. The interview panel selects them as the preferred candidate for the position with the title of 'neuropsychologist'.	<p>Issue: The position description listed being a registered psychologist as the only essential criteria. The interview panel was uninformed about the threshold credentials mandatory for this job role and title and the implications under national law. The national law prohibits unregistered persons knowingly or recklessly taking or using a title. Using a protected title falsely or holding yourself out to be registered may be an offence under the national law. This duty extends to others holding out that a practitioner is registered under the national scheme.</p> <p>Action: The psychologist could not be employed as a 'neuropsychologist'. There is potential in this case for the individual or organisation to be convicted of an offence under national law.</p>
3.	A podiatrist with overseas training applies for a position in a rural community-based service. The position has been difficult to recruit to. The interview panel consists of human resources personnel and a doctor.	<p>Issue: National registration is mandatory for working as a podiatrist in Australia.</p> <p>Action: The AHPRA register is checked and the podiatrist is not a registered clinician. They are ineligible to work in Australia until they have met the national registration requirements for podiatrists.</p>
4.	An experienced speech pathologist applies for a position in a community rehabilitation centre. The manager is an occupational therapist.	<p>Issue: Speech pathology is not a registered profession. Clinicians must be eligible for membership of the professional association, Speech Pathology Australia, or be a member. Eligibility requires that an individual meets the association's entry standards for the membership category they are applying for. For example, a practising member must have worked a minimum of 1,000 hours in speech pathology practice in the preceding five years.</p> <p>Action: Check that the speech pathologist is a member of Speech Pathology Australia. If so, they are able to work as a speech pathologist. If not, check their resume to ascertain where the clinician has worked in the preceding five years. If, for example, the clinician has worked full time in an unrelated vocation for the past six years, they will need to contact Speech Pathology Australia to undertake a re-entry program. In this case they would be currently ineligible to work as a speech pathologist.</p>

CSOP scenario	Identified issue and action taken by the health service organisation
Regulatory compliance (cont.)	
<p>5. A new graduate social worker applies for a position in a metropolitan hospital. The manager of the position is a social worker.</p>	<p>Issue: Social work is not a registered profession. The professional association is the Australian Association of Social Workers (AASW). Many employers in Australia require social worker job applicants to be <i>eligible</i> for AASW membership.</p> <p>Action: For Australian trained social workers, an AASW-accredited Bachelor of Social Work or Master of Social Work (qualifying) is required for entry into the profession of social work, and to meet the minimum eligibility requirements for AASW membership. For social workers who have studied outside Australia, the process of determining AASW membership eligibility is conducted through an assessment of the social work qualification(s) and any post-qualifying social work experience an applicant might have.</p>
<p>6. An experienced speech pathologist with overseas training applies for a position in a community-based program. The team leader is a nurse.</p>	<p>Issue: Speech pathology is not a registered profession. Overseas-trained clinicians must be approved and be members of the professional association, Speech Pathology Australia.</p> <p>Action: Check they are a member of Speech Pathology Australia. If not, they are ineligible to work as a speech pathologist.</p>
<p>7. A podiatrist in private practice advertises as an 'acupuncturist' and, while having substantial training in this area of practice, does not have an endorsement on their registration from the Podiatry Board of Australia.</p>	<p>Issue: There are penalties for falsely using protected titles under the national law. Depending on the individual circumstances, a person may be investigated for holding themselves out, and therefore be prosecuted under the national law.</p> <p>Action: A complaint is made to AHPRA and the clinician is required to remove all reference to the title 'acupuncturist'.</p>
AHA CSOP, supervision and delegation	
<p>8. A grade 3 allied health assistant (AHA) working in dementia and delirium support in an acute medical ward setting is delegated tasks and operationally supervised by a nurse unit manager.</p>	<p>Issue: The work of an AHA must be supervised and delegated by an allied health practitioner (AHP). This is a requisite of their work practice as outlined in their qualification and the <i>Supervision and delegation framework for allied health assistants</i> (Department of Health 2012).</p> <p>Action: After a mapping exercise that reviewed the tasks performed, the individual's scope of practice in the work role, the supervision and delegation processes being applied and the range of qualifications and experience necessary to meet the requirements of the job, the work role was reclassified and the practitioner was no longer under the professional governance of allied health.</p>
<p>9. A medical staff member routinely uses an AHA to position patients in preparation for a procedure performed while the patient is sedated. The work is directed by a doctor who is unaware of the supervision and delegation requirements of the AHA workforce.</p>	<p>Issue: The work of an AHA must be supervised and delegated by an AHP. This is a requisite of their work practice as outlined in their qualification and the <i>Supervision and delegation framework for allied health assistants</i> (Department of Health 2012).</p> <p>Action: The requirements of supervision and delegation of the AHA workforce is outlined, and alternate workers are used to undertake the task.</p>

CSOP scenario	Identified issue and action taken by the health service organisation
AHA CSOP, supervision and delegation (cont.)	
<p>10. A grade 3 AHA, with a Certificate IV in Allied Health Assistance including a physiotherapy specialisation, is employed to be part of a multidisciplinary AHA team. The new work role includes dysphagia screening delegated and supervised by the speech pathologist.</p>	<p>Issue: While the core and prerequisite units for a Certificate IV in AHA are mandated, the electives are not; individuals holding this qualification will vary considerably in their specific skill and knowledge base. Even if assistants have the Cert. IV in AHA with a speech and dietetics specialisation, they may not meet the performance standard required of the organisation for a specific practice such as dysphagia screening.</p> <p>Action: The certificate of attainment of the AHA's qualification is reviewed to establish the units of competency completed. The health service organisation determines the threshold credentials for an AHA using this skill (for example, employed as a grade 3 and Cert. IV in AHA). The AHA completes the specialisation with a registered training organisation and/or undergoes competency-based training and assessment in the workplace. The AHA is then credentialled for the practice, and this is recorded by the organisation.</p>
<p>11. An AHA with a dual qualification (Cert. IV in AHA and division 2 nurse) is employed in a multidisciplinary AHA role that includes assisting a podiatrist in annual, basic foot health screening and low-risk nail care in a residential care service. Clients to the service are triaged to the AHA or the podiatrist. The procedure relating to this service is clearly defined as 'low risk' and excludes patients without intact skin. Many clients to the service have foot wounds that require monitoring by a podiatrist. The AHA is keen to draw on her nursing qualification and to use her skills in this area and reduce the waiting time for patients triaged as requiring a podiatrist.</p>	<p>Issue: The AHA is employed to a job role as an AHA, not as a nurse. The scope of practice for the individual is defined currently by the position description. Wound management is beyond the scope of the employed job role and that of an AHA.</p> <p>Action: The AHA is unable to change her individual scope of practice in this case unless a service review finds there is a benefit to a change in the job role and the position description is reviewed to indicate criteria requesting the dual qualification. In this case currency of registration with AHPRA as a nurse would also be required.</p>
New technology or clinical practice	
<p>12. A new piece of evidence-based equipment, used in other health service organisations but not previously used within this organisation, is purchased with the assumption that it can be used in practice, provided it is supported by education of staff.</p>	<p>Issue: The introduction of a new piece of equipment not previously used within an organisation is considered to be a 'new technology or clinical practice', and the safe introduction of this requires approval through the established channels.</p> <p>Action: The parameters for introducing and evaluating the equipment are set out by the responsible organisational committee for the safe introduction of new technologies and clinical practice. Training to support competency attainment is developed, in addition to a procedure. After evaluation of its use the equipment is approved for ongoing application.</p>
<p>13. A clinician attends an accredited training program through their peak body and learns a new practice – dry needling. The clinical practice is applied widely in other health service organisations but has not been used within this one by any profession.</p>	<p>Issue: The introduction of a clinical practice not previously used within an organisation is considered to be a 'new technology or clinical practice', and the safe introduction of this requires approval through the established channels.</p> <p>Action: The parameters for the safe introduction of new technologies and clinical practice are set out by the responsible organisational committee. A credentialling standard is set for the clinical practice, which includes a review of the eligibility of various professions to apply for this 'advanced scope of practice' and the formal/informal training and experience required.</p>

CSOP scenario	Identified issue and action taken by the health service organisation
AHP scope of practice change	
<p>14. A skill such as electrotherapy is clearly within scope for one profession (for example, physiotherapy). This is supported by undergraduate theory and practicum, reflected in scope of practice documentation and is traditionally performed by this occupational group in the broader health setting.</p> <p>Another profession group without the undergraduate training or supporting scope of practice documentation is using it. There are identified risks attached to the skills. Use by this profession in specific patient groups and context is gaining momentum in the broader health environment and is supported by a strong evidence base.</p>	<p>Issue: The skill is being applied in the workplace and supported by informal education, but it varies considerably from the scope of practice documentation for that profession and there is no documented standard for verifying the credentials and/or competency of the skill.</p> <p>Action: The organisation develops a credentialling standard that outlines the prerequisite courses, external training and/or experience acceptable to support credentialling of a practitioner.</p> <p>A competency-based training and assessment program for the organisation is developed as an alternate credentialling mechanism for this skill.</p> <p>Until the clinician is credentialled for independent practice, clinical supervision is provided by a physiotherapist.</p>
<p>15. An established physiotherapist-led osteoarthritis hip and knee service in a regional centre is recruiting to a clinical service delivery role. This is supported by a clinical lead advanced musculoskeletal physiotherapist. The desirable criteria for the position include a Master of Musculoskeletal Physiotherapy. The preferred candidate has significant (seven years) relevant clinical experience but no master's qualification. The service has an established training and clinical supervision program, which is based on the department's clinical education framework for advanced musculoskeletal physiotherapy.</p>	<p>Issue: Apart from being a registered physiotherapist, any other essential criteria for this position is not externally regulated.</p> <p>Action: The preferred candidate is employed by the organisation with increased levels of clinical supervision until an assessment of competence has been made to the satisfaction of the organisation. The workplace training is based on the department's clinical education framework for advanced musculoskeletal physiotherapy, as it applies to an osteoarthritis hip and knee service.</p>
<p>16. Dietitians in a health service wanted to be able to prescribe nutritional supplements as a medication on medication charts. Previously these supplements had been recommended by the dietitian in the patient's health record and were required to be documented on the medication chart by a medical officer. Relying on documentation by medical staff led to delays in prescription and hence administration.</p>	<p>Issue: The applied skills were beyond standard practice for their profession in addition to requiring internal regulatory change to allow the practice.</p> <p>Action: An application to the responsible committee was made, a credentialling standard was set and a training program run by the pharmacy department was used to assess each dietitian's competency in this skill area. A procedure supports this practice, and it is represented on a profession-specific credentialling document as a skill that will be credentialled by the organisation.</p>

CSOP scenario	Identified issue and action taken by the health service organisation
AHP scope of practice change (cont.)	
<p>17. Diagnosing and managing simple fractures by an advanced musculoskeletal physiotherapist in the emergency department is a skill traditionally performed by medical staff. A new advanced practice role for a physiotherapist was introduced to the organisation that requires physiotherapists to provide primary care to patients with simple fractures in line with clinical guidelines. The physiotherapist can request imaging if authorised by the emergency department director.</p>	<p>Issue: The applied skills are beyond standard practice for physiotherapists. Diagnosis and management of simple fractures is usually carried out by a doctor in the emergency department.</p> <p>Action: With the introduction of an advanced practice role that included this skill, a credentialling standard was set, which included: a review of postgraduate qualifications and experience; a structured competency-based training and assessment process based on the department's clinical education framework; and the establishment of a clear clinical supervision process using senior medical staff as supervisors. The competency framework implemented uses a variety of evidence to support competency assessment including case-based presentations targeted to different presentations, direct workplace observation, periodic documentation audits and an established review period where x-ray interpretation for every patient is reviewed by a senior doctor.</p> <p>Radiation safety training prior to initiating imaging requests is undertaken by the therapist. The prescription of medication in the emergency department, or that which is required for discharge such as analgesics, is conducted by the senior medical staff in consultation with and on request by the physiotherapist.</p>
Translation of skills across allied health professional groups	
<p>18. The organisation requires clinicians employed into a generic role such as care coordination to have a set of core clinical skills that are important to meet waiting time targets in the emergency department. Each of the core skills required are traditional scope of practice for one or more professions, but not for all. Clinicians are concerned their specialised skills will be undermined by parts of their traditional scope of practice being extended to other professions.</p>	<p>Issue: The required core skill may not be within the standard scope of practice for the profession and may be considered to be advanced, extended or not appropriate based on threshold qualifications.</p> <p>Action: The health service adjusts the scope of practice for each profession, with approval through the responsible committee. The credentialling requirements for each core skill as it applies to each profession is determined, strict patient inclusion and exclusion criteria are negotiated and performance standards are set to outline the expected level of performance and to direct workplace training and assessment. Clinical audits are used to evaluate the change in scope.</p>

CSOP scenario	Identified issue and action taken by the health service organisation
<p data-bbox="188 1890 209 2078">Return to work</p> <p data-bbox="240 1323 427 2078">19. A physiotherapist returns to work after a long absence. She is recruited with a three-month probationary period into a regional community health service. The physiotherapist qualified in the 1970s with a diploma and has limited AHPRA registration due to a long absence from the profession.</p>	<p data-bbox="240 232 331 1323">Issue: During the employee's three-month probation period, management discovers the employee has not participated in any structured professional development since graduating and concerns about her competency are raised.</p> <p data-bbox="344 232 435 1323">Action: Management review her current skills and knowledge, which results in a determination that she is 'not considered to be competent compared with today's standards'. The employee is not offered employment beyond the probationary period.</p> <p data-bbox="448 232 539 1323">To assess her competency, management uses clinical questioning, reviews of clinical notes, supervision of treatment sessions and consumer feedback. This review involves experienced physiotherapists. After deliberation, no complaint is formally submitted to AHPRA.</p> <p data-bbox="552 232 675 1323">The service feels that 'access to competency tools and standards would have provided a more objective and clear structure to assessing competency'. They also feel that 'utilisation of a robust credentialling system would have identified these skill and knowledge deficits at the initial recruitment phase'.</p> <p data-bbox="687 232 746 1323">Referring to profession-specific professional standards would have also provided a benchmark for decision making.</p>

Challenges

Developing and implementing a credentialling and defining scope of practice framework for your organisation may produce a series of challenges.

Definitions

The *Standard for credentialling and defining the scope of clinical practice* (ACSQHC 2004) provides definitions for both credentialling and scope of practice. There is little consensus beyond these two definitions of many of the commonly used terms in the field of credentialling. This document has used definitions from allied health, nursing and medicine to develop the concepts of expanding practice.

Your organisation may have different definitions in common usage.

Scope

Traditional credentialling and defining scope of practice frameworks deal with staff. Quality standards and concepts of duty of care mean that the scope of CSOP frameworks must extend beyond the traditional employee to contractors, students and volunteers.

Registered and non-registered professions

Setting standards is often easier for professions regulated by legislation, compared with self-regulated professions. Using a reference group for both registered and non-registered professions assists in challenging norms and establishing standards that are realistic, representative and pragmatic. Ensuring there is representation from professional groups additionally increases buy-in into CSOP processes from staff.

Conflict of Interest

The processes of credentialling and defining scope of practice balance the competing interests of community, organisation and the allied health practitioner. Managing conflicts of interest or potential conflicts of interest is essential to building a framework that is fair, transparent and equitable. This is applicable in reference groups as much as committees.

Multiple qualifications

In building a skilled and flexible workforce allied health practitioners with skill sets in multiple areas are an attractive addition to the workforce. Managing scope of practice for these individuals can be a challenge. Coming back to first principles, and understanding the role and how the role may be developed within the scope of practice for the specified profession, may assist in determining how scope of practice may be defined for these individuals.

