

Department of Health

health

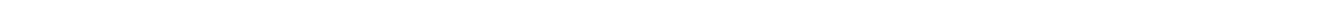
# Supervision and delegation framework for allied health assistants

Case studies



# Supervision and delegation framework for allied health assistants

Case studies



## Acknowledgements

These case studies formed an integral part of the workshop series, conducted by the Victorian Department of Health in partnership with Healthcare Management Advisors, to launch the *Supervision and delegation framework for allied health assistants*.



The department would like to thank all of the participating services for their assistance with the development of these case studies.

If you would like to receive this publication in an accessible format, please phone 03 9096 9876 using the National Relay Service 13 36 77 if required, or email: [claire.brett@health.vic.gov.au](mailto:claire.brett@health.vic.gov.au).

This document is also available in PDF format on the internet at: [www.health.vic.gov.au/workforce](http://www.health.vic.gov.au/workforce)  
© Copyright, State of Victoria, Department of Health 2012

This publication is copyright, no part may be reproduced by any process except in accordance with the provisions of the *Copyright Act 1968*.

Authorised and published by the State Government of Victoria, 50 Lonsdale Street, Melbourne.

Published by the Workforce, Leadership and Development branch, Victorian Government, Department of Health, Melbourne, Victoria.

Except where otherwise indicated, the images in this publication show models and illustrative settings only, and do not necessarily depict actual services, facilities or recipients of services.

Print managed by Finsbury Green. Printed on sustainable paper.

September 2012 (1204005)

---

# Contents

<b>Introduction</b>	<b>1</b>
<b>Delivering community care to build patient independence</b>	<b>2</b>
Ballarat Health Service	2
<b>Active Lorikeets — addressing readiness for school entry</b>	<b>6</b>
Gippsland Lakes Community Health	6
<b>Supporting patients from rehabilitation to ambulatory care</b>	<b>10</b>
Goulburn Valley Health, Shepparton	10
<b>Implementation of a remote supervision model</b>	<b>14</b>
Omeo District Health	14
<b>Supporting patient-centred care at Casey Hospital</b>	<b>18</b>
Southern Health	18
<b>Improving outcomes for patients through malnutrition screening</b>	<b>22</b>
Swan Hill District Health	22
<b>Improving care outcomes in speech pathology</b>	<b>26</b>
Barwon Health	26
<b>Supporting the Serious Mental Illness Laughter and Exercise program</b>	<b>29</b>
Northeast Health Wangaratta	29

---



# Introduction

The allied health workforce is an essential component of the health workforce. Demand for allied health services will further increase with the ageing of the population, the growing burden of chronic disease and an increasing emphasis on the delivery of multidisciplinary care. The challenge is to meet this demand.

Our response to this challenge needs to consider new service models that make best use of available skills in the current and future health workforce, and to acknowledge the important part these models will play in meeting evolving and increasing service demands.

While the allied health assistant (AHA) workforce has operated in Victoria for many years, the sector is now recognising the enormous benefits these roles can bring to the delivery of allied health services across a broad range of disciplines, settings and program areas.

The following case studies describe how eight different health and community services from across Victoria identified a service need and expanded their allied health services through the utilisation of AHAs.

There are many innovative and inspiring examples of AHA roles that have been developed across Victoria. These case studies are not put forward as representative, or more worthy or successful than others. Instead, they build on the usefulness of the *Supervision and delegation framework for allied health assistants* by providing a cross section of examples where a service need has been identified and AHA roles have been scoped, implemented and reviewed, as part of a successful workforce solution.

These case studies will hopefully assist other health and community services to explore opportunities to better utilise their AHA workforce by developing innovative allied health service models to address increasing service demands.

# Delivering community care to build patient independence

## Ballarat Health Service

The Strengthening Life Skills occupational therapy project, delivered by an occupational therapist (OT) and a Grade 2 allied health assistant (AHA) at Ballarat Health Service (BHS), has successfully addressed the needs of eligible patients to remain independent in the community, as well as achieving an effective reduction in the urgent service waiting list.



### Identifying a service need

Ballarat Health Service (BHS) has experienced ongoing high demand for home and community-based OT interventions, typically for patients requiring an immediate response to prevent falling at home. Due to this high demand, the existing service was unable to move beyond managing its urgent and high-needs patients to implement less clinically urgent or preventative interventions.