Credentiailling appendix

Appendix	Title
1.1	National quality and safety standards relevant to allied health credentialling and scope of practice
1.2	Protected titles and practices (all health practitioners) under the national law

Appendix 1.1: Quality and safety standards relevant to allied health credentialling and scope of practice

Standard	Standard/criterion/principle	Actions/expected outcome
National quality and safety standards (ACSQHC 2012)	1.10 Implementing a system that determines and regularly reviews the roles, responsibilities, accountabilities and scope of practice for the clinical workforce	<p>1.10.1 A system is in place to define and regularly review the scope of practice for the clinical workforce.</p> <p>1.10.2 Mechanisms are in place to monitor that the clinical workforce are working within their agreed scope of practice.</p> <p>1.10.3 Organisational clinical service capability, planning and scope of practice is directly linked to the clinical service of the organisation.</p> <p>1.10.4 The system defining the scope of practice is used whenever a new clinical service, procedure or other technology is introduced.</p> <p>1.10.5 Supervision of the clinical workforce is provided whenever it is necessary for individuals to fulfil their designated role.</p>
The community common care standards (Australian Government 2010b)	1 Effective management The service provider demonstrates effective management processes based on a continuous improvement approach to service management, planning and delivery	<p>Expected Outcome 1.1: Corporate governance The service provider has implemented corporate governance processes that are accountable to stakeholders.</p> <p>Expected Outcome 1.2: Regulatory compliance The service provider has systems in place to identify and ensure compliance with funded program guidelines, relevant legislation, regulatory requirements and professional standards.</p> <p>Expected Outcome 1.6: Risk management The service provider is actively working to identify and address potential risk, to ensure the safety of service users, staff and the organisation.</p> <p>Expected Outcome 1.7: Human resource management The service provider manages human resources to ensure that adequate numbers of appropriately skilled and trained staff/volunteers are available for the safe delivery of care and services to service users.</p>
National standards for mental health services (Australian Government 2010a)	Standard 8: Governance, leadership and management The mental health service (MHS) is governed, led and managed effectively and efficiently to facilitate the delivery of quality and coordinated services	<p>8.4 The MHS has processes in place to ensure compliance with relevant Commonwealth, state/territory mental health legislation and related Acts.</p> <p>8.6 The recruitment and selection process of the MHS ensures that staff have the skills and capability to perform the duties required of them.</p> <p>8.7 Staff are appropriately trained, developed and supported to safely perform the duties required of them.</p>

Appendix 1.2: Protected titles and practices (all health practitioners)

Profession	Title	Specialist title	Practice protections	Divisions	Endorsements
Aboriginal and Torres Strait Islander health practice	<ul style="list-style-type: none"> Aboriginal and Torres Strait Islander health practitioner Aboriginal health practitioner Torres Strait Islander health practitioner 				
Chinese medicine	<ul style="list-style-type: none"> Chinese medicine practitioner Chinese herbal dispenser Chinese herbal medicine practitioner Oriental medicine practitioner Acupuncturist 			<ul style="list-style-type: none"> Acupuncturist Chinese herbal medicine practitioner Chinese herbal dispenser 	<ul style="list-style-type: none"> Acupuncture
Chiropractic	<ul style="list-style-type: none"> Chiropractor 		<ul style="list-style-type: none"> Manipulation of cervical spine 		
Dental	<ul style="list-style-type: none"> Dentist Dental therapist Dental hygienist Dental prosthetist Oral health therapist 	<ul style="list-style-type: none"> Dental specialist Refer to the Dental Board of Australia for a full list of specialist titles 	<ul style="list-style-type: none"> Restricted dental act 	<ul style="list-style-type: none"> Dentist Dental therapist Dental hygienist Dental prosthetist Oral health therapist 	<ul style="list-style-type: none"> Area of practice Subtype Conscious sedation
Medical	<ul style="list-style-type: none"> Medical practitioner 	<ul style="list-style-type: none"> Medical specialist Refer to the Medical Board of Australia for a full list of specialist titles 	<ul style="list-style-type: none"> Restricted dental act Prescription of optical appliances Manipulation of cervical spine 		<ul style="list-style-type: none"> Acupuncture

Profession	Title	Specialist title	Practice protections	Divisions	Endorsements
Medical radiation practice	<ul style="list-style-type: none"> • Medical radiation practitioner • Diagnostic radiographer • Medical imaging technologist • Radiographer • Nuclear medicine scientist • Nuclear medicine technologist • Radiation therapist 			<ul style="list-style-type: none"> • Diagnostic radiographer • Nuclear medicine technologists • Radiation therapist 	
Nursing and midwifery	<ul style="list-style-type: none"> • Nurse • Registered nurse • Nurse practitioner • Enrolled nurse • Midwife • Midwife practitioner 			<ul style="list-style-type: none"> • Registered nurse (division 1) • Enrolled nurse (division 2) 	<ul style="list-style-type: none"> • Supply scheduled medicines • Nurse practitioners • Prescribe scheduled medicines for eligible midwives <p><i>Subtype</i></p> <ul style="list-style-type: none"> • Rural and isolated practice
Occupational therapy	<ul style="list-style-type: none"> • Occupational therapist 				
Optometry	<ul style="list-style-type: none"> • Optometrist • Optician 		<ul style="list-style-type: none"> • Prescription of optical appliances 		<ul style="list-style-type: none"> • Scheduled medicines
Osteopathy	<ul style="list-style-type: none"> • Osteopath 		<ul style="list-style-type: none"> • Manipulation of cervical spine 		<ul style="list-style-type: none"> • Acupuncture
Pharmacy	<ul style="list-style-type: none"> • Pharmacist • Pharmaceutical chemist 				

Profession	Title	Specialist title	Practice protections	Divisions	Endorsements
Physiotherapy	<ul style="list-style-type: none"> • Physiotherapist • Physical therapist 		<ul style="list-style-type: none"> • Manipulation of cervical spine 		<ul style="list-style-type: none"> • Acupuncture
Podiatry	<ul style="list-style-type: none"> • Podiatrist • Chiropodist 	<ul style="list-style-type: none"> • Podiatric surgeon 			<ul style="list-style-type: none"> • Scheduled medicines
Psychology	<ul style="list-style-type: none"> • Psychologist 				<ul style="list-style-type: none"> • <i>Area of practice Subtype</i> • Clinical psychology • Counselling psychology • Forensic psychology • Clinical neuropsychology • Organisational psychology • Sport and exercise psychology • Educational and developmental psychology • Health psychology • Community psychology

Section 2: Competency framework



Aim

This framework focuses on what a person can do in the workplace, how they perform in relation to a required standard and how we might use this information to support changing work roles and practices. While there are various methods that can be applied to determine clinical competency, the central aim here is to define what and how we verify specific aspects of clinical competency using competency-based training and assessment processes. The primary but not exclusive focus is on the knowledge and skills needed to support clinical competency for specific work roles or skills while providing a pathway for recognising undergraduate and postgraduate qualifications, experience and training.

The competency framework is designed to supplement and strengthen other governance processes in the local organisational environment. It is not intended to be a competency-based career framework, replace accredited training, be aligned with remuneration or replace or retest entry-level professional standards or qualifications.

Programs developed using this framework might be used to support credentialling and defining the scope of practice for specific practice roles or skills or to verify that the learning outcomes of training programs have been achieved.

Introduction

In the current healthcare climate, ensuring and developing a competent workforce is of particular relevance to support changing scope of practice, health workforce innovation and reform, and for implementing safety and quality initiatives. At the core of this is the patient and their access to timely, safe and quality healthcare.

Standard 1 of the *National safety and quality health service standards* requires that the 'clinical workforce have the right qualifications, skills and approach to provide safe, high-quality health care' (ACSQHC 2012, p. 14). The competency framework is used in partnership with other clinical governance processes described within this framework, together forming a foundation for monitoring and verifying the credentials and clinical competence of allied health professionals and assistants in the workplace.

The concept of clinical 'competency' is inconsistent across the Victorian health system. At the heart of the issue is that the concept of 'competency' is not a universal one (Department of Human Services 2009). While the language used across the health workforce sector varies between higher education, the vocational education and training (VET) sector regulatory bodies and the workplace, 'each to some extent describes knowledge and skill sets for learning attainment and work practice' (Department of Human Services 2009a).

What is competency?

Despite the relevance of the concept of competency to the entire health workforce, a common understanding of it evades us. There is much ambiguity, lack of consensus and considerable variation in the terms and definitions used in this domain (Brownie et al. 2011). From the conception of the competency movement, there has been no one definition of the term 'competency' or 'competence' agreed (Lawlor & Tovey 2011); however, 'internationally, healthcare providers are more and more moving toward adopting competence and competency standards, rather than moving against them' (Department of Human Services 2009a, p. 3) as 'multiple benefits have been identified that support the use of competency frameworks' (Brownie et al. 2011, p. 22).

Distinguishing between the terms '**competence**' and '**competency**' assists us to clarify what we are describing when speaking the language in the workplace. Competence is a generic term referring to a person's overall capacity, while competency refers to specific abilities in a given area and is made up of a combination of attributes, such as knowledge, skills and attitudes.

Overall competence will therefore be a collection of many specific competencies performed to the desired level. Individuals develop competence through various methods, including both educational and experiential pathways, and so any determination of 'competence' or 'competency' should provide an avenue for both pathways to be acknowledged in a recognition process.

Translated into the workplace, a contemporary view of competency incorporates all the dimensions of competence: the ability to perform individual tasks within a job and workplace; the ability to manage any number of tasks within a job or workplace; the ability to respond appropriately to irregularities and breakdowns in routine within a job and workplace; and the requirement to deal with responsibilities and expectations in the work environment (Lawlor & Tovey 2011).

While it is acknowledged that it is impossible to fully define all the dimensions that combine to produce a competent worker, the intention of the framework as a whole is to support a more holistic notion of competence by separating in part the more generic aspects of competence such as behaviours into a capability framework and leaving the more observable aspects such as knowledge and skills in a competency framework. Any descriptors of workplace competency developed using this framework for the purpose of assessment are therefore reflective of this; they describe observable knowledge and skills and highlight behaviours that are distinctive of a clinician undertaking the clinical practice or work role. They do not fully describe all the behaviours assumed by attainment of an entry-level qualification.

The competency framework therefore aims to reflect the broad nature of competency and is in line with the definition provided by the National Quality Council (2014) (see box).

‘Competency is the consistent application of knowledge and skill to the standard of performance required in the workplace. It embodies the ability to transfer and apply skills and knowledge to new situations and environments’ (National Quality Council 2014, p. 4).

Competency-based training is defined by the Australian Commission on Safety and Quality in Health Care as ‘an approach to training that places emphasis on what a person can do in the workplace as a result of training completion’ (Department of Human Services 2009a, p. 8).

‘Competency-based assessment is a purposeful process of systematically gathering, interpreting, recording and communicating to stakeholders, information on candidate performance against industry competency standards and/or learning programs’ (National Quality Council 2014, p. 5).

Summary points

There is considerable variation in ideology and terminology surrounding ‘competence’ and ‘competency’.

Competence is a generic term referring to a person’s overall capacity, while competency refers to specific abilities in a given area.

Competency in the workplace incorporates all dimensions of competence.

Competency resources table

A summary of the competency tools, samples and appendices are included below. All the resources can be accessed electronically in the competency resource kit available on the Department of Health and Human Services website (www2.health.vic.gov.au).

Competency resource name	Description or purpose
General tools	
2.1 Self-assessment tool: Competency	Use this self-assessment tool to identify areas for targeted action by your health service. If you have identified an area of need please refer to the competency methodology section or access the other samples and tools to assist you in this process.
2.2. Competency-based learning and assessment process overview	This diagram provides an overview of the development and implementation process for competency-based assessment. It includes key definitions, underpinning principles and a process flow chart.
Developers' resources	
Use these resources to determine if a competency-based training and assessment program is recommended and to guide you through the process of developing competency-based training and assessment in the workplace for an identified area of competency. Check off the items in Resource 2.4 , the 'Developers' checklist', as you progress through the process.	
Developers' tools	
2.3 Decision tool: 'Do we need a competency standard?'	This tool can assist decision-makers in identifying skill areas where the development of performance standards is recommended to direct training and assessment in the workplace.
2.4 Developers' checklist: Process summary and checklist for developers of competency-based programs	This tool assists developers to systematically work through the process of developing competency-based learning and assessment programs.
2.5 Developing a unit of competency: Process guide and checklist	This tool provides a step-by-step process to developing a detailed competency standard against which performance can be measured. It uses a standardised format adopted within the framework.
2.6 Competency-based terminology: Based on Bloom's taxonomy of educational objectives	Based on Bloom's taxonomy of educational objectives, this list provides support for writing performance criteria.
2.7 Competency standard template	Once the competency standard has been developed using tool 2.5, the parameters of the competency standard are recorded in this template.

Competency resource name	Description or purpose
Developers' tools (cont.)	
2.8 Evidence planning document template	The elements and performance criteria from the competency standard are translated to this template and then it is used by the reference group to discuss the types of evidence to be gathered to provide proof of competence. This exercise will help to inform the assessment methods used.
2.9 Learning needs analysis (LNA): Self-assessment template	Use this tool as a self-assessment against the elements and performance criteria and the underpinning skills and knowledge at the beginning of the program to assist in establishing the learning needs of the individual and to allow tailoring of the learning and assessment plan.
2.10 Learning and assessment plan (LAP) template	The LAP is separated into two sections: the learning plan and the assessment plan. The learning plan outlines learning resources and describes various learning activities to be undertaken as directed by the LNA and as set by the organisation. The assessment plan outlines the methods in which the competency assessment will occur such as work-based observed sessions, case-based presentations and oral appraisals. The assessment is mapped back to the performance criteria of the competency standard and recorded on the LAP.
2.11 Learning resource development template	This is a sample template to record what resources are already available and what needs to be developed to support learning.
2.12 Assessment tool type A template (binary performance rating scale)	This assessment tool template uses a binary performance scale. It has provision for performance cues, which can add further detail to describe what a competent performer might look like in action.
2.13 Assessment tool type B template (binary performance rating scale, multiple items)	This assessment tool template uses a binary performance scale. It is useful for areas of competency where multiple items such as equipment may need to be assessed.
2.14 Assessment tool type C template (Bondy 1983) (performance rating scale)	This assessment tool template uses the Bondy scale for performance rating. It is useful for areas of competency where competence is likely to be developed over an extended period of time, supported by clinical supervision. Assessment of performance is likely also to occur over time. It also provides the option of indicating only those criteria that are relevant to the job role. This may be helpful to reflect variances in role expectations between sites/services.

Worked examples of competency-based programs:

2.15	<i>Conduct an allied health assistant (AHA)-led adult footwear program:</i> Training and assessment program handbook
2.16	<i>Training a pharmacy technician to use an automated compounding system to fill elastomeric devices with fluorouracil:</i> Training and assessment program handbook
2.17	<i>Perform ventilator hyperinflation (VHI) in an adult intubated patient</i>
	2.17.1 Competency standard
	2.17.2 Evidence planning document
	2.17.3 Learning and assessment plan
2.17.4 Assessment tool	
2.18	<i>Perform PICC line insertion by radiographers:</i> Training and assessment program handbook
2.19	<i>Refer to a housing crisis support agency (transdisciplinary practice)</i>
	2.19.1 Competency standard
	2.19.2 Evidence planning document
	2.19.3 Learning and assessment plan
2.19.4 Assessment tool	
2.20	Individual register of competency achievement

Assessors' resources

Assessors can use these resources to support the assessment process for developed competency-based programs. Check off the items in **Resource 2.21**, 'Assessors'/ supervisors' checklist', as you address them.

Competency resource name	Description or purpose
2.21 Assessors'/supervisors' checklist: Process summary and checklist for assessors implementing competency-based programs	This tool helps assessors to systematically work through the process of implementing competency-based learning and assessment programs
	Systematically review the items on the checklist to guide you through the process.

Competency resource name	Description or purpose	
2.22 Appropriate assessors' self-assessment checklist	To establish the suitability of the workplace assessor in accordance with recommended minimum criteria	All workplace assessors should complete the checklist to establish their suitability as a workplace assessor prior to assessing the competency of candidates. This is to be used as a guide only where there are no legislated requirements or additional organisational requirements to be applied.
2.23 Conditions and context for assessment: Instructions	To inform candidates and assessors of the contexts and conditions required for workplace assessment	These instructions can be adapted as needed but in their current format provide general principles and instructions to guide the assessment process. The candidate should have access to these instructions and any assessment tool(s) prior to the assessment task. An opportunity for clarification of these instructions prior to assessment would also be given to the candidate.
2.24 Preparing the candidate for direct observation assessment	To promote consistent conduct and adequate preparation of the candidate prior to assessment	This checklist is to be used by the assessor before assessing the candidate to ensure the candidate can adequately prepare. It is particularly applicable for direct workplace observation assessments.
2.25 Guidelines for allied health assessors during a direct observation assessment	To promote consistent conduct by assessors during direct observation assessment	This provides a guide to how an assessor should conduct themselves during a direct observation assessment. It is particularly applicable for direct workplace observation assessments, but the principles can and should be applied to other forms of assessment.

Competency resource name	Description or purpose
Learners' resources	
2.26 Learners' checklist, process summary and checklist of competency-based programs	Learners can work through this checklist to systematically work through the process of participating in a competency-based learning and assessment program.
Evaluation resources	
2.27 Learner evaluation survey: Competency-based programs	A survey sample used for evaluating competency-based programs
Case studies (based on using Resource 2.3: Decision tool: 'Do we need a competency standard?')	
1.	Do we need a competency standard for allied health assistants to apply dressings, padding and pressure relief in a podiatry department? (submitted by Monash Health)
2.	Do we need a competency standard for a physiotherapist to perform dry needling? (submitted by Gippsland Lakes Community Health)
3.	Do we need a competency standard for pharmacy technicians to use an automated pump system to fill elastomeric devices with fluorouracil? (submitted by Western Health)

Resource 2.1: Self-assessment tool

Use this self-assessment tool before you progress through the rest of the competency section. It can be used to identify areas for targeted action. If you have identified an area of need please refer to the methodology section below to access information, samples and tools to assist you in this process.