Up to one hundred patients remained on the waiting list, often until their status had changed and their clinical risk had increased.

BHS and other local health and community care (HACC) funded services<sup>1</sup> had established a partnership to define a consistent patient referral prioritisation structure (category 1 being most urgent and category 3 being non-urgent referrals), and to coordinate services to optimise the management of urgent referrals.

The participating services acknowledged the need for a change in approach to address the continued long waiting lists and agreed on a strategy to provide resources to address the needs of less urgent referrals, with interventions aimed at facilitating independence and community access. The challenge would be to avoid diversion of these resources towards more urgent cases.

### Strengthening Life Skills program

An OT-based steering committee led by a senior BHS OT and including other OTs from BHS and Grampians HACC services<sup>1</sup> and a BHS HACC quality manager, was formed to design and oversee the project. A supporting reference group was established with management involvement from each HACC-funded service, with representation from the Department of Health (the department) Grampians Region office and the BHS AHA manager.

The steering committee developed the overarching goals for the Strengthening Life Skills program. The agreed approach for the program was to:

- support patients' quality of life through early intervention
- develop, promote and embed a patient-centred model across providers, including councils and health services
- promote a model of care for OTs and AHAs that maximises the person-centred approach and builds capacity for service providers.

<sup>1</sup> Included City of Ballarat, District Nursing Service, Golden Plains HACC



The steering committee also developed a clear vision for the outcomes to be achieved in the project. Guided by the aims of the HACC active service model<sup>2</sup>, the program would use a patient-centred, goal-driven approach to intervention, which in turn would inform the role of the OT and AHA in assisting patients to meet their goals.

The Strengthening Life Skills program was developed over six months. It was initially funded for 18 months (commencing June, 2011) by the Grampians Region HACC service, to provide 0.8 EFT OT and 0.5 EFT Grade 2 AHA positions, with program-specific resources to support program delivery.

## The Canadian Occupational Performance Measure

The Canadian Occupational Performance Measure (COPM) is an internationally recognised and validated, person-centred, goal-setting tool and measure of participation in daily life. BHS chose the COPM as an appropriate framework for identifying patients' goals and to measure the impact of interventions.

Within the design of the Strengthening Life Skills program, the COPM is administered by the OT at the beginning and at the end of the intervention period, to measure how well the patient considers they are performing tasks and how satisfied they are with their level of ability to undertake the tasks identified.

Performance problems are weighted in terms of importance, to clearly articulate the patient's priorities and provide information for goal setting and treatment planning. This tool provides both an outcome measure for the impact of the care provided, as well as a scoring mechanism for measurement of the overall success of the program.

The committee determined that an OT supported by an AHA could effectively deliver the program to patients in a community setting and assist them to achieve their goals for independent living.

## Defining the Grade 2 AHA role

A Grade 2 AHA working closely with a single-discipline allied health professional (AHP) was a new model for BHS. AHAs at BHS routinely focus their formal training in generic units of competency, equipping them with a broad range of skills to undertake activities across program streams.

The new AHA position description was developed to specifically meet the needs of the Strengthening Life Skills program. The goals of the program are clearly reflected in the responsibilities of the role and competencies required for effective support of patients.

The OT was recruited to the project two months prior to filling the AHA role. A staggered start provided time for the OT to set up the program effectively. This included developing links across HACC networks, understanding the COPM tool, ensuring clarity of their role in supervising the AHA and planning the types of tasks suitable for delegation.

The different types of patient needs identified through the COPM ranged broadly across:

- self-management at home (for example, independence with showering, cooking meals and managing housekeeping duties)
- independence in accessing local services (for example, using the bus, being confident with scooter use)
- maintenance of social connectivity (for example, resuming group hobbies, increasing or connecting with social networks).

A significant part of the AHA role involves assisting patients with therapy sessions. Delegation of tasks is determined by the AHA's skills and competencies as they develop in the role, along with changes in service need. Some AHA upskilling in particular tasks may be required.

The OT prepares a written handover document for the AHA with details of specific therapy activities for each patient. Additional activities routinely include sourcing required equipment and follow up on behalf of patients, which releases the OT from often very time-consuming tasks, so they can focus more directly on patient care.