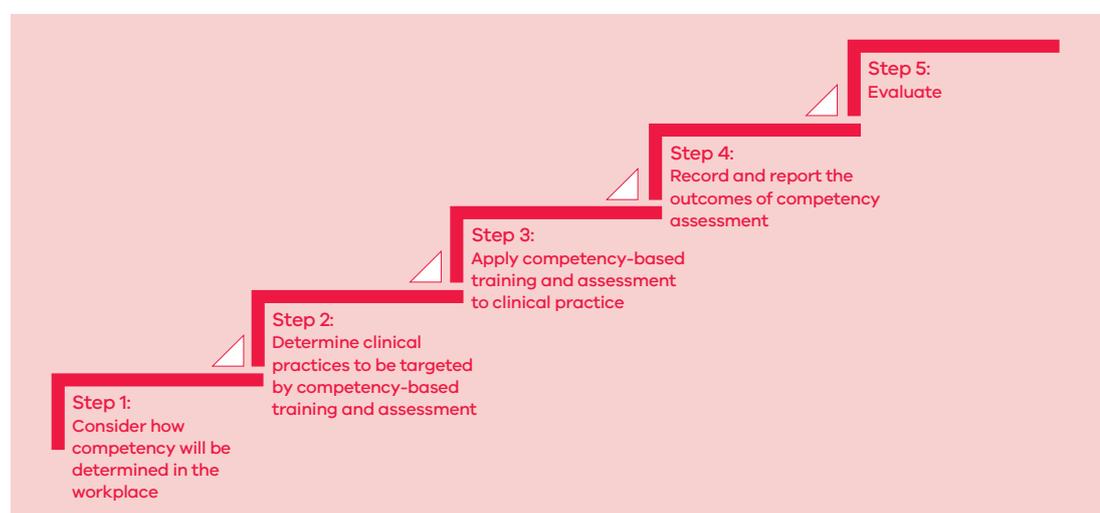
Competency question	Planned	Partly implemented	Established	Not applicable	Review date
Concept and terminology					
1. Does your organisation have an agreed concept of competence and competency to work from? And does it align with the concept provided?					/ /
What will be assessed?					
2. Do you have a method for determining which clinical practices will be assessed using competency-based processes?					/ /
3. Do you have a prioritised working list of these clinical practices?					/ /
How will it be assessed?					
4. Do you have a documented method for developing competency standards?					/ /
5. Do you have developed standards in all identified priority areas?					/ /
6. Do all the developed standards provide for skills recognition?					/ /
7. Do you have a systematic mapping of evidence to a standard to determine competency for all competency-based programs?					/ /
8. Have learning and assessment plans been developed for all competency-based programs?					/ /
9. Have assessment tools been developed for all competency-based programs?					/ /
10. Have criteria for workplace assessors been established for each clinical practice?					/ /

Competency question	Planned	Partly implemented	Established	Not applicable	Review date
Record and report outcomes					
11. Do you have a method for recording the outcomes of a competency assessment?					/ /
12. Are the outcomes of a competency assessment integrated into the overall governance framework for your program?					/ /
Evaluate					
13. Have you developed an evaluation plan?					/ /

Methodology: How to implement competency-based training and assessment in your workplace

There are five key steps to implementing competency-based training and assessment in the workplace after recruitment, as depicted in **Figure 2.1**. The intent of this section is to provide an overview of the how the competency framework can be practically applied in the workplace.

Figure 2.1: Steps to implementing competency-based training and assessment in the workplace



Step 1: Consider how competency will be determined in the workplace

While gross incompetence on one hand is likely to be reported and easily identified through risk-reporting frameworks or complaints data, competence, on the other hand, is a little more difficult to determine.

The determination of clinical competency commonly uses various methods applied at different times in the workplace. Some areas of clinical competency can be assumed based on attainment of undergraduate/postgraduate qualifications or accredited training certification. This will be supported by AHPRA registration and endorsements for some professions, or eligibility for membership of professional organisations for others.

At the point of recruitment, organisations establish some measure of competency by setting threshold credentials and essential criteria, in addition to an evaluation of work history, training and experience. This is supported by the use of third-party reports in reference checking and a mapping of suitable evidence against the expected standard of performance as outlined in a position description. To this point, assessments of clinical competency seem indistinguishable from credentialling.

After recruitment, competence might be monitored by performance enhancement processes including clinical supervision, behavioural performance measures and peer review. These are commonly supported by orientation processes, professional position/scope statements, clinical guidelines and organisational procedure and policy documents.

In the workplace, formal organisation-driven measures of competency are common in the form of mandatory training. These are mostly in areas of competency that are *common* to the health workforce as a whole such as hand hygiene, or *shared* by particular professions within the workforce such as basic life support. Other measures of competency are being applied in *shared* or *specific* clinical areas such as higher risk clinical skills. In this process, performance descriptors or standards are used, against which performance evidence is mapped. This is then applied in a context that closely relates to the demands of the workplace. This process is commonly referred to as competency-based training and assessment. Despite the common usage of competency-based processes, many health organisations have not articulated the rationale or method for its application in the workplace. This will be addressed in subsequent steps.

Allied health clinicians share many areas of competency between professions and with other health workers. When considering how competency will be determined, it is useful to view the clinical practice within one of the categories depicted in **Table 2.1**. In most cases allied health driven competency-based programs will fall into the shared and specific categories.

Table 2.1: Categories for areas of competency, measured in organisations

Generic: many staff across sectors, independent of discipline	Example: behaviours (teamwork)
Common: most healthcare workers	Example: hand hygiene
Shared: undertaken by many allied health disciplines	Example: basic life support, falls risk reduction
Specific: one context or specific groups	Example: suctioning by speech pathologists and physiotherapists, ventilator hyperinflation by physiotherapists in the intensive care unit

Source: Department of Health and Skills for Health 2008

Step 1: Summary action

- Will competency-based training and assessment be considered as a method to determine 'competency' in the workplace?
- Establish a list of potential practices to be considered.

**MOVE
TO STEP 2**

Step 2: Determine clinical practices to be targeted by competency-based training and assessment

Determining what discrete areas of clinical competency need to be formally assessed and recorded beyond graduate level is an arbitrary process, as evidenced by the variation seen between health services. In Australia all allied health practitioners have documents outlining entry-level competency standards; however, few formally address credentialling and competency attainment beyond entry level. In addition there is little guidance provided at present from professional or regulatory bodies for either registered or non-registered professions. Speech Pathology Australia is, however, an exception here. It provides a broad framework for assessing advanced clinical practices, outlined in its position statement on credentialling (Speech Pathology Australia 2009).

The need for clinicians to be able to apply clinical practices competently and autonomously can be heightened in certain contexts for the allied health workforce. There are environments where direct profession-specific clinical supervision may be limited. In addition, access to expert colleagues of any profession who can provide specific, timely and direct guidance may also be limited. Sole practitioners working in isolation are a good example here.

Learning programs and activities without assessment components are common practice in allied health and it is clear we don't have the resources, the need nor the desire to assess all clinical practices that may be refined or developed over the course of an individual's career. However, having guidelines to assist decision-makers in determining those specific clinical practices where formal assessment and recording of competency is desirable, would be welcomed. These guidelines have been put together in the decision tool at *Resource 2.3: Decision tool: 'Do we need a competency standard?'*

The decision tool relies on some basic assumptions regarding the clinical practice to be formally assessed and recorded, which are:

- the clinical practice is permitted by legislation and supported by professional standards and evidence and is in line with organisational objectives
- there is organisational support for use of this practice, by this profession and for this client group and in this context
- there are resources and expertise available to support development and implementation of a competency-based program.

Step 2: Summary action

- Use the decision tool 'Do we need a competency standard?' to determine clinical practices where competency-based processes could be applied in the workplace to verify clinical competency.



**MOVE
TO STEP 3**

Resource 2.3: Decision tool: 'Do we need a competency standard?'

Instructions

Outline the clinical practice, profession, client group and context you are considering a competency assessment program for.

Answer each of the following 10 questions, and check them against affirmative answers to determine if development of an organisational competency standard is recommended to support assessment of competence in the workplace for this practice.

Indicate that the following essential prerequisites to initiating the process, have been met:

- The clinical practice is permitted by legislation, supported by professional standards and evidence and is in line with organisational objectives.
- There is organisational support for use of this practice by this profession and for this client group and in this context.
- There are resources and expertise available to support development and implementation of a competency-based program.

Evaluate scope of practice

- 1. Does the clinical practice vary significantly from standard practice for the profession or is it considered 'advanced practice' for the profession, according to your organisation?
- 2. Will the scope of clinical practice of the individual be restricted by the organisation until 'proof' of competency, is established by a qualified person?

Yes to any

No to all

Risk assessment

- 3. Is the risk rating (likelihood of harm x consequence) for the clinical practice above the acceptable level for your organisation?
- 4. Has training and workplace assessment been identified as a key control measure by subject matter experts, or as an organisational directive?
- 5. Is the current training as a key control measure below acceptable control effectiveness levels for your organisation?

Yes to any

No to all

Training and assessment for establishing competency

- 6. Is there a need to regularly assess competency over time, against a defined benchmark?
- 7. Does the professional, registering or governing body recommend competency assessment prior to independent clinical practice?
- 8. Do stakeholders demand robust assessment processes prior to supporting a change process (such as medical staff supporting substituted practices)?
- 9. Is there a gap between the staff skill base and organisational need that can be best met by competency-based training and assessment process in the workplace?
- 10. Does the availability of clinical supervision or appropriate and timely access to education limit independent application of the activity in the workplace?

Yes to any

No to all

Yes to any question

No to all questions

Action

Competency standard development to support workplace training and assessment is recommended

Higher priority: Yes responses to questions 1–5 and/or multiple Yes responses

Lower priority: Yes response(s) to questions 6–10

Action

Competency standard development to support workplace training and assessment is not required

Step 3: Apply competency-based training and assessment to clinical practice

What is competency-based training and assessment?

Competency-based training is defined by the Australian Commission on Safety and Quality in Health Care as '*an approach to training that places emphasis on what a person can do in the workplace as a result of training completion*' (ACSQHC 2012, p. 8). It has the potential to offer benefits to the organisation, the allied health workforce and consumers.

Competency-based assessment, on the other hand, is a purposeful process of *systematically gathering, interpreting, recording and communicating to stakeholders, information on candidate performance against industry competency standards and/or learning programs*' (National Quality Council 2010, p. 5).

Competency-based assessment is an important part of any training system, not only for the learner but for the clinical educator and for stakeholders. For the learner, assessment provides feedback to guide their future learning and monitor their own progress. For clinical educators, assessment allows them to verify that learning is taking place in line with the required standard of performance and to determine their success in facilitating the learning process. For stakeholders, assessment provides a way of knowing if people have the required knowledge, skills and behaviours for the job.

Defining features

Central to competency-based training and assessment in any context is a documented standard against which evidence of competence can be systematically mapped. Evidence in this context is information gathered that, when matched against the requirements of the competency standard, provides proof of competency achievement. The type and amount of evidence required to support decisions of competence remains at the discretion of the organisation. Within the process, candidates help to determine the assessment process, which is flexible. The key features of competency-based assessments are summarised in Table 2.2.

Table 2.2: Defining features of competency-based assessment

Defining features of competency-based assessments
Standards or criterion-based
<ul style="list-style-type: none">• Learners are not ranked and performance is measured against fixed criteria/standards/benchmarks
Evidence-based
<ul style="list-style-type: none">• Sufficient evidence is gathered to make a judgement about whether the specific standards have been met
Participatory
<ul style="list-style-type: none">• The candidate helps determine the process of assessment such as negotiating the assessment timeframe, location and time of assessments

Tools and worked examples have been developed to assist in this process and can be accessed electronically in the competency toolkit from the Department of Health and Human Services website (www2.health.vic.gov.au).

Step 3: Summary action

- For the practices identified as benefiting from the application of a competency-based process in step 2, proceed to the competency resource kit.
- Use the resource kit to develop competency-based processes for specific areas of competency.



**MOVE
TO STEP 4**

Step 4: Record and report the outcomes of competency assessment

Recording processes are applied throughout the 'competence' cycle in the allied health workforce.

Organisation-wide and program-specific databases of various formats and purpose are commonly implemented at the front end of recruitment to capture registration and credentialling data. After recruitment, methods to record clinical supervision or performance-enhancement processes are common and a variety of methods to record participation and the assessment outcome of workplace training takes the form of spreadsheets, registries, databases and learning management systems.

Also used in this process are numerous and varying 'checklists' as tools for recording direct observations in the workplace. Ongoing plans related to performance development and competence are commonly recorded in professional development plans.

The key is to have a recording system for competency-based processes that articulates relevant information to stakeholders and that can be readily accessed when required, in addition to complying with any external or internal regulatory requirements. The level and type of information relevant to organisations, managers, clinical supervisors and clinicians will be different.

A database will need to be developed to report information to organisations and managers for use in credentialling and operational matters. Assessment tools will be used by clinical supervisors and assessors to gather evidence, record outcomes and provide proof of competency achievement.

Tools and worked examples have been developed to assist in this process and can be accessed in the competency toolkit. Refer to *Resource 2.20: Individual register of competency achievement* for an example of a basic spreadsheet for recording competency attainment.

Step 4: Summary action

- Access resources in the toolkit to develop reporting and recording processes.
- Develop assessment tools to capture evidence of competency assessment.
- Develop a database to communicate the outcomes of competency assessment.



**MOVE
TO STEP 5**

Step 5: Evaluate

As with planning evaluation in any project or program, it is important to consider the key purpose, the appropriate timing, the resources available and the information required by different stakeholders to inform decision making. The approach to evaluation will very much depend on what is being evaluated and the state of the program (for example, being developed, implemented or well established). Evaluation types and methods should be tailored to meet the needs of the organisation.

Within the area of competency, the purpose of evaluation may be, for example, to:

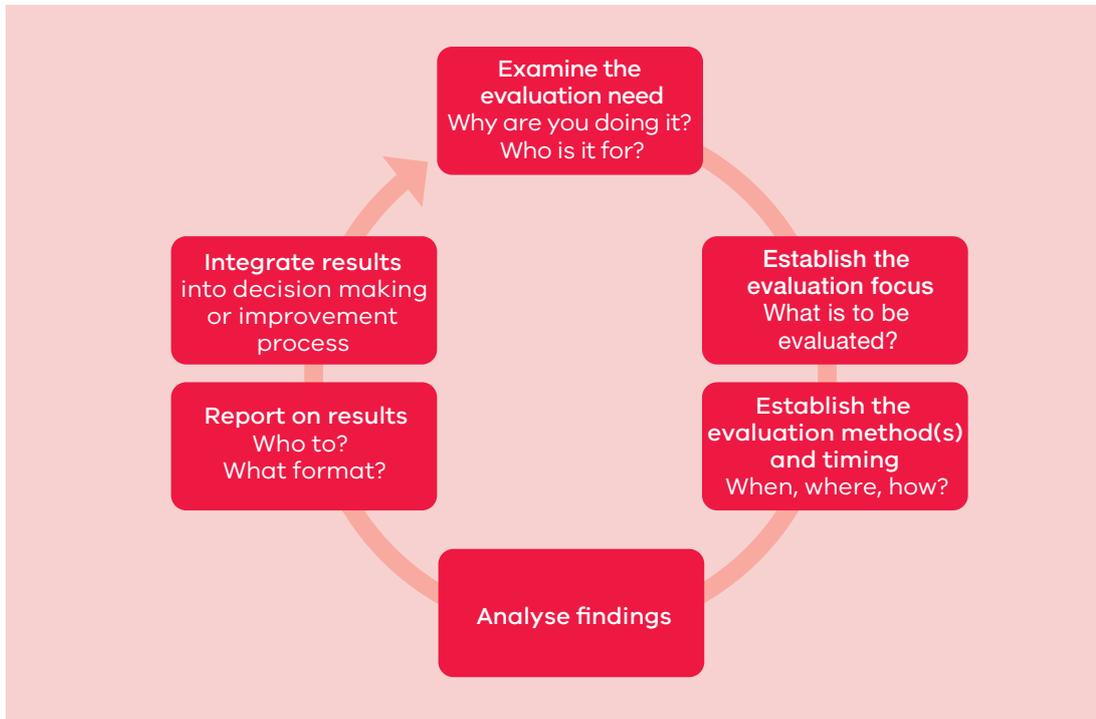
- identify current organisational processes to assess and record workplace competency
- establish a database of areas for potential development of competency-based processes
- evaluate developed competency-based training and assessment programs
- demonstrate the expected standard of performance has been met by clinicians in areas of increased risk and changing scope of practice
- demonstrate core and/or developmental actions are being met against the *National safety and quality health service standards*.

Within the area of competency, this may include gathering information, for example, on:

- existing training and assessment programs within an organisation
- the adequacy and confidence in current or implemented measures of workplace competency
- the reaction levels of learners to training programs such as learners providing feedback on the content, trainer or delivery method of a training program
- the behaviour or skill change level of learners and clinical supervisors after training completion such as learners using the skill in the workplace and clinical supervisors' confidence in delegating tasks
- the outcomes achieved by the training program such as program development rates, training completion rates, the organisation's workforce capacity to deliver health services and the effectiveness of the training program in improving safety and quality
- the level of consumer satisfaction.

Resource 2.27: Learner evaluation survey: Competency-based programs is an example of evaluation for improving competency-based programs.

Step 5: Summary action



Supporting evidence and learnings: what will be assessed?

This competency framework represents the results of an analysis of information gathered through the metropolitan and regional workforce consultation forums and published literature and includes learnings from existing work done by Monash Health in the area of workplace competency assessment.

Sources

Key sources informing decisions around 'what will be assessed' within the competency framework are listed in Table 2.3.

Table 2.3: Key sources informing decisions around 'what will be assessed'

Key sources
Data from metropolitan and regional consultation forums associated with this project
Monash Health 2013, <i>Allied health competency framework</i> , Monash Health, Clayton
Department of Health 2012, <i>Supervision and delegation framework for allied health assistants</i> , State Government of Victoria, Melbourne
Australian Nursing and Midwifery Council 2007, <i>Nursing practice decisions summary guide</i> , ANWC, Canberra
Department of Health and Skills for Health 2008, <i>Modernising allied health professions (AHP) careers: a competence-based framework</i> , Department of Health, London
Australian Commission on Safety and Quality in Health Care (ACSQHC) 2011, <i>National safety and quality health service standards</i> , ACSQHC, Sydney
Australian Health Practitioner Regulation Agency: registration standards and endorsements
Professional association position statements and policy
Review of professional competency standards across allied health in Australia
Health service organisations' strategic goals and plans
Office of the Health Commissioner's annual report
Sampling of allied health risk registers, RiskMan and complaints data
Risk management strategies used in health service organisations
Sampling of allied health, nursing and medical CSOP frameworks from Victorian health service organisations
Sampling of training, education and assessment programs used in the Victorian health workforce, with a focus on allied health

The main drivers to verify competency in the allied health workplace are based on the sources listed in **Table 2.3** and are summarised in **Table 2.4**.

Table 2.4: Drivers to verify competency in the workplace

1.	Variation in undergraduate experience
2.	Managing risk: perceived clinical risk and adverse events
3.	Variation in access to clinical supervision or peer support
4.	The advent of new services, procedures and technologies
5.	Changes to scope of practice, including advanced and extended roles
6.	Workforce substitution or delegation models
7.	Variation in threshold credentials for work roles
8.	Training: access to and confidence in achievement of outcomes
9.	Skilled workforce shortages
10.	Other factors such as consistency of service, supporting evidence-based practice, workforce retention

Learnings from the workplace

Learnings from the workplace, informing decisions around 'what will be assessed', are summarised in Table 2.5.

Table 2.5: Key learnings informing decisions around 'what will be assessed' within the competency framework

Key learnings
Many sources combine to provide direction on what should be formally assessed and recorded using competency-based processes.
Registration standards and endorsements detail clinical practices where regulatory requirements require formal credentialling, rather than competency-based assessment.
Professional standards typically provide no clear decision-making rules regarding which clinical practices require competency-based assessment; however, they can contribute significantly to the criterion for competency assessment.
Peak professional or regulatory bodies provide little guidance to determine what is 'advanced' or 'extended' scope of practice for most professions in allied health.
Determining what discrete areas of clinical competency need to be formally assessed and recorded is currently arbitrary, inconsistent and lacks clarity.
Competency-based processes are applied commonly in the local, national and international health sector for allied health and other professional groups, but there is considerable variation in how this is done.
Variable terminology relating to competency is used throughout the workplace.
Allied health professionals appear risk-averse and there is a keenness to limit scope of clinical practice that may need to be challenged.
Professional development programs with attendance only and no recorded assessment component are common.
Competent autonomous practice is needed for the application of clinical practice in many contexts for the allied health workforce. This is highlighted by geographically or professionally isolated environments.
Discrete areas of competency can be delineated into 'generic', 'common', 'shared' and 'specific'. Many generic competencies are divided into a capability framework, and many common competencies are divided into organisational training.
Allied health doesn't have the resources or the need to assess all clinical practices that may be refined or developed over the course of an individual's career.
Risk registers describe risks that are commonly addressed at the organisational level.
RiskMan data and complaints data is typically limited but may be relevant to decision making.
Certified assessors are used exclusively within some assessment programs; many others don't articulate the requirements of a 'suitable assessor'.

Key learnings (cont.)

Practices listed as 'advanced' now may, over time, become part of standard practice for a profession. Profession consensus on what is considered 'advanced' practice may not be possible.

Areas of changing scope of practice, in particular 'advanced' practices, should be targeted for development.

Areas outside of the 'traditional scope of practice' should also be targeted areas – for example, where there is translation of skill across occupational groups.

Defining the risk rating for clinical practices remains somewhat subjective and variable, but during consultation 'high risk' ratings were considered a trigger for assessment.

Attention should not only be given to high-risk/high-volume practices but also to high-risk/low-volume practices.

Reference groups are a rich source of information to guide the development of competency-based processes.

When training is identified as the main risk control measure, then the training and assessment processes need to be robust.

Stakeholders demanding robust assessment processes before endorsement within an organisation was flagged as a trigger.

Varied entry-level ability and undergraduate experience was flagged as a potential trigger. The suitability of the assessors was flagged as an area to be defined.

Registers of submissions/approvals by allied health credentialling committees may provide insight into potential areas for development.

The national standards should be considered and reflected in any competency-based programs developed; for example, any assessments in areas where pressure injuries could be incurred should reflect management of that risk in the competency-based training and assessment program.

Decision tool refinement

Resource 2.3: Decision tool: 'Do we need a competency standard?' was originally developed as part of the Monash Health, *Allied health competency framework* (2013) and is the result of the learnings outlined above in Table 2.5. The metropolitan and regional forums within the project also evaluated this tool. In the main, the tool was considered useful, with some recommendations made by the group regarding formatting, wording and instructions for use. One participant at the forum commented that 'the tool was a good prompt for deeper reflection'.

The tool is a starting point to determine if development of an organisational competency standard is necessary; however, the limitations of the tool are acknowledged here. When using the tool, it is noted that developers who are keen to implement competency-based training and assessment may consistently arrive at the action recommending this. It is therefore also worth examining the implication of competency assessment outcomes. If there will be no impact on any of the stakeholders as a result of the competency assessment outcome, is development really warranted? The following examples highlight this.

Examples:

- Will independent practice be restricted locally until a decision of competency is achieved? For example, podiatrists endorsed to prescribe at Monash Health require successful completion of an organisational, competency-based program in addition to their primary qualification.
- Will the provision of the service be limited to include only staff deemed competent in a particular task? For example, a physiotherapist or radiographer may not be able to be to work on the weekend when clinical supervision is limited.
- Will there be an additional burden on clinical supervisors until competency is achieved (such as to provide direct supervision of procedural tasks)?
- Will there be barriers to applying evidence-based treatments (such as ventilator hyperinflation in adult intubated patients)?
- Will funding for the service provision be affected? For example, dieticians competently recording a Subjective Global Assessment of nutrition risk can impact on funding.

Summary points

Determining what areas of competency will be formally assessed and recorded is arbitrary, inconsistent and lacks clarity.

The proposed tool can be used to guide decision-makers in identifying areas for developing competency-based programs.

Supporting evidence and learnings: competency-based training and assessment

Central to competency-based training in any context is a documented standard against which evidence of competency can be systematically mapped. When clinicians are asked to describe the standard against which clinical competence is measured, there is considerable reference to use of 'position descriptions, professional standards, clinical practice guidelines, procedures, checklists, observation, documentation audits, clinical supervision, peer review and comparison against acknowledged competent clinicians in the area' – all in broad terms. There is less or no reference to documented benchmarks with specific descriptors, performance criteria, stated prerequisites, stated ongoing competency requirements or stated credentials of the assessor. When clinicians are asked to describe the types of evidence they used to assess clinical competence, there is considerable reference to registration requirements, formal credentials, work history, engagement in continuing professional development, direct workplace observation, clinical logs to capture diversity of practice, self-assessment tools, RiskMan data and performance appraisal. There is, however, no consistent approach observed in the application of competency-based training and assessment and mapping of evidence against standards to make competency judgements in many workplaces.

During the forums there was much reference to professional standards as a benchmark for measuring competence. In general these standards are relatively broad statements and although they are essential in providing certification of entry-level competence they have limitations when drilling down to specific clinical tasks or roles and the detail needed to guide the learner, the assessor or the supervisor in a training and assessment process beyond this. Professional standards do, however, provide a broad framework to scaffold any descriptors or performance criteria used in to assess clinical tasks.

Despite the potential value competency-based training can add to the allied health workforce, it would be remiss to think it can provide all the training needs for the allied health workforce as a stand-alone method. Clearly there are clinical practices where the application of competency-based processes in the workplace will not be adequate and verification of competence through accredited training will be required and in all likelihood regulated – for example, extended practices such as prescribing of medication for physiotherapists.

Implementing competency-based training is designed to fill the gap in the local environment when there is no other timely, suitable or acceptable avenue for measuring competence and it is deemed necessary and prudent to do so. It is not designed to take the place of formal qualifications awarded by a recognised training organisation or higher education institution.



Summary points

There is considerable variation in the types of standards used to measure clinical competency.

There is no consistent approach to the application of competency-based training and assessment where performance evidence is systematically mapped to make assessment judgements.

The role of professional standards within competency-based systems is acknowledged. They can inform developed benchmarks, but more detail is required to assess at the clinical task level.

Competency-based training in the workplace does not negate the need for accredited training for some clinical practices.

A summary overview of competency-based training and assessment as it can be applied in the workplace is depicted in **Resource 2.2** and is available in the competency resource kit.

Resource 2.2: Competency-based learning and assessment process overview

Phase	Definition	Guiding principles	Development and implementation process	Developed resources
Competency standards	<p>Competency To consistently apply knowledge and skills, in the range of situations and to the standard expected in the workplace</p>	<ol style="list-style-type: none"> 1. Consistent with Professional practice standards/ evidence based practice 2. In line with Professional body position statements 3. Consistent with professional scope of practice 4. Consistent with relevant clinical guidelines 5. Complies with the law 6. Reflects any threshold credentials for the work role 7. Reflects the appropriate AQF level descriptor 8. Incorporate the dimensions of competency, such as integrating knowledge, skills, and behaviours in a changing environment 9. Captures performance identified by subject matter experts, as being additional to entry level practice 10. It assumes core knowledge, skills and behaviour defined by threshold credentials 11. Risks have been identified and reflected in the standard 		Competency Standard
	<p>Competency standards explicitly describe the essential work outcomes and performance level, required to demonstrate workplace competence</p>			
Evidence	<p>Evidence Information gathered which when matched against the requirements of the standard, provides proof of competency</p>	<ol style="list-style-type: none"> 1. Evidence can be of various forms Direct e.g. witnessed by assessor, indirect e.g. reviewed later(portfolio) and supplementary e.g. 3rd party report, training 2. Evidence gathered is valid, sufficient, current, authenticises a range of sources is not reliant on self-assessment as a stand-alone method must include direct workplace observationsuits and is acceptable to stakeholders 		Evidence planning document
Workplace learning	<p>Workplace Learning The acquisition of knowledge and skills as individuals participate in clinical practice supported and guided directly or indirectly by expert colleagues</p>	<ol style="list-style-type: none"> 1. Promotes adult learning principles 2. Learners, assessors and mentors have access to descriptors of expected performance 3. Use self appraisal/ reflection where possible 4. Provide opportunity for learning of both experiential and theoretical knowledge 5. Independent study essential 6. Secure activities that are appropriate and sequence them from less to more complex 7. Ensure availability of expert colleagues particularly in the early stages 8. Where possible, provide teaching from a range of experts 9. Clinical experience or patient mileage is recommended 10. Provide opportunity for direct guidance/observation and constructive feedback, not just critical 11. Promote case based discussions and reviews of difficult cases with expert colleagues 12. Apply a flexible learning approach, that is targeted to meet organisational, job role and individual need. 13. Promote participation in external formal training +/- qualification (s) as required by the organisation 		<p>Learning Needs Analysis: Self-assessment tool</p> <p>Learning module/ package</p> <p>Learning and Assessment Plan</p>
Assessment	<p>Assessment The process where competence is measured against all aspects of the workplace standard</p>	<ol style="list-style-type: none"> 1. Workplace assessors meets specified criteria 2. Assessment principles are applied (validity, reliability, flexibility, fairness and sufficiency) 3. Assessment includes a range of methods mapped to the competency standard 4. Regardless of the assessment method used, preparation of the candidate, assessor and mentor is essential 5. Assessment suits and is acceptable to stakeholders 6. Be a combination of formative +/- summative assessment 7. Judgement is supported by the evidence gathered and the evidence accurately reflects; <ul style="list-style-type: none"> • real workplace requirements • dimensions of competency • requirements set out in the competency standard • the range and complexity of patient presentations found in the workplace. 		Assessment Tools

Pearce A, 2013, Monash Health: Allied health competency framework

How will competency be assessed using competency-based processes?

Using competency standards in the credentialling process

In the main, competency standards are developed to guide training and assessment programs. However, they can have a dual purpose, being a useful tool to assist in credentialling and defining the scope of practice of a practitioner. For this use they may form part of a credentialling standard, against which a practitioner is compared to establish their approved scope of practice.

Example:

A speech pathologist successfully completes a competency-based training and assessment program for fibre endoscopic evaluation of swallowing (FEES) at one organisation. The credentialling standard set by the responsible committee for approval of this scope of practice is stated as 'successful completion of the competency-based program'. The speech pathologist provides evidence of successful completion to the committee, and their scope of practice is approved.

The speech pathologist is then employed at a second organisation and provides detailed documentation of successful completion of the FEES competency-based program at the first organisation. The competency standard provided is compared with the organisation's own. The performance standard is deemed equivalent – the evidence provided to support decision making is authentic, sufficient, current and valid, so the scope of practice for the individual is approved. In some instances organisations may also require that the practitioner present for direct observation of the FEES procedure in the new organisation.

Example:

A radiographer successfully completes a competency-based training and assessment program in using an MRI machine at one organisation. The radiographer takes a new position at another organisation that uses the same MRI machine. The clinician provides detailed documentation of successfully completing a competency-based training and assessment program on the same MRI machine from the first organisation. The competency standard provided is compared with the organisation's own. The performance standard is deemed equivalent – the evidence provided to support decision making is authentic, sufficient, current and valid. The radiographer is asked to perform the first MRI imaging under direct observation. After successful operation of the MRI machine under direct observation, the radiographer scope of practice for using the MRI machine is approved.

What format should be used for competency standards?

Competency program versus learning program

Terminology used in this space is confusing. Within the allied health workforce a common outcome of local 'competency program' development is a list of learning activities for learners to engage in. For example, *Read the procedure for X* or *Read article Y*. While such a list is valuable as part of a documented learning program, completion of learning activities within a list is not a valid assessment of competency in the workplace. Engagement in learning activities does not guarantee learning or its application at the point of care.

Developers of any 'competency' or 'learning' program need to be clear about what the intended educational goal is at the end of that program and how much proof of achievement of that goal is required. Is the goal knowledge acquisition or is it application of skill in vivo? In either case, if information on candidate performance is systematically gathered, interpreted, recorded and communicated to stakeholders, then it can be considered a competency-based program.

If programs are being used as a means of ensuring autonomous, quality and safe application of skill in the workplace, then application of that skill in vivo would commonly be included in performance assessment. Application to the standard required in the workplace is certainly the focus and intention of the competency framework provided here. So when the term 'competency-based program' is used in this framework, in the main it refers to assessing a skill as it is applied in the workplace. It is not used here to refer to purely knowledge-based assessment, which is commonly also couched as a 'competency assessment'.

Available formats

The VET sector provides competency-based training for a wide range of industries, including health. These are based on the use of nationally endorsed *units of competency* formally approved by the National Quality Council. These endorsed units of competency are developed using a standardised format consisting of several standard parts (National Skills Standards Council 2012). When compared with the model used by the National Office of Overseas Skill Recognition (NOOSR) to evaluate and assess international qualifications, there are many similarities (Department of Human Services 2009a). By adopting a standard format, Australian trainers and assessors have a single document that clearly outlines what is required in an industry or enterprise for national accreditation.

While local development of standards for our purposes is not about accreditation, the principle of using a standardised format that closely reflects the components and content as seen in the VET and NOOSR model has been applied in this framework. Some adaptations of the National Skills Council format have been made to accommodate the expected needs of allied health services and to facilitate understanding of their use.

The key components of a unit of competency and their content are set out in Table 2.6. Further detail on how to use this format for development is set out in *Resource 2.4: Developers' checklist: Process summary and checklist for developers of competency-based programs*.

Table 2.6: Components of the standard format adapted where indicated* for use in allied health

Component	Description
1. Unit title	Describes the outcome of the unit concisely.
2. Unit descriptor	An overall statement about the learning area, clarifying the purpose of the unit.
3. Application*	Describes how the unit is practically applied in the workplace and in what contexts.
4. Prerequisite units*	Lists any conditions the candidate must meet prior to being eligible for determination of competency by the organisation, in the learning area described. Lists any other relevant conditions that apply.
5. Co-requisite units	States other units of competency related to the application of this unit in the workplace.
6. Skills recognition*	States conditions where recognition of prior experience or training would be accepted to verify competence, including who would make the determination.
7. Ongoing competency requirements*	Sets out any ongoing requirements to maintain competency in a specific clinical practice.
8. Element	An element is a basic building block of the competency standard. Elements describe the tasks that make up the broader function or job. They are actions or outcomes that are observable and assessable.
9. Performance criteria	Specifies the level of performance to demonstrate achievement of the element. Terms in italics are elaborated in the range statement.
10. Range statement	Provides further intentional detail to the terms in italics as needed to help define the context and any relevant conditions or restrictions.
11. References*	Includes a list of sources, local and otherwise, used to inform the development of the competency standard.

Component	Description
12. Assessment requirements outline* (formerly the evidence guide)	<p>Its purpose is to guide assessment against the standard in the workplace or training environment and includes:</p> <ul style="list-style-type: none"> • performance evidence (formerly essential skills) • knowledge evidence (formerly essential knowledge) • assessment conditions. <p>Such a statement confirms for the learner, assessor or training program developer the underpinning knowledge and skills that are integrated into performance to demonstrate competency in the standard and sets out contexts and conditions related to assessment.</p>

Source: National Skills Standards Council 2012

How might standards for competency-based processes be developed?

Expertise

The development of competency standards would ideally be facilitated and overseen by an allied health professional with expertise in competency-based training and assessment or postgraduate education qualification, coupled with local subject matter experts. Where access to expertise is absent, it is recommended that subject matter experts lead development using the competency resource kit provided to complete the process. This might also include conferring with other health services, special interest groups or the like.

Process

Initially, the development of units of competency or competency standards and supporting processes and tools requires a thorough inspection of the learning area as it is applied in the organisation and within the broader health context. For this purpose, identification of a subject matter expert(s) or best practice performer(s) is made initially to scope out the learning area and develop an initial draft of the standard. After the initial draft, formation of a wider reference group provides a forum for verification of the standard beyond the initial expert(s) and ensures the area of competence is fully described to the satisfaction of the organisation. After completion the competency standard is verified at the organisational level (where necessary) and made available for local use in an electronic format. Learning and assessment programs and tools can then be developed (where necessary) to support implementation. In practice the responsibility for this falls mainly to senior allied health professionals with relevant content knowledge.