Having an AHA assist the OT to deliver more intensive and frequent therapy helped to maximise achievable therapy outcomes. Some examples of the direct patient tasks delegated to the AHA included:

- scooter retraining practice sessions
- implementing strategies to manage daily routines for people with cognitive impairments, or organisation and planning difficulties
- setting up required resources or assistive devices for patients (such as checklists, visual prompts, memory prompts and assistive equipment)
- conducting therapy sessions to practice identified tasks (such as accessing shopping centres, managing household tasks and meal preparation)
- developing a resource list of community-based groups (such as exercise or social groups) to which patients may be referred if requested.

## Developing AHA competencies

The BHS AHA manager and steering committee recognised the importance of assessing the AHA's skills and knowledge, in order to develop a structured learning plan to ensure the AHA had the required skill set to support the new program.

The AHA recruited to work on the project had completed an AHA induction program within BHS and was completing a Certificate IV in Allied Health Assistance. She had had broad exposure to the existing multidisciplinary AHA roles within a range of BHS programs.

Her experience included working with strong role models within the existing AHA staff group, who provided learning opportunities and demonstrations of their tasks, approaches and clinical thinking. This was in addition to clinical time with a range of AHPs, including OTs, speech pathologists and physiotherapists.

The previous workplace experience of the selected AHA had been solely ward-based. As the new position required the AHA to work in a community environment, under the indirect supervision of the AHP, additional internal training on the BHS protocol for working safely in the community was completed.

## Addressing gaps in knowledge and experience

To address the AHA's knowledge gap in the delivery of community programs, the AHA manager facilitated linkages between the AHA and BHS AHAs experienced in planned activity groups. Observation of group sessions provided exposure to activities, lifestyle and recreation approaches used with community groups, which she has been able to use when supporting patients during group activities.

To address an identified skill gap regarding working with patients with early onset dementia, the AHA participated in the 'Alzheimer's Essentials' package of training delivered by Alzheimer's Australia.

Given the community-based nature of the program and indirect supervision requirement, the OT initially determined activities that were appropriate for delegation and identified patients who could be supported by an AHA. The establishment of competencies in therapy interventions was strengthened through appropriate clinical supervision processes.

At commencement of the project, the OT and AHA always worked together on patient tasks, with the OT demonstrating a required task or approach, then observing the performance of the task by the AHA. There was significant advantage to having one clinical supervisor. A strong supervisory relationship developed, where the OT strongly encouraged reflective practice, and worked on both the AHA's confidence and skill development with a high level of success.

The AHA has progressed to more independent practice and supervision requirements have been streamlined. Successful program delivery has been underpinned by a strong and open working relationship, with a clearly defined scope of practice, supported by regular communication.

With support from BHS, the AHA now holds a Certificate IV in Allied Health Assistance.

## Service and role review and improvement

The results of the COPM have been analysed for the first 29 patients to undertake the Strengthening Life Skills program. The COPM tool was completed with each patient at the commencement and end of their program. Each patient determined their program goals and scored both their perceived performance and satisfaction level with their identified goals.

The mean scores increased by a significant margin of more than two points on each score parameter (Table 1). Individual cases have demonstrated even more dramatic score improvements for some patients.

The number of direct patient contact hours spent delivering the program by both the OT and AHA has also been measured since the program commenced. In the first two months of the program (from July to September, 2011), the OT spent approximately half the allocated EFT in direct patient contact, the other time being spent in developing relationships with other organisations, developing new processes and resources, and promoting the project to generate referrals.