Use the competency resource kit

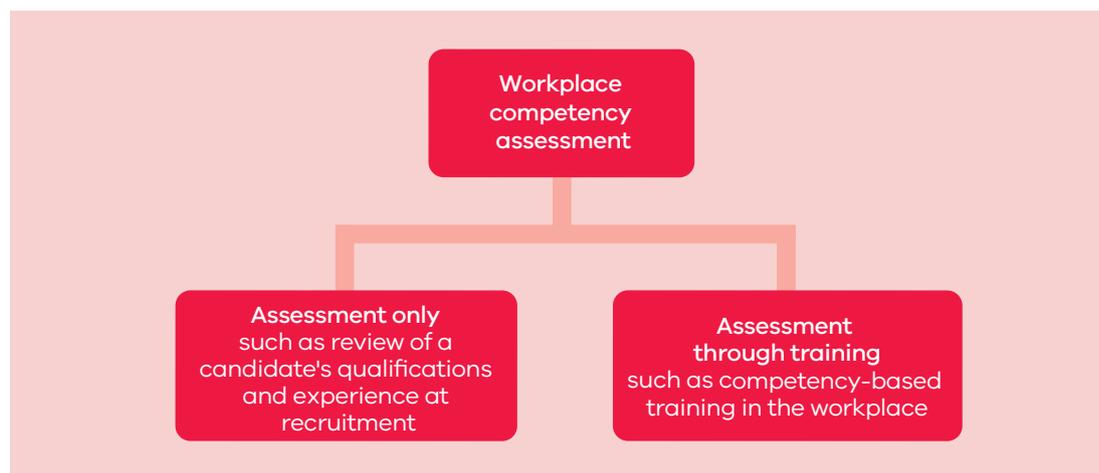
Resource 2.4: Developers' checklist: Process summary and checklist for developers of competency-based programs has been developed and is available in the competency resource kit. It includes a list of preliminary information to be gathered or clarified prior to competency standard development such as: professional association guidelines or position statements; relevant evidence-based clinical guidelines; relevant organisational policy and procedures; and identification of risk. In addition it provides guidance on developing all of the components listed in **Table 2.6**.

What assessment processes will be used?

It is worth restating here that any training currently performed and assessed using this framework remains non-accredited and is not subject to the same regulatory requirements as accredited training. Even so, it is prudent to apply key principles used in accredited competency-based assessment in addition to those applied in health professional education.

When assessment of competency is indicated, candidates can be assessed via two pathways as depicted in **Figure 2.2**. This provides an avenue for training to the required level of performance in addition to enabling the recognition of previous formal or informal training and experience.

Figure 2.2: Assessment pathways



Assessment only

This is where skills and knowledge have already been gained and the candidate is ready to be assessed against criteria without needing to go through a training program. This pathway is called many things: 'skills recognition' for our purposes, or 'recognition of prior learning' (RPL) for the purposes of accredited programs.

Example:

A grade 2 allied health assistant has been performing home visits for the purposes of collecting preliminary data in the home environment for one organisation and is employed by another, which requires the same task to be undertaken. This task has been performed multiple times in recent history and can be verified by a referee and a descriptor in the previous position description. In such a case as this, an assessment against the new organisation's competency standard and orientation to relevant organisational procedures would be advised, but a full training and assessment pathway would be unnecessary.

In cases where formal qualifications are held, it may be deemed appropriate not to assess against benchmarks and assume that the rigorous nature of the qualification satisfies the requirements of working in a specified job role within the organisation.

Example:

Attainment of a graduate certificate in pelvic floor rehabilitation qualifies an individual to do internal examinations, and no further workplace assessment would be deemed necessary.

Assessment through training

This is where the candidate needs to learn skills and knowledge first and then the assessment is conducted at intervals during the course of the training and/or at the end of the training.

Example:

Expansion to additional sites of a service providing footwear to patients by allied health assistants uses both the training and assessment pathway mapped to a locally developed competency-based training and assessment program. Even if an individual held a Cert. IV in AHA with specialisation in podiatry, this would not be sufficient to verify an individual's workplace competence in this case, as determined by the reference group.

Example:

A pharmacy department in an organisation has undergone expansion and will now be compounding in-house chemotherapy. They will need to hire more pharmacy technicians to work in the Pharmacy Oncology department. The new Pharmacy Oncology department has also purchased an automated compounding system to help produce chemotherapy and reduce the incidence of repetitive strain injury. Even if a pharmacy technician held a Cert. IV in Hospital/Health Services Pharmacy Support (including successful completion of HLTPHA007 Conduct small-scale compounding and labelling of aseptic pharmaceutical products), this would not be sufficient to verify an individual's workplace competency in this case. This is because it is a high-risk procedure, a new setting and new equipment being introduced. Any one of these factors would require additional competency assessment.

Evidence

Evidence of competence is information gathered, which when matched against the requirements of the standard, provides proof of competency achievement.

Adapted from Department of Training and Workforce Development 2012

For the purposes of the competency framework some guiding principles regarding evidence have been established based on those widely accepted within competency-based training systems (Department of Training and Workforce Development 2012) and based on a review of current practices being applied within the health workforce, particularly within the nursing workforce (EdCaN 2008). In summary, evidence gathered can be of various types but needs to meet the 'rules of evidence' and be acceptable to stakeholders.

Types of evidence

Evidence of a candidate's competency may take many forms, and what is accepted will be influenced by the purpose of the assessment and the required outcomes of performance. The various types of evidence are described in Table 2.7. A combination of evidence types is usually used to assess competence.

Table 2.7: Various types of evidence

Type	Explanation
Direct evidence	This involves the assessor directly witnessing the candidate's performance – for example, direct observation of performance in the workplace, viewing a video of performance in the workplace or observation in a simulated workplace that closely matches the demands of the real workplace.
Indirect evidence	This evidence is used when it is not possible or desirable to observe the candidate during the actual performance of the task; the evidence is reviewed later. This form of evidence may also be gathered to minimise costs or there may be confidentiality or privacy issues. An example here would be a review of clinical notes or other documentation.
Supplementary or third party	This evidence is used when additional evidence is required to support other forms of evidence; it is often obtained through third-party sources such as a previous supervisor or employer, or through oral or written questioning.

Principles to be applied to gathered evidence

There are certain principles that apply to all gathered evidence when supporting decisions of competence. The evidence should be valid, current, authentic and sufficient as described in Table 2.8.

Table 2.8: Rules of evidence

Rule	Explanation
Valid	The evidence gathered needs to meet the requirements of the specified standard. This evidence should reflect the type of performance described in the standard, whether this is knowledge, skills or behaviours. All critical evidence is stated in the evidence guide. For our purposes, this process is guided by any recommendations made by professional bodies, reference groups or subject matter experts.
Current	This relates to the recency of the evidence and whether it demonstrates the candidate's current abilities. The currency of evidence needs to be considered closely. For example, if a candidate is returning from extended leave, they may not have performed a particular clinical practice for years and there may be new technologies to be applied in the workplace. Stipulations regarding what constitutes currency may need to be advised by reference groups or subject matter experts.
Authentic	The evidence gathered needs to be the work of the candidate. If unsure, then evidence may need to be corroborated or verified. Follow-up questioning may be useful here.
Sufficient	The initial three rules relate to each piece of evidence, while this relates to the overall collection of evidence. The key here is that there needs to be enough evidence gathered to satisfy that the candidate is competent across all aspects of the stated standard and that they can demonstrate the ability to apply this in the range of contexts required in the workplace. Inferences are drawn about competence by an assessor putting together the range of evidence sources.

Sources of evidence and assessment methods

There are numerous sources of data (evidence) that can be gathered during the assessment process to support decisions of competence for both 'assessment only' and 'assessment through training' pathways.

In summary the literature supports gathering evidence from a number of sources using multiple sampling and including both content knowledge and performance evidence to provide proof of competence (Norman 1979). Self-assessment as a stand-alone method is not recommended (Eva et al. 2004) but can be used: as a cost-effective means of identifying the individual strengths and areas for development of the candidate; to help direct the focus of work-based learning; and to provide assistance for the trainee to reflect meaningfully. Where possible, self-assessment should be matched to benchmarks (EdCaN 2008). The context in which assessment of competency occurs is considered essential, so the use of direct workplace observation should be included as a form of evidence wherever possible. This is well supported by a broad range of literature.

Some examples commonly used in health are described in Table 2.9.

Table 2.9: Assessment methods applied in the health sector as sources of evidence for competency decisions

Source	Example
Direct workplace observation	<ul style="list-style-type: none">• Observing the candidate performing real work/real-time activities at the workplace• Work activities in a simulated workplace setting such as simulation centre or simulated setup• Recording performance using checklists• Clinical supervision
Structured assessment activities	<ul style="list-style-type: none">• Case-based presentations observed by an assessor• Clinical audit such as a review of the content of medical record entries against evidence-based practice and best practice is undertaken by a peer group• Review of a clinical log such as occasions of applied clinical practice in the workplace, which are recorded in a log• A review of completed documentation• A review of scanned medical record entries
Questioning	<ul style="list-style-type: none">• Written questions such as short answer questions• An online quiz such as on hand hygiene• Interviews such as those conducted at recruitment• Self-assessment such as ranking your own performance against standards or a position description• Oral appraisal such as using a bank of questions

Source	Example
Contents of a portfolio/resume	<ul style="list-style-type: none"> • Continuing professional development record • Training record • Qualifications • Professional registration endorsements • Clinical appointments • Reflective journal • Report of quality activities
Review of products	<ul style="list-style-type: none"> • Review of products as a result of a project • Equipment set up correctly • A fault is found and rectified
Reports from third parties	<ul style="list-style-type: none"> • Testimonial from a referee • Evidence of training delivered or attended • Patient satisfaction survey

Within the competency framework, reference groups or subject matter experts are asked to make recommendations regarding the amount and types of evidence that would provide evidence of competency for the identified work role or practice. The key questions asked are: *What will be accepted to prove competence in this case?* and *Are there any 'musts'?*

Example:

When the reference group for nuclear medicine established the evidence required to support decisions of competency for lymphoscintigraphy, a range of methods were included such as completing a clinical log and direct workplace observation.

Considering the types and amount of evidence early in the development process will help to shape the wording of the performance criteria and the assessment processes that ensue.

Example:

If it is unlikely that an adverse event or 'near miss' will occur during the assessment timeframe, performance criteria relating to competence in this area might read 'explains clearly potential adverse events or near misses related to this procedure and outlines the appropriate action', rather than, 'takes appropriate action in the event of an adverse event or near miss'. In the former an oral appraisal is the type of evidence accepted; in the later you would have to rely on an actual event to occur to gather evidence. This may never happen during the assessment timeframe.



The type of evidence that will suit and be acceptable to stakeholders is an important consideration when deciding on sources of evidence. This will vary considerably and may be dependent on context.

Example:

Mandatory training related to occupational aggression and appropriate workplace behaviours is common, with formal assessment taking the form of an online quiz. While gathering data (evidence) using a quiz may be appropriate in this instance, it is unlikely to be acceptable for an assessment of competency such as when allied health professionals perform tracheal suction. A direct workplace observation is more suitable and acceptable to stakeholders.

When work roles and tasks are being delegated or substituted by an alternate workforce, or skills are being translated across occupational groups, those groups delegating the task are likely to have strong opinions as to what type of evidence would support a decision of competency.

Example:

In a Health Work Australia project looking at an advanced musculoskeletal physiotherapist in the emergency department, emergency physicians at a regional hospital requested direct observation on a number of occasions before they would deem an individual competent to assess and manage simple fractures.

An important and not-to-be-overlooked consideration when deciding on the types of evidence required are resource considerations and the practicalities of implementing these in the workplace.

Example:

Direct observation of all possible oxygen therapy setups as they are applied at the bedside may not be possible in a timely manner. It may, however, be appropriate to view two of the most common or complex setups at the bedside and then view a practical demonstration of other variations.

The assessor meets specified criteria

There is considerable support for clinical supervision competency in the allied health workforce. The *National clinical supervision competency resource* (Health Workforce Australia 2013a) is a good example of this. The lack of clarity defining who an appropriate assessor is needs to be addressed.

Many allied health professional standards do not explicitly state who an appropriate assessor of those standards is.

In the VET sector, the general rule of thumb is you can assess anyone at your qualification level or below, providing you have ‘appropriate’ experience (Australian Qualifications Training Framework 2010). The Australian Nursing Council (2002) developed a useful resource that outlines the principles it applied for assessing the national competency standards for registered and enrolled nurses.

For local application of organisational competency standards organisations can make their own decisions about the requirements of an appropriate assessor. Suggested practice would be to use a clinician who is at the same grade level or above the candidate. In some cases, using non-allied health professionals such as medical and nursing staff would be appropriate to assess roles or practices that are considered advanced or extended and that fall within their scope of clinical expertise.

It is not uncommon for workplace assessors to undertake a competency-based training and assessment program where competency as a clinical assessor is determined and recorded by the organisation. In addition, industry regulators and registering bodies may agree to additional requirements for trainers and assessors, where there are legislated requirements for licensing purposes.

Where there are no legislated requirements or additional organisational requirements, it is recommended that workplace assessors meet the recommended criteria list in Table 2.10 as a minimum and complete a self-assessment checklist against these criteria. This self-assessment tool is available in a checklist as *Resource 2.22: Appropriate assessors’ self-assessment checklist*.

Table 2.10: Minimum criteria for appropriate workplace assessors

Criteria
<input type="checkbox"/> Tacit knowledge of the assessment area (the assessor’s real or understood knowledge of the expected standard of performance of the clinical practice to be assessed)
<input type="checkbox"/> Recent and broad experience in the area being assessed
<input type="checkbox"/> Expertise in performance assessment processes
<input type="checkbox"/> Working knowledge of the competency standard content
<input type="checkbox"/> Working knowledge of the assessment plan and tool
<input type="checkbox"/> Working knowledge of the responsibilities as an assessor including: <ul style="list-style-type: none"> • ensuring the assessment takes part in the practice setting • ensuring the candidate has appropriate preparation for and information about the assessment process • conducting assessments fairly • providing effective performance feedback • recording results and maintaining confidentiality in accordance with organisational requirements
<input type="checkbox"/> Have relevant clinical competencies at least to the level being delivered or assessed by virtue of a qualification, training or experience

Principles of assessment

The principles of validity, reliability, flexibility, fairness and sufficiency should be applied to assessment processes and decisions. These principles are outlined in Table 2.11.

Table 2.11: Principles of competency-based assessment as they apply to the competency framework

Principle	Key ideas
Validity (assessing what it claims to assess)	<ul style="list-style-type: none"> • The assessor’s knowledge and skill is crucial to enhancing the validity of the assessment process • Evidence is gathered about performance by the assessor to justify assessment judgements • Assessment includes the range of knowledge and skills needed to demonstrate competency with their practical application • Where possible, it includes judgements based on evidence from a number of sources, occasions and across a number of contexts
Reliability (consistent and accurate decisions)	<ul style="list-style-type: none"> • Clear instructions for the assessor as to what must be identified and what constitutes the required performance level (this is enhanced by the competency standard and use of assessment tools) • Consideration is given to the amount of error included in the evidence
Flexibility (when it can accommodate the needs of learners, a variety of delivery modes and delivery sites)	<ul style="list-style-type: none"> • Assessment should reflect the candidate’s needs • Must provide for recognition of knowledge, skills and attitudes, regardless of how they have been acquired • Assessment must be accessible to learners through a variety of methods appropriate to the context and the candidate
Fairness (when it places all learners on equal terms)	<ul style="list-style-type: none"> • The assessor considers the needs and characteristics of the candidate and includes reasonable adjustment where applicable • Assessment is based on a participative and collaborative relationship between the assessor and the candidate • The assessment procedure is clear to all learners before assessment • The assessor is open and transparent about all assessment decision making and maintains impartiality and confidentiality throughout the assessment process • Assessment decisions can be challenged, and appropriate mechanisms are made for reassessment as a result of the challenge

Principle	Key ideas
Sufficiency (relates to the quantity and quality of the evidence assessed)	<ul style="list-style-type: none"> • Refers to evidence as well as assessment • Enough appropriate evidence needs to be collected and assessed to ensure all aspects of the competency standard have been satisfied • Evidence should accurately reflect real workplace requirements and include the range and complexity of patient presentations found in the practice context • Includes a range of methods mapped to the competency standard • Provides evidence from the assessment process that is acceptable to stakeholders

Assessment conduct

The manner in which assessments are conducted is crucial to supporting the above principles. Additional resources to support this can be accessed in *Resource 2.25: Guidelines for allied health assessors during a direct observation assessment*.

Learning and assessment plan

Within this competency framework, learning and assessment programs are recorded on a standardised yet adaptable *Learning and assessment plan* template, available as **Resource 2.10**. The Learning and assessment plan is separated into two sections:

- The learning plan outlines learning resources and describes various learning activities to be undertaken, as set by the organisation, and can be adapted to meet the individual learning needs of the candidate.
- The assessment plan outlines the methods in which the competency assessment will occur such as work-based observed sessions, case-based presentations and oral appraisals. The assessment is mapped back to the competency standard's performance criteria. This can again be adapted to meet the needs of the organisation and the candidate.

To develop the *Learning and assessment plan*, subject matter experts will need to indicate what methods of assessment or types of evidence would be acceptable and also what, if any, would be considered a 'must'. The evidence planning document available as **Resource 2.8** can be used to assist this process and is available in the resource kit. Assessment methods are then mapped against performance criteria and recorded on the *Learning and assessment template* available in the toolkit. These can be adapted to meet organisational need.

Assessment tools

After the *Learning and assessment plan* has been established, assessment tools are developed to support assessors to conduct assessments and optimise the quality and consistency of the process. Tools allow for evidence collection and provide guidance for the learner and the assessor. They record assessment outcomes and, wherever possible, they should be piloted to see if they are realistic and appropriate.

A common preference noted is to have just one assessment tool to record assessment for an area of competency. This tool might collate evidence from a number of different assessment methods such as direct workplace observation and oral appraisal. This can be appropriate in many instances, but sometimes multiple tools need to be developed to capture different assessment activities, particularly if the area of learning is broad and complex.

Example:

An advanced musculoskeletal physiotherapist working in an emergency department in a primary contact role provides treatment for a diverse range of presenting conditions. It would not be practical to record an assessment of all areas of competency on the one assessment tool when there is likely to be multiple assessment occasions using multiple assessors and assessment methods. Compare this with an assessment of an AHA's competency to perform outcome measures. A number of different outcome measures may need to be viewed, but the learning area is not as broad or complex and could be recorded on the one tool.

The key components of assessment tools are set out in Table 2.12.

Table 2.12: Suggested key components of an assessment tool

Components
<input type="checkbox"/> Have a simple layout that is practical to use
<input type="checkbox"/> Records candidate's name and designation
<input type="checkbox"/> Records assessor's name and designation
<input type="checkbox"/> Records area/name of competency standard being assessed
<input type="checkbox"/> Records assessment timeframe or dates of assessment
<input type="checkbox"/> Contains details of the assessment task, including context as needed
<input type="checkbox"/> Contains the standard of performance to be observed such as performance criteria
<input type="checkbox"/> Contains the rating scale to be used and any definitions
<input type="checkbox"/> Has sufficient space to record responses/comments either against individual items or for overall performance, including both good points and areas for improvement
<input type="checkbox"/> If knowledge questions are included these should be documented, with space left to indicate acceptable responses
<input type="checkbox"/> Uses a sequential order of performance where possible
<input type="checkbox"/> Indicates the final results of assessment
<input type="checkbox"/> Contains a field for the assessor's and candidate's signatures
<input type="checkbox"/> Contains details of the manager's verification if required
<input type="checkbox"/> Contains version control information
<input type="checkbox"/> Contains any further recording processes required by the assessor
<input type="checkbox"/> Contains clear instructions for candidates and assessors

A number of assessment tool templates and samples are available in the competency resource kit.

Competency rating scales

There is no one performance rating scale applied to measures of overall competence or specific clinical competency throughout the health sector for pre-entry, entry or post-entry level clinicians.

In current competency-based assessment processes applied within many health services, binary scales are the norm such as competent or not yet competent, satisfactory or unsatisfactory. This is consistent with the ratings used in the VET sector. Under this model candidates are expected to meet the level of performance specified in the competency standard and defined by performance criteria. Some would argue this has a way of discouraging excellence (Department of Human Services 2009a). To support clinical governance and assist in defining the scope of individual and clinical practice, binary scales may be acceptable and meet the needs of the organisation.

The alternative is classification systems using staged descriptors. These non-binary models allow for the mapping of a learner's progress; they can reflect increasing levels of performance across a range of descriptors and discriminate more accurately between learners if this is required. Some examples of this include:

- the *National common health capability resource* (Health Workforce Australia 2013b)
- *Assessment of physiotherapy practice* (Dalton et al. 2009)
- Miller's pyramid, which describes the assessment of clinical competence as a continuum based on differing levels of educational goal states from 'knows' and 'knows how', through to 'shows' and 'does' (Miller 1990)
- Benner's application of the Dreyfus model of skill acquisition in nursing, which uses ratings based on skill acquisition through sequential stages and progresses from 'novice', 'advanced beginner' and 'competent' through to 'proficient' and 'expert' (Benner 1984)
- the Bondy scale, which uses language common to allied health clinicians in ratings based on the standard of procedure, quality of performance and the level of assistance given to the learner. It moves from 'not observed', 'dependent', 'marginal', 'assisted' and 'supervised' to 'independent' (Bondy 1983).

Regardless of the scale used to articulate performance levels to describe competency beyond entry level and in the workplace, all measures of demonstrated performance need, at the very least, to be matched to documented standards of performance, to the satisfaction of the organisation and other stakeholders.

Summary points

If information on candidate performance is systematically gathered, interpreted, recorded and communicated to stakeholders, then it can be considered a competency-based program.

A standard format for competency standards is recommended.

The use of reference groups or subject matter experts is integral to developing suitable assessment processes.

Assessment should provide an avenue to both up-skill individuals to the required level of performance and enable the recognition of previous formal or informal training and experience.

Evidence gathered to support decisions of competence can be of various types but needs to meet the 'rules of evidence' and be acceptable to stakeholders.

In most cases a range of evidence sources using multiple samples is recommended to support decisions of competence.

Self-assessment as a stand-alone method is not recommended to provide proof of competency assessment.

Wherever possible, direct workplace assessment in context is recommended as a source of evidence.

Principles of validity, reliability, flexibility, fairness and sufficiency should be applied to assessment processes and decisions.

The suitability of the workplace assessor should be established.

Documented learning and assessment plans outline the learning program and map assessment methods against the competency standard.

Assessment tools support the assessment process and optimise the quality and consistency of the process.

There are a variety of performance rating scales used within the health workforce that have varied application within this competency framework.

Challenges

The challenges in defining and assessing workplace competency for such a diverse group of clinicians are numerous and are encountered at each of the five steps.

Step 1: Consider how competency will be determined in the workplace

Inconsistent understanding of competency-based processes as a whole and their role in the allied health workplace

Inconsistent use of terminology

Step 2: Determine clinical practices to be targeted by competency-based training and assessment

Establishing priority areas for development. Competency-based processes can be applied to any area of knowledge and skill, but it would be an unwise use of healthcare resources

Applying some clinical practices in more remote or professionally isolated areas adds complexity to the learning and assessment process

Knowing when competency-based processes are not enough and an additional threshold credential is required is not clearly defined

Integrating the clinical practices to be assessed in the workplace into other governance processes

Step 3: Apply competency-based training and assessment to clinical practice

Releasing resources to develop robust learning and assessment programs

Ensuring adequate preparation of clinical assessors

Implementing competency-based programs where there is limited access to subject matter experts or clinical supervision

Learner buy-in to workplace assessment beyond entry level

Getting non-allied health assessor buy-in where necessary

Reliability and validity of assessments; making substantiated and fair judgements about performance in the workplace

Developing the processes without face-to-face expertise by someone skilled in the development process

Ensuring organisation-wide versus site-based approaches

Determining ongoing competency requirements

Implementing a framework without a developed learning management system

Step 4: Record and report the outcomes of competency assessment

Integrating the results with credentialling requirements

Getting often fragmented processes into an usable system, particularly if you don't have access to a learning management system

Step 5: Evaluate

Establishing what to evaluate at which stage

General

Buy-in at all levels; 'competency packages' are in vogue, but for well-developed processes it takes time and effort

Currently there is no central way of sharing resources between health services

Balancing improved processes versus unnecessary processes

Section 3: Capability framework



Aim

Capability frameworks aim to promote the development of shared skills, behaviours and attributes required within the allied health workforce for delivering high-quality, safe and effective care.

Developing a capability framework gives the health service organisation a common language to describe the skills, knowledge and attitudes required for quality service delivery. It provides a platform for strategic and efficient human resource processes including:

- workforce planning
- service design
- recruitment
- performance management.

Using a capability framework to target workforce development in priority areas can also help align culture with strategic directions and educational objectives (Foley & Conole 2003).

What is capability?

Example:

Capabilities are underpinning behavioural skills that characterise work being performed well (Health Workforce Australia 2013a).

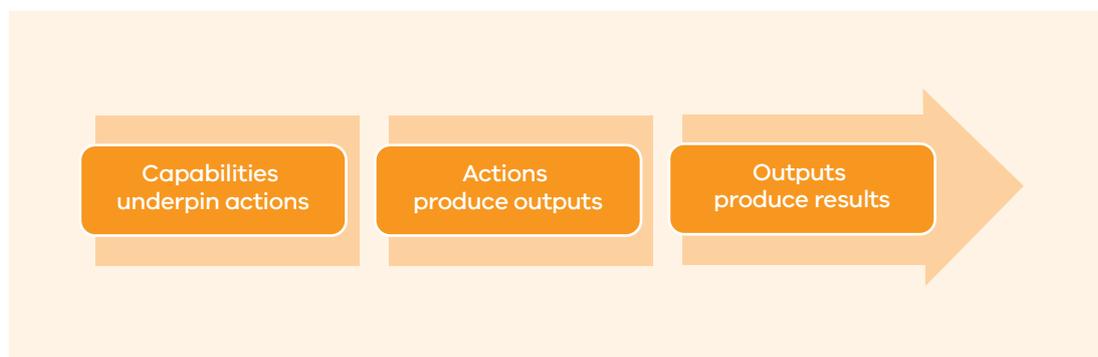
Capabilities specify the expected behaviours and attributes of clinicians as they progress through grading structures. They reflect the expanding sphere of influence and control expected of individuals of a higher grading.

Put simply, capability is 'the ability to do something'. However, the broader definition of the word is more applicable to the workforce and the use of this framework:

'Capability incorporates the skills, knowledge and attitudes that a person brings to their work. It includes technical, business, personal and professional expertise which can be developed by formal and informal learning, observation, mentoring, guidance, feedback, lifelong experience and reflection.' Queensland Public Service 2010, p. 150

Capabilities are observable 'abilities' that are necessary to perform a particular type or level of work activity. They are important for performance, results and organisational success (NSW Government 2010). They underpin actions that lead to results, as depicted in **Figure 3.1**.

Figure 3.1: Capabilities produce results



Background

It is widely recognised that professional development or continuing education is a critical component in ensuring the delivery of safe and effective healthcare. To date, education in health has largely focused on the acquisition of knowledge and skills identified as important in deeming the individual 'competent' to perform their role. In the current context, it is increasingly evident that 'health services in the 21st century must aim not merely for change, improvement, and response, but for change-ability, improvability, and responsiveness' (Fraser & Greenhalgh 2001, p. 799). We are therefore challenged to facilitate not just skill acquisition and competence but also capability development.

The concept of capability has been well grounded in practice and draws upon social cognitive theory. Competence refers to the ability to apply skills in the 'here and now', but capability also refers to 'that capacity or potential to do more, in unfamiliar or novel circumstances' (Cairns 1999, p. 7). Health services should provide an environment and framework that enables individuals to develop sustainable capabilities appropriate for a continuously evolving environment.

The importance of the person-centred approach in contemporary healthcare is well documented. However, with increasingly complex needs, meeting patient-centred goals requires collaborative working between healthcare professionals. By using an interdisciplinary framework, we can promote collaborative practice by providing a shared platform for discussing common capabilities and how these are applied and developed in the ever-changing healthcare sector.

By promoting and rewarding the desired behaviours in the workforce, it is possible to cultivate a culture that embraces new and better ways of providing healthcare. This may result in innovation and reform efforts being more likely to succeed and being sustained long term.

Developing capability

Education aimed at enhancing capability requires learners to engage with ambiguous and unfamiliar contexts in a meaningful way (Fraser & Greenhalgh 2001). This type of education does not lend itself to typical learning approaches in health where structured, content-driven events such as lectures and workshops predominate. Capability is best developed through less traditional methods that incorporate structure to support learning but do not dictate content or prohibit the exploration of complexities that are inherent in the contemporary healthcare setting. **Figure 3.2** outlines suggested learning methods for capability development.

Figure 3.2: Suggested learning methods for capability development

- | | |
|--|---|
| <ul style="list-style-type: none">• Simulation, role-play• Peer learning – peer teaching, peer support groups• Individual mentoring, coaching, shadowing | <ul style="list-style-type: none">• Personal learning log• Case-based discussions• Small-group learning• Team-building exercises |
|--|---|

Summary points

Capability development can:

- promote behaviours important for the complex contemporary healthcare environment
- foster collaboration
- support innovation.

Developing key capabilities is an essential component of professional development.

Capability resources table

The following resource table is a summary of the tools and samples related to capability. The capabilities identified in the framework have been mapped against the allied health professional (AHP) and allied health assistant (AHA) grades identified in the relevant Victorian public health sector enterprise agreements.¹

The resources can be accessed electronically in the capability resource kit available on the Department of Health and Human Services website (www2.health.vic.gov.au).

Competency resource name	Description or purpose
Tools	
3.1 Self-assessment tool: Capability	Use this self-assessment tool before you progress through the rest of the capability section. It can be used to identify areas for targeted action. If you have identified an area of need, please refer to the capability methodology section or access the other samples and tools to assist you in this process.
3.2 Decision tool: How can a capability framework be used in my organisation?	Determine how a capability framework might be used in your organisation.
Worked examples	
3.3 Capability cards	These cards have been developed using the <i>National common health capability resource</i> (NCHCR), which is published by Health Workforce Australia. The cards can be used to support mapping and implementation of a capability framework.
3.4 Capability mapping by grade level: worked example	These worked examples map expected behavioural capabilities against grade levels for allied health professionals and assistants.
3.4.1	Fundamental and desirable capabilities mapped against AHP grades and levels of the NCHCR
3.4.2	Fundamental and desirable capabilities mapped against AHA grades and levels of the NCHCR
3.4.3	Visual representation of expected fundamental behavioural capabilities mapped against AHP grades and levels of the NCHCR
3.4.4	Visual representation of expected behavioural capabilities mapped against AHA grades and levels of the NCHCR
3.4.5	NCHCR level descriptors of expected behavioural capabilities: grade 1 allied health professional

¹ These include the *Victorian public health sector (health professionals, health and allied services, managers and administrative officers) enterprise agreement 2011–2015*, the *Victorian public health sector (medical scientists, pharmacists and psychologists) enterprise agreement 2012–2016*, the *Public community health sector enterprise agreement 2012–2016*, the *Victorian public health sector (health and allied services, managers and administrative employees) multiple enterprise agreement 2009–2011* and the *Health Services Union (health professionals) – multiple enterprise agreement 2009*.

Competency resource name	Description or purpose
Worked examples (cont.)	
3.4.6	NCHCR level descriptors of expected behavioural capabilities: grade 2 allied health professional
3.4.7	NCHCR level descriptors of expected behavioural capabilities: grade 3 allied health professional
3.4.8	NCHCR level descriptors of expected behavioural capabilities: grade 4 allied health professional
3.4.9	NCHCR level descriptors of expected behavioural capabilities: grade 2 allied health assistant
3.4.10	NCHCR level descriptors of expected behavioural capabilities: grade 3 allied health assistant
3.5 Position description incorporating capabilities: worked example	This mock example outlines the capabilities expected of a grade 2 AHP, incorporating them into a position description and using the NCHCR.
3.6 Position description incorporating capabilities: worked example	This example from Western Health outlines the capabilities expected of an intern radiographer, incorporating them into a position description and using the NCHCR.
3.7 Behavioural interviewing: worked example	Provided here are example interview questions aligned with the NCHCR.
3.8 Capability assessment: worked example	This mock example uses the expected capabilities of a grade 2 AHP, incorporating them into a tool that can be used for self-assessment for annual performance appraisal. It is based on the NCHCR.
3.9 Capability assessment: worked example	This example from Western Health uses the expected capabilities of intern radiographers, incorporating them into a tool that can be used for self-assessment for annual performance appraisal and is based on the NCHCR.

Resource 3.1: Self-assessment tool: capability

Use this self-assessment tool before you progress through the rest of the capability section. It can be used to identify areas for targeted action. If you have identified an area of need please refer to the methodology section below to access information, samples and tools to assist you in this process.