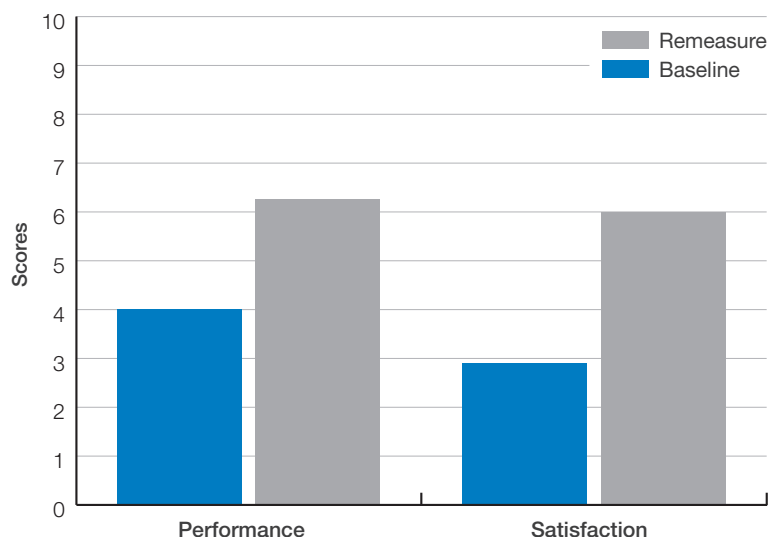
The AHA commenced in August 2011 and has increased the proportion of time spent in direct patient contact as her level of skill has increased, up to approximately 75 per cent of her work time. Implementation of the professional development program has facilitated increasing transition of tasks from the OT to the AHA.

A review of the AHA role over a seven-month period (since commencement) has identified additional opportunities for delegating tasks and delivery of services to the AHA. It is anticipated that as the current AHA continues in her role, she will develop into a highly effective and skilled community-based worker.

Overall, the patient waiting list for all levels of community OT service need improved as a result of the successful implementation of the Strengthening Life Skills program. By specifically targeting non-urgent referrals for earlier intervention, the demand for more complex and high-needs interventions has reduced over time.

The program will reach completion at the end of 2012, and recurrent funding has been secured from internal sources to continue and further develop the expertise of the OT and AHA. BHS plans to build further connectivity with community care workers to facilitate greater understanding of the program, increase awareness of patient goals, and promote the AHA's role in supporting patients to achieve and maintain their goals for independence in the community.

Figure 1: Mean COPM results (n=29)



# Active Lorikeets – addressing readiness for school entry

## Gippsland Lakes Community Health

A long waiting list for public paediatric speech pathology and occupational therapy services prompted the development of a program for speech and fine-motor skill development in kindergarten-aged children. This program was developed and supervised by Gippsland Lakes Community Health (GLCH) allied health professionals, and is coordinated by Grade 2 allied health assistants (AHAs), who assist with standard screening and delivery of group sessions. Resources are now better targeted to meet more children's needs in readiness for school.



### Identifying a service need

Research has identified that spoken language and fine-motor skills acquired during the preschool years are precursors for the later development of reading and writing.<sup>3,4</sup> Children who are developmentally not ready for school may often struggle to catch up.

GLCH is the only service offering public paediatric allied healthcare in the Gippsland Lakes area. GLCH identified that referrals of preschool and school-age children with speech difficulties and under-developed fine motor skills were increasing. Average waiting lists and times for initial assessments by an OT and speech pathologist were 30.1 and 33.3 days, and were predicted to continue to increase.

In addition, there was not a process to ensure that children most in need of assistance were identified and prioritised. Both teachers and parents expressed concern at delays in accessing services for low-risk referrals.

GLCH identified that a new program to proactively address the lengthy waiting list was required. As in many rural and remote locations, skills shortages were an ongoing issue at GLCH, with particular difficulties in attracting and retaining sufficient qualified allied health professionals (AHPs). Given the identified service need, the proposed program structure included utilising appropriately skilled AHAs working closely with the AHPs.

GLCH received a Commonwealth Communities 4 Children program grant to support the implementation of the program.

### Active Lorikeets program

Active Lorikeets, which commenced in 2010, is a ten-week block program for preschool children requiring speech or occupational therapy to accelerate development of their language and fine motor skills. The program is delivered over a school term.

3 Ramey CT, Ramey SL, 2004, 'Early learning and school readiness: Can early intervention make a difference?' *Merrill-Palmer Quarterly*, vol. 50, no. 4, pp. 471–491.

4 National Research Council, 1998, *Preventing Reading Difficulties in Young Children*, The National Academies Press, Washington, DC.

The OT and speech pathologist, supported by the program AHAs, screen each referred child for their suitability to participate in the program, using the Brigance test and the Renfrew Action Picture test (the screening tools used by the OT and speech pathologist) to determine each child's requirements.

Children assessed as requiring intensive or specialised intervention with the speech pathologist and/or OT on the basis of screening are referred to the relevant service(s). If included as part of the care plan, an AHA will work with a child for an additional 15-minute 'busy-bee' speech practice session, to enable the speech pathologist to work with the child's parents.

The majority of referred children require weekly group therapy skill sessions that provide structured group development activities to address their needs. These sessions are delivered and supported by two AHAs. The speech pathologist and OT lead the AHAs in intensive initial and ongoing skills development, and oversee the delivery of the group sessions.

Parents observe and participate with their children, and learn strategies to support their child's development. They are encouraged to continue using these techniques during normal daily activities.

Home-based programs are also implemented for children requiring this level of support. An individualised program is developed by the AHPs, which includes simple games and activities, and supports parents to provide opportunities for children to practice and develop their skills throughout the week.

A range of activity kits are prepared by the AHAs as part of a resource library. These are available to the Active Lorikeets team to lend out for home use. Parents are encouraged to actively engage with the team, and to discuss their child's program and progress.

Initially, program referrals of preschool age children were received from local kindergarten teachers. Over time, the GLCH team has developed and strengthened links with fifteen kindergartens across far east Gippsland, and the team now provides screening sessions at the kindergartens. Parents are invited to have their child assessed through the routine screening process. Uptake has been good. This screening method has facilitated an increase in referrals to and participation in the Active Lorikeets program.

A total of 113 screens were undertaken by the AHA over the past 18 months. Nineteen patients were referred to the speech pathologist, six to the OT and 19 to both the OT and speech pathologist, representing 39 per cent of all patients screened. A total of 90 patients (80 per cent) participated in the group therapy program over the past 18 months.

## Defining the AHA roles

The GLCH Executive Manager of Community Health Services, a physiotherapist by profession, has a long history of working with AHAs and recognised more than twenty years ago, the benefit of bringing AHAs into the team, initially to assist in the delivery of physiotherapy programs.

At times, GLCH has had difficulty in recruiting and retaining AHPs. Additional AHA positions have been created to assist AHPs to deliver the services needed in response to local demand. With the success of AHAs working in the delivery of exercise and fitness programs, the benefit of utilising AHAs across other allied health disciplines was recognised.

The first AHA was employed 22 years ago to support physiotherapy services at GLCH. She is still working with the physiotherapy service, having developed a strong and diverse skill base, and now holds a Certificate IV in Allied Health Assistance.

Ten years ago, a second AHA, originally trained as an enrolled nurse, was employed to assist with the OT and physiotherapy service. She remains with GLCH and now has a Certificate IV in Allied Health Assistance, with a specialisation in podiatry. She works with the podiatrists and supports the delivery of a number of other programs, also providing support to the AHA team as a mentor, sharing responsibility for their management and professional development, along with the executive manager. This has recently become a Grade 3 position.

The growth of the AHA team has been gradual. Over time, grants have been accessed to support additional AHA positions, and training grant program funds have supported AHAs at GLCH to complete the Certificate IV in Allied Health Assistance.

With an increase in the number of AHA positions from one to eight over the last twenty years, it has been necessary to develop appropriate governance and supervision structures that support the growth and diversity of the roles and programs delivered.

AHAs who are part of the *Active Lorikeets* program receive extensive exposure to speech pathology and OT sessions, with frequent skills development and practice prior to receiving delegated clinical tasks, including administration of standard screening tests. To facilitate learning, the AHAs observe and reflect on screening sessions undertaken by the AHPs.

From the start, the AHPs ensure that each AHA is clear regarding their role in supporting program delivery. The development of a shared vocabulary has facilitated strong communication and feedback mechanisms. Structures are in place to allow AHAs to appropriately answer commonly asked questions from parents and to refer questions outside of their scope to one of the AHPs. Processes are also in place to allow AHAs to immediately refer to an AHP if certain difficulties are identified (for example, a stutter).

## Implementing the AHA role

Over a number of months, the AHAs build their skills and knowledge in the delivery of group activities, supporting children's skill development and involving parents in activities through a structured program of professional development. Activities, such as regular review of the books used for children's group sessions, are included to facilitate development of the AHAs' skills in asking children questions to check their understanding of the story and language used.

Any issues requiring additional assessment, or outside the scope of the AHA role, are referred to the appropriate AHP. Programs conducted outside the GLCH premises are delivered jointly by the program AHAs and one of the AHPs. This provides