Capability question	Planned	Partly implemented	Established	Not applicable	Review date
1. Does your organisation have an agreed concept of capability to work from?					/ /
2. Does your organisation have a capability framework that meets the needs of allied health?					/ /
3. Do you have an agreed set of expected capabilities for each grade level?					/ /
4. Are the expected capabilities incorporated into recruitment processes (such as position descriptions, interview questions)?					/ /
5. Are the expected capabilities incorporated into supervision practices?					/ /
6. Are the expected capabilities incorporated into performance development processes?					/ /
7. Have education/professional development opportunities been linked to the identified capabilities?					/ /

Methodology: how to implement in the workplace

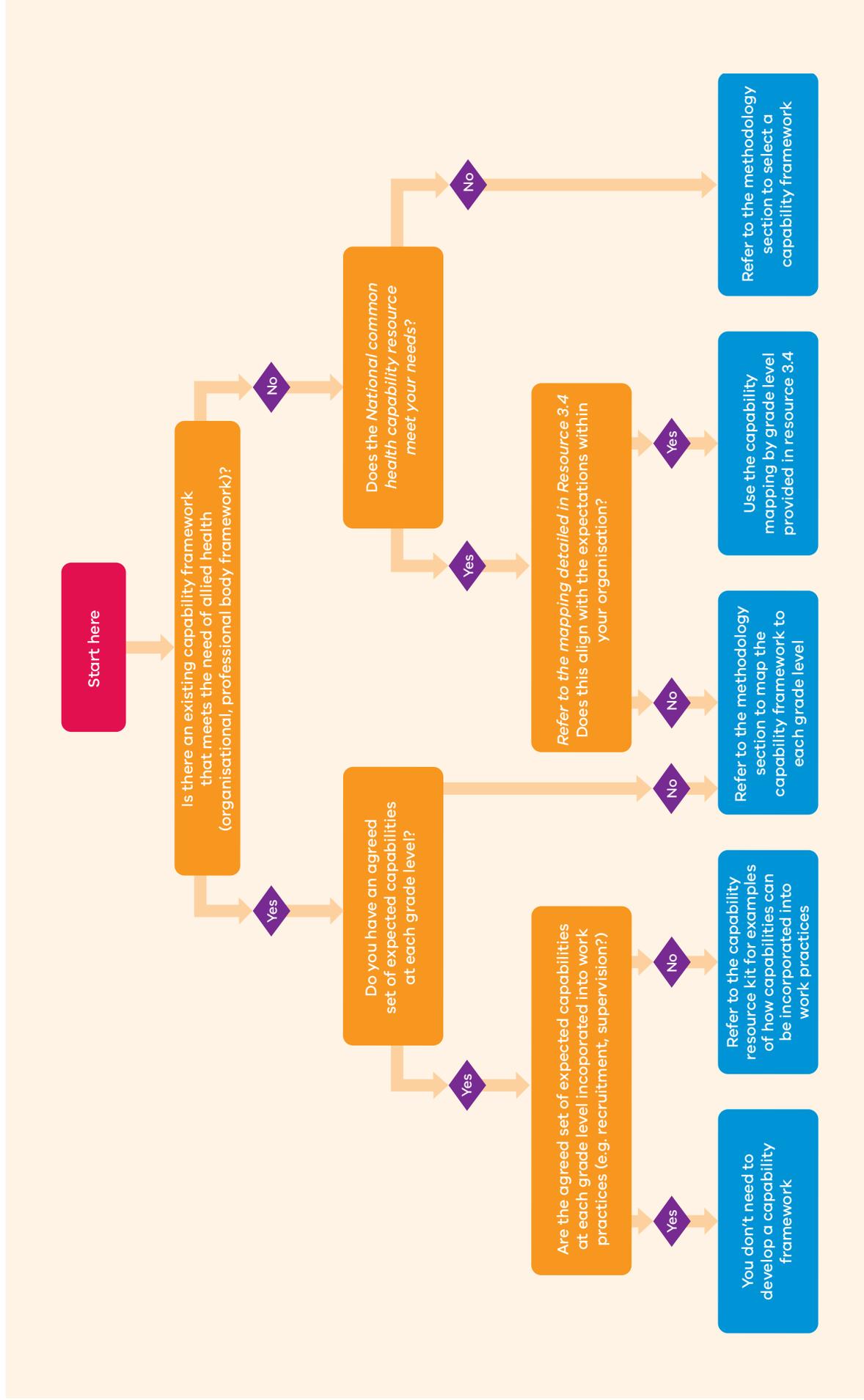
Figure 3.3: Steps to mapping out and applying the capability framework



Step 1: Determine how a capability framework might be used in my organisation

Resource 3.2: Decision tool: How can a capability framework be used in my organisation?

Work through the decision tree and the follow the recommended actions to progress on.



Step 2: Establish your stakeholder group

Next, establish your stakeholder group. It is recommended that the group be no larger than 10 people to aid in decision making. The group should include a range of profession backgrounds, work areas and seniority. Consideration should also be given to including representatives from human resources, organisational development and allied health executive.

The stakeholder group should have a clear understanding of the purpose of developing a capability framework in your context. Several meetings and/or workshops may be required to reach a consensus in the mapping phase, therefore the group should be prepared to commit for the entire process.

Step 3: Select your framework

Select your framework. The examples provided use the *National common health capability resource* (Health Workforce Australia 2013b) as its framework of reference; however, this methodology can be applied to any available framework. Users of this process may wish to explore other frameworks within their workplace or sector, including organisational, professional and other frameworks. It may also be appropriate to use more than one framework as a basis within your context. There are numerous frameworks that have been published in varied workforce sectors. Some examples from health include:

- *National clinical supervision competency resource* (Health Workforce Australia 2013a)
- *NSW public sector capability framework* (NSW Government 2010)
- *Victorian public employment capability framework* (State Services Authority 2006)
- WA Country Health Service allied health competency frameworks (WACHS 2008).

Step 4: Become familiar with the contents of the framework

Become familiar with the structure and statements within the framework. The stakeholder group should be aware of the different levels in the framework and consider how these may be applied. A decision should be made about how the framework is going to be incorporated into existing supervision/development procedures and how it will be used to support recruitment. For example:

- Will the expected capabilities be incorporated into position descriptions? How will this process be managed? Will capabilities be assessed as part of the application process?
- How will existing staff be informed about the framework?
- How will the framework be used in supervision? Will staff be asked to reference the framework in annual performance plans? Will a self-assessment/reflection process be encouraged?

Step 5: Map expected capabilities against grades and test your results

For each grade level (as applicable), select the expected behaviour level for each domain/activity. The group may then wish to prioritise these by area of importance for your context. Another option is to set fundamental or entry-level expectations versus advanced or stretch-level expectations within a grade level. Consideration should also be given to the desired culture and/or strategic direction of the organisation and how the capability priorities support this.

It is recommended that this mapping takes place in a face-to-face meeting or workshop, of which more than one may be required to complete the process. There should be a group consensus on the chosen capability levels for each grade and domain/activity. Any differences in opinion should be resolved via negotiation until a consensus is reached.

The mapping process can be facilitated by using 'capability cards'. The cards allow the stakeholder group to easily compare performance levels for different domains in order to come to a consensus decision. *Resource 3.3: Capability cards* provides an example of how this can be done using a capability framework. This resource is available in the capability resource kit. *Resource 3.4: Capability mapping by grade level: worked example* provides an example of mapped capabilities to grade levels for both professionals and assistants.

Check with other stakeholders, managers and clinicians to ascertain whether your group's decisions resonate with others. This may be completed via a meeting or workshop with a wider stakeholder group or by conducting a pilot.

Step 6: Use mapped capabilities

Once the mapping process has been completed, the selected capabilities can be used to inform the following.

Position descriptions

To demonstrate how position descriptions can incorporate behavioural capabilities see *Resource 3.5: Position description incorporating capabilities: worked example*.

Recruitment (including interview questions)

Behavioural questions will provide insight that makes your selection choices easier and informed. Behavioural questions provide information about past behaviours, achievements and challenges candidates have had. In giving insight to a candidate's previous behaviours and activities, you are well positioned to predict what their performance will be like.

Behavioural questions have three key components:

- Situation: Have your candidate describe a situation they were in when carrying out the competency/attribute you are questioning them about.
- Action: What action did they take in response to it?
- Result: What was the outcome they had?

Remember to use probe questions along the way. These are the additional questions you ask that probe the candidate's answers further. Use probe questions when answers lack detail, are incomplete or need to be expanded on.

To demonstrate how behavioural interviewing can incorporate capabilities see *Resource 3.7: Behavioural interviewing: worked example*.

Performance enhancement and supervision

Using a capability framework within performance enhancement and supervision promotes assessment and reflection against a benchmark and sets clear and consistent expectations of behaviour.

To demonstrate how behavioural interviewing can incorporate capabilities see *Resource 3.8: Capability assessment: worked example*. This mock example uses the expected capabilities of a grade 2 AHP, incorporating them into a tool that can be used for self-assessment for annual performance appraisal, and is based on the NCHCR.

Targeted professional development

Departments may wish to consider how their professional development topics/sessions relate to the capabilities identified.

By agreeing on a common, interprofessional description of the skills, knowledge and attitudes required for quality service delivery in your context, the framework also provides a platform for exploring alternate models of care.



Supporting evidence and learnings

Through the consultation process, stakeholders told us that the current approach to identifying expected behavioural capabilities is highly variable. Most commonly, where expectations were identified it was done at the point of recruitment such as 'identified in the PD'. Although some made mention of using expectations through 'supervision' and 'performance enhancement', most agreed with the statement 'We don't do this well'.

Most groups did not have an existing capability framework that they felt addressed their needs in allied health. Some used the code of ethics from their professional bodies; however, few could identify an interprofessional framework that provided a platform for discussion.

There was a significant amount of feedback that indicated that using a framework would be useful:

- 'Would be useful in developing a position description.'
- 'To allow an opportunity to advance roles.'
- 'Basis for performance management.'
- 'To optimise service provision.'

There was also general consensus that the mapping done for the NCHCR aligned with expectations: 'It's fairly spot on'.

Summary points

The development of capabilities is important for delivering safe and effective care in the context of a complex and changing health service and can help to promote innovation and reform.

A shared understanding of expected behaviour can help promote collaboration and provide a platform for exploring new models of healthcare delivery.

Mapping capabilities to grade levels by key stakeholders is a valuable process that can be used to document and communicate expected behaviours.

Documented expected capabilities can be used to assist with recruitment, supervision and professional development.

Case studies: practically applying the allied health credentialling, competency and capability framework

The case studies presented below are examples of how the framework and resource kit might be practically applied in the workplace. For each scenario, recommendations outlining the proposed actions to take are given. These actions direct you to the relevant parts of the framework and recommend general resources that could be used to help implement the allied health workforce initiative described. The resources referred to are an example only and have not been adapted to meet the specifics of each case example:

Case study 1: Implementing a new model of care with an interdisciplinary focus in the community setting	
I	<p>Introduction: Who? Perspective? Drivers?</p> <p>A community-based service is reviewing its model of care. The new model of care will focus on providing interdisciplinary care to a broad range of clients. The aim is to provide a 'one-stop shop' for patients in the community setting, with timely access to safe, quality, patient-centred care, to be hallmarks of the new model of care.</p>
S	<p>Situation: What is happening?</p> <p>This will mean that clinicians who have previously only seen clients eligible for services under one funding stream will see clients with a broader spectrum of care needs. Teams have previously worked in a mix of unidisciplinary, multidisciplinary and interdisciplinary modes.</p>
B	<p>Background: What are the issues that led to this situation?</p> <ul style="list-style-type: none"> • Complex eligibility criteria and service guides • Long waiting lists (not consistent across the catchment) • Increasing cost of healthcare • Changing community expectations • Relatively long length of service for staff group • Ageing workforce • Fragmented/non-targeted education and training to approaches
A	<p>Assessment: What do you believe the problem is?</p> <ul style="list-style-type: none"> • How will the scope of practice of individual professions need to adapt to reflect the needs of a broad population group? • How is the change in scope of practice going to be supported, such as changes to the clinical supervision structure and processes, education or the introduction of formal competency assessment? • What capabilities are important in supporting a change in scope of practice? • Are there some capabilities that are more important in an interdisciplinary team?

Recommendation: How might this be done? How can the framework help?

Credentialling

- There are no anticipated changes to the types of individual professions employed within the service.
- Individuals would still need to have basic credentialling performed when recruited to their role and at re-credentialling as required.
- A review of the individual funding body requirements for credentialling will need to be done. For example, some funding bodies such as the federal Department of Health require a national police check every three years.

Scope of practice

- Review the individual's and profession's scope of practice and re-credential to ensure alignment with funding requirements and community needs.
- Does the current or planned scope of practice reflect the needs of the client groups presenting? An audit could be done to examine this further.

Capability

- Use the *National common health capability resource* to identify capabilities that support interdisciplinary care. How will expectations change with different grading levels?
- These capabilities could be incorporated into work practices such as position descriptions and performance reviews. Any identified needs could be linked to training.

Competency

- Are there any required skills the clinician now needs to be able to perform that are higher risk? The inherent nature of the task may be of a higher risk or the risk may be because the clinician does not have recency of practice for the specific practice they are now required to apply.
- Do we need a formal competency-based training and assessment program for these skills or can some practice enhancement be supported with additional clinical supervision and informal learning?

Summarised recommendations and finding help in the framework

1. Review the basic credentialling and re-credentialling process to ensure it meets all essential parameters required by the service.

- The framework (section 1) credentialling and defining the scope of practice
 - Table 1.3: Possible components of initial credentialling
- Resource kit (section 1) credentialling and defining the scope of practice
 - Resource 1.4 Sample: New appointment, re-appointment, change of scope of practice for individual allied health professionals

2. Review the position description templates to reflect the range of skills and capabilities of an interdisciplinary team.

- The framework (section 3) capability
- Resource kit (section 3) capability
 - Resource 3.2 Decision tool: How can a capability framework be used in my organisation? (Determine how a capability framework might be used to support an interdisciplinary team)
 - Resource 3.3 Capability cards
 - Resource 3.4 Capability mapping by grade level: worked example
 - Resource 3.5 Position description incorporating capabilities: worked example

R	<p>Summarised recommendations and finding help in the framework (cont.)</p> <p>3. Ensure annual performance appraisal templates are updated to incorporate a review against the capabilities.</p> <ul style="list-style-type: none"> • Resource kit (section 3) capability <ul style="list-style-type: none"> – Resource 3.6 Capability assessment: worked example <p>4. Address the clinician's learning needs by providing support for both capability and clinical competency.</p> <p>For example, with:</p> <ul style="list-style-type: none"> • formal/informal supervision of the individual • other formal/informal continuing professional development as required, such as work-based learning, peer review, self-directed learning, formal education • competency-based training as required <ul style="list-style-type: none"> – the framework (section 2) competency – resource kit (section 2) competency <ul style="list-style-type: none"> – 2.3 Decision tool: Do we need a competency standard? – 2.4 Developers' checklist: process summary and checklist for developers of competency-based programs
<p>Case study 2: Allied health assistant supporting speech pathology services in a rural health context</p>	
I	<p>Introduction: Who? Perspective? Drivers?</p> <p>A rural community health centre has an extensive waiting list for speech pathology intervention in paediatrics. An AHA position is introduced to run a speech and language development group for appropriate, low-complexity, lower priority clients on the waiting list.</p>
S	<p>Situation: What is happening?</p> <p>A new therapy group and new AHA position are introduced. Lower priority clients who have previously waited lengthy periods to see a speech pathologist will be directed straight to a fixed period in a structured, prescribed group program facilitated by an AHA.</p> <p>On completion of the group, the clients can be redirected to the speech pathologist for one-to-one intervention if further assessment and/or treatment is indicated. Guidelines and pathways for decision making have been set up by the speech pathologist in conjunction with the community health centre manager.</p>
B	<p>Background: What are the issues that led to this situation?</p> <p>Long waiting lists</p> <p>Changing community expectations</p> <p>Lack of service accessibility</p> <p>Increasing service demand</p> <p>Difficulty recruiting and retaining speech pathologists to the service</p>

A	<p>Assessment: What do you believe the problem is?</p> <ul style="list-style-type: none"> • What capabilities are required for the AHA role? • How does the centre decide on the scope of practice of the AHA role? • What would the credentialing standard be?
R	<p>Recommendation: How might this be done? How can the framework help?</p> <p>There is no 'right' answer to these questions.</p> <p>Capabilities, scope of practice and the credentialing standard for this role will depend on the specific context and setting. For example, a sole AHA may independently facilitate the prescribed group in a rural centre, with the speech pathologist available for remote supervision via Skype. Alternatively, the AHA may facilitate the group in a regional centre under indirect supervision of an on-site speech pathologist, with other AHAs available for peer support.</p> <p>Capability</p> <p>The capability framework can be used to assist in identifying which capabilities are high priority and at what level they need to be performed. The capability mapping can be used to assist in determining whether the capabilities required for the role are more aligned with a grade 2 or a grade 3 AHA role.</p> <p>Scope of practice</p> <p>Consider the following in determining the scope of practice for the role:</p> <ul style="list-style-type: none"> • What are the roles, responsibilities, tasks and duties expected of the AHA? What will be conducted independently versus under supervision? (For example, if the AHA is facilitating the group independently, this task falls in line with a grade 3 AHA role.) The example position description (PD) in the resource kit provides useful headings under which roles and responsibilities may be outlined. • What is the supervision structure and the availability and type of supervision (for example, remote, indirect and direct)? Are there any other AHAs to supervise? The AHA supervision and delegation framework may be used to assist here. • What forms of decision making and escalation are required in the role? (For example, if some independent decision making around modification of the group activities may be required, this will alter the capability level and potentially the grade level expectations. See the NCHCR descriptor for capability 1.1.4: Provision of care, performing healthcare activities, modify or replan.) <p>Competency</p> <ul style="list-style-type: none"> • Are there any particular tasks that require specific demonstration of competency (such as application of a screening tool for entry to the group program, conducting group sessions for individual client outcomes)? • Will a competency-based training and assessment program need to be developed and implemented to support the introduction of the service? <p>Credentialing</p> <p>In determining the credentialing standard, consider:</p> <ul style="list-style-type: none"> • the basic requirements for this role such as a Working with Children Check • the training available for AHAs and how this aligns with the role (Will a Cert. IV in AHA (or equivalent) be mandatory or desired? What units of specialisation (such as communication and dietetics units) would be preferable?) • what other experience and/or training would be preferred (such as experience in facilitating groups, experience working with clients with communication disorders)?

Recommendation: How might this be done? How can the framework help? (cont.)

Once the scope of the role, the capabilities and credentialling standard have been outlined, a PD can be written. Recruitment to the role can occur against the established PD. Behavioural interviewing questions mapped to the capability levels can be used to interview candidates.

Once the successful candidate has been selected, their skills and capabilities should be mapped against the scope of practice and position description, with any gaps identified. Using a capability self-assessment tool, areas that may need to be addressed as a priority can be identified. A training and assessment plan may need to be established prior to particular roles being undertaken.

Summarised recommendations and finding help in the framework

- 1. Establish the essential capabilities and the expected performance level to support the scope of practice.**
 - Resource kit (section 3) capability
 - Resource 3.4.2 Fundamental and desirable capabilities mapped against AHA grades and levels of the NCHCR
 - Resource 3.4.4 Expected behavioural capabilities mapped against AHA grades and levels of the NCHCR
 - Resource 3.4.9 NCHCR level descriptors of expected behavioural capabilities: grade 2 allied health assistant
 - Resource 3.4.10 NCHCR level descriptors of expected behavioural capabilities: grade 3 allied health assistant
 - Resource 3.3 Capability cards
- 2. Establish the credentialling standard to support scope of practice.**
 - The framework (section 1) credentialling and defining the scope of practice
 - Table 1.3: Possible components of initial credentialling
- 3. Write a position description that reflects the required capabilities and credentialling standard.**
 - Resource kit (section 3) capability
 - Resource 3.5 Position description incorporating capabilities: worked example
- 4. Use behavioural interviewing.**
 - Resource kit (section 3) capability
 - Resource 3.7 Behavioural interviewing: worked example
- 5. Review the individual's scope of practice and establish a learning plan.**
 - Resource kit (section 1) credentialling and defining the scope of practice
 - The framework (section 1) credentialling and defining the scope of practice
 - Resource 1.12 Sample: Scope of practice documentation
 - Resource kit (section 3) capability
 - Resource 3.3 Capability cards
 - Resource 3.8 Capability assessment: worked example
- 6. Develop and implement specific competency-based programs required for safety and quality.**
 - The framework (section 2) competency
 - Resource kit (section 2) competency
 - Resource 2.3 Decision tool: 'Do we need a competency standard?'
 - Resource 2.4 Developers' checklist: Process summary and checklist for developers of competency-based programs
 - Resource 2.5 Developing a unit of competency: Process guide and checklist

Case study 3: Establishing a physiotherapist-led orthopaedic shoulder clinic in the acute setting

I Introduction: Who? Perspective? Drivers?

An acute metropolitan hospital is commencing a physiotherapist-led orthopaedic shoulder clinic to better coordinate the management of patients with shoulder pain and to prioritise patients referred to their outpatients orthopaedic service according to clinical need. The aim is to improve access for patients and free up orthopaedic consultants' appointments for patients who require an opinion on surgical management.

S Situation: What is happening?

To improve access to the orthopaedic service at the hospital, a physiotherapist-led orthopaedic shoulder clinic is planned to be commenced by the physiotherapy service in conjunction with the orthopaedic unit. Advanced practice roles for physiotherapists are already in place within this health service and within the broader health setting.

B Background: What are the issues that led to this situation?

- Long waiting lists
- Changing community expectations
- Increasing cost of healthcare
- Not all patients referred to the orthopaedic service at the hospital needed to consult with an orthopaedic surgeon; many could be assessed and advised on the correct treatment by a physiotherapist working alongside the orthopaedic surgeons
- The orthopaedic unit is supportive of the introduction of the service but are requesting robust processes to maintain quality and safety

A Assessment: What do you believe the problem is?

- There is currently an absence of documented clinical criteria for triaging shoulder patients.
- What will be the credentialling standard for physiotherapists working in this advanced practice role? Will this vary depending on whether the physiotherapist is operating as a clinical or service lead or clinician operating as an independent clinician?
- What will be the capabilities of the allied health professional working as a clinical lead or independent clinician in this role?
- How will the new scope of practice for the profession be reflected?
- How will 'proof of competency' to operate as an independent clinician in this advanced practice role be established to the satisfaction of stakeholders?
- What resources are available to support competency assessment?
- Is there a need for ongoing competency assessment?

R Recommendation: How might this be done? How can the framework help?

Credentialling

- Establish the credentialling standard for the practice role. Consider whether a Master of Musculoskeletal Physiotherapy or an Australian Physiotherapy Association titled musculoskeletal physiotherapist is desirable or is essential criteria for the role. Is there an experiential pathway rather than purely academic pathway that can be set as the credentialling standard? What are other health services setting as the credentialling standard?

Scope of practice

- The additional scope of practice can be reflected in a profession credentialling and scope of practice document and/or the position description.

Recommendation: How might this be done? How can the framework help? (cont.)

Capability

- The NCHCR, or an organisational alternative, can be used to identify capabilities that support the needs of the new service. These might include additional capabilities or capabilities set as a higher performance level for individuals operating as clinical or service leads.
- These capabilities could be incorporated into work practices such as PDs and performance reviews. Any identified needs could be linked to training.

Competency

- To operate as an independent clinician within the clinic, initial evidence of competency is established by gathering evidence against a competency standard. It is recommended in this case that the department's Advanced musculoskeletal physiotherapy clinical education framework (Department of Health 2013a) be accessed to assist in this process.
- Competency in this case needs to include the triaging of patients presenting with shoulder pain and, to support this, documented clinical criteria for triaging shoulder patients' needs to be developed to support service implementation.
- The type and amount of evidence required to support decisions of competency can be determined collaboratively with the orthopaedic unit and the physiotherapy department, and guidance for this can be sought from the department's, *Advanced musculoskeletal physiotherapy clinical education framework*.
- Ongoing competency requirements can be set. This might include peer review, a clinical log, case-based presentations or documentation audits.
- Clinical supervision needs to be established for each clinician that meets the needs of their role and that meets the requirements of any competency-based training and assessment program that is established.

Summarised recommendations and finding help in the framework

1. Review the basic credentialling and re-credentialling process and ensure it meets all essential parameters required by the service.

- The framework (section 1) credentialling and defining the scope of practice
 - Table 1.3: Possible components of initial credentialling
- Resource kit (section 1) credentialling and defining the scope of practice
 - Resource 1.4 Sample: New appointment, re-appointment, change of scope of practice for individual allied health professionals
 - Access the department's *Advanced musculoskeletal physiotherapy clinical education framework*. It is available at <www2.health.vic.gov.au>.

2. Establish the essential capabilities and the expected performance level of physiotherapists operating in different capacities within the service.

- Resource kit (section 3) capability
- Resource 3.4.2 Fundamental and desirable capabilities mapped against AHA grades and levels of the NCHCR
 - Resources 3.4.5–8 Expected behavioural capabilities mapped against AHA grades and levels of the NCHCR
 - Resource 3.3 Capability cards

Summarised recommendations and finding help in the framework (cont.)

3. Review the position description templates to reflect the expected performance level of physiotherapists operating in different capacities within the service (clinical/service lead versus independent clinician).

- The framework (section 3) capability
- Resource kit (section 3) capability
 - Resource 3.2 Decision tool: How can a capability framework be used in my organisation? (Determine how a capability framework might be used to support an interdisciplinary team)
 - Resource 3.3 Capability cards (they can be used to support mapping and implementation of a capability framework)
 - Resource 3.4 Capability mapping by grade level: worked example
 - Resource 3.5 Position description incorporating capabilities: worked example

4. Ensure that annual performance appraisal templates are updated to incorporate a review against the capabilities.

- Resource 3.8 Capability assessment: worked example

5. Develop and/or review the profession credentialling and scope of practice documentation to reflect the new scope of practice for physiotherapists.

- Resource kit (section 1) credentialling and defining the scope of practice
- The framework (section 1) credentialling and defining the scope of practice
 - Resource 1.12 Sample: Scope of practice documentation

6. Implement competency-based training and assessment.

- The framework (section 2) competency
- Resource kit (section 2) competency
 - Resource 2.4 Developers' checklist: Process summary and checklist for developers of competency-based programs
- In this case it is advisable to access the department's *Advanced musculoskeletal physiotherapy clinical education framework*. This has been developed based on the framework presented here and contextualised for specific application. It is available at <www2.health.vic.gov.au>.

Appendix: Steering committee, consultation forums and contributors

Allied Health Therapy Steering Committee

Kath Philip (Chief Allied Health Advisor of Victoria, Department of Health and Human Services)

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Donna Markham (General Manager, Allied Health, Monash Health)

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Andrea Pearce (Framework implementation and competency lead, Monash Health)

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Sam Sevenhuysen (Framework capability lead, Monash Health)

Cylie Williams (Framework evaluation lead, development phase, Monash Health)

Allied Health Science Steering Committee

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Andrea Pearce (Monash Health)

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Sally Martin (Project Lead, Western Health)

Catherine Radkowski (Project Manager, Western Health)

Kath Macdonald (Western Health)

Christie Van Beek (Project Officer, Allied Health, Department of Health and Human Services)

Metropolitan sector	Rural sector
<p>Alfred Health Austin Health Cabrini Health Cobaw Community Health Dietitians Association of Australia Donvale Rehabilitation Hospital Eastern Health Epworth Healthcare Exercise and Sport Science Australia Health Workforce Australia Healthcare Chaplaincy Council of Victoria Inner East Community Health Knox Community Health Service Melbourne Health Mercy Health Monash Health Northern Hospital Orthoptics Australia Peninsula Health Peter MacCallum Cancer Centre Ramsay Healthcare South East Medicare Local South West Allied Health Network South West Allied Health Network (Osteopath Victoria) St Vincent's Hospital Melbourne The Royal Children's Hospital The Royal Victorian Eye and Ear Hospital The Royal Women's Hospital Victorian Paediatric Rehabilitation Werribee Mercy Hospital Western Health</p>	<p>Albury Wodonga Health Alexandra District Hospital Ballarat Health Services Barwon Health Bass Coast Regional Health Benalla Health Bendigo Health Castlemaine District Community Health City of Greater Geelong Cobram District Health Colac Area Health Department of Health (Benalla) Department of Health (Bendigo) Department of Human Services (Maryborough) Djerriwarrh Health Services Echuca Regional Health Gippsland Lakes Community Health Goulburn Valley Health Hume Medicare Local Hume Mental Health Clinical Triage Alliance La Trobe Rural Health School Macedon Ranges Health Monash University Northwest Health Wangaratta Ovens and King Community Health Service Robinvale District Health Service Rochester and Elmore District Health Rural North West Health South West Health South West TAFE Stawell Regional Health University of Ballarat Vision Australia (Albury Wodonga) Vision Australia (Shepparton)</p>
<p>Multiple participants also represented a diverse range of professional associations in addition to their nominated health service</p>	<p>West Gippsland Healthcare Group Yarram and District Health Services</p>

Glossary

Term	Definition
Additional skills	Defined as any procedures and skills that are acquired and/or refined as an individual progresses in knowledge, work standard, autonomy and coping with complexity, in their profession or area of practice. They commonly require additional training and experience.
Advanced scope of practice	Includes work that is currently within the scope of practice (for the profession) but that through custom and practice has been performed by other professions. The advanced role requires additional training and competency development as well as significant clinical experience (APA 2009). Advanced scope of practice is a level of practice characterised by an increase in clinical skills, reasoning, critical thinking, knowledge and experience so that the practitioner is an expert working within the scope of established contemporary practice (South Australian Department of Health 2013).
Allied health assistant	Allied health assistants provide therapeutic and program-related support to allied health professionals under the guidance and supervision of an allied health professional.
Allied health professional	Allied health professionals are qualified to support and enable diagnosis of health conditions, provide treatment to maintain and optimise physical, social and mental function across the continuum of care, and promote healthy living. In Victoria, the diverse group of professions comprising allied health are considered as forming two broad subgroups: allied health therapy and allied health science
Allied health practitioner	A generic term referring to an individual working within the field of allied health. They are commonly allied health professionals or allied health assistants but could include other professions under the professional governance of an allied health director.
Assessment	This refers to the process of collecting evidence and making judgements on whether competency has been achieved to confirm an individual can perform to the standard expected in the workplace, as expressed in industry competency standards and/or learning outcomes.
Assessment methods	The particular techniques used to gather different types of evidence such as direct observation, oral appraisal or a portfolio.
Assessment tool	Contains both the instrument and instructions for gathering and interpreting evidence.
Capability	Capabilities are underpinning behavioural skills that characterise work being performed well (Health Workforce Australia 2013). Capabilities specify the expected behaviours and attributes of clinicians as they progress through grading structures. They reflect the expanding sphere of influence and control expected of individuals of a higher grading. They are non-clinical attributes.

Term	Definition
Competence	Competence is a generic term referring to a person's overall capacity, while competency refers to specific abilities in a given area.
Competency	'The demonstrated ability to provide healthcare services at an expected level of safety and quality' (ACSQHC 2004, p. 5). 'Competency is the consistent application of knowledge and skill to the standard of performance required in the workplace. It embodies the ability to transfer and apply skills and knowledge to new situations and environments' (National Quality Council 2010, p. 4).
Competency-based assessment	'Competency-based assessment is a purposeful process of systematically gathering, interpreting, recording and communicating to stakeholders information on candidate performance against industry competency standards and/or learning programs' (National Quality Council 2010, p. 5).
Competency-based training	This is 'an approach to training that places emphasis on what a person can do in the workplace as a result of training completion' (ACSQHC 2012, p. 8).
Competency standards	These define the essential work outcomes and performance level required for effective performance of a work role and/or task in the workplace.
Co-regulation	This typically refers to the situation where industry develops and administers its own arrangements, but government provides legislative backing to enable the arrangements to be enforced (Australian Government 2013, p. 56).
Core skills	These are the basic practices, knowledge, attitudes and skills that allied health practitioners use routinely to deliver safe, efficient and effective patient/client care. They are the minimum set of skills the clinician is expected to have regardless of experience. They are the practices and skills that define the role.
Credentiailling	'Refers to the formal process used to verify qualifications, experience professional standing and other professional attributes for the purpose of forming a view about their competence, performance and professional suitability to provide safe, high quality health care services within specific organisational environments' (ACSQHC 2004, p. 3).
Element	An element is a basic building block of the competency standard. Elements describe the tasks that make up the broader function or job.
Endorsement	An endorsement of registration recognises that a person has an extended scope of practice in a particular area because they have an additional qualification that is approved by the national board.
Evidence	Information gathered which, when matched against the performance criteria, provide proof of competence. Evidence can take many forms and be gathered from a number of sources. Quality evidence is valid, sufficient, current and authentic; it enables the assessor to make the assessment judgement.

Term	Definition
Evidence guide	This is part of the competency standard, and its purpose is to guide assessment against the standard in the workplace or training environment.
Extended scope of practice	This is a role that is outside the currently recognised scope of practice and one that requires some method of credentialling following additional training, competency development and significant professional experience, as well as legislative change (APA 2009). Extended scope of practice is a level of practice that incorporates practice beyond the established, contemporary scope of practice (South Australian Department of Health 2013).
Formative assessment	These occur at various points within a training program and are designed to provide the learner with feedback on their progress as they build skills towards competency. These assessments can be individual aspects of a larger skill or simpler, smaller stages within a complex process. A number of formative assessment events can be scheduled into the training program.
Independent practice	This refers to an individual deemed competent against the requirements of the competency standard and working within the usual operational and clinical governance framework for the practice context without additional monitoring requirements or restrictions.
Learning and assessment plan	This is the overall planning document for learning and assessment processes used. There may be supplementary documents to support it, such as a training timeline.
Learning needs analysis	Within the allied health program at Monash Health, self-assessment against the elements, performance criteria and underpinning knowledge and skills is used at the beginning of the program to help establish a person's learning needs.
New technology or clinical practice	This is a therapeutic intervention or diagnostic procedure that is considered by a reasonable body of clinical opinion to be significantly different from existing clinical practice. It includes a procedure that has not been performed within the organisation, as well as any variation to an existing procedure or treatment where a new devices or item or equipment is introduced, including situations where new devices are provided by manufactures without charge. A new technology or clinical practice does not include a situation where a clinician proposes to use a technology or clinical practice that has already been undertaken within the organisation but has not been previously used by that clinician.
Performance criteria	This specifies the level of performance to demonstrate achievement of the element.
Performance cues	Practical examples of what a competent performer may look like in action.

Term	Definition
Re-credentialling	Verification of all changes since previous declaration (ACSQHC 2005, p. 8).
Reference group	This is a group convened that includes experienced clinicians across the health service and other stakeholders as required to provide expert opinion.
Scope of practice	<p>A profession's scope of practice is the full spectrum of roles, functions, responsibilities and decision making capacity that individuals within that profession are educated, competent and authorised to perform. Some functions within the scope of practice of any profession may be shared with other professions or other individuals or groups. The scope of practice of all health professions is influenced by the wider environment, the specific setting, legislation, policy, education, standards and the health needs of the population' (Australian Nursing and Midwifery Council 2007, p. 1).</p> <p>'The scope of practice of an individual is that which the individual is educated, authorised and competent to perform. The scope of practice of an individual clinician may be more specifically defined than the scope of practice of their profession. To practise within the full scope of practice of the profession may require individuals to update or increase their knowledge, skills or competence' (Australian Nursing and Midwifery Council 2007, p. 2).</p>
Self-assessment	This is the assessment of one's own performance against the competency standard. It is a cost-effective means of identifying the individual strengths and areas for development to help direct the focus of work-based learning and provide assistance for the trainee to reflect meaningfully.
Self-regulation	Generally characterised by industry-formulated rules and codes of conduct, where industry is solely responsible for enforcement (Australian Government 2013).
Standard practice	Together, the core and additional skills make up standard practice.
Subject matter expert	A clinician who exhibits the highest level of expertise in performing a specialised job, task or skill within the organisation.
Summative assessment	Final confirmation of their ability to perform tasks just as they are performed in the workplace and usually at predetermined intervals throughout the program. The summative assessment is a holistic or integrated assessment.
Tacit knowledge	An assessor's real or understood knowledge of the expected standard of performance.
Underpinning skills and knowledge	Such a statement confirms for the learner, assessor or training program developer the underpinning knowledge and skills that are integrated into performance to demonstrate competency in the standard.

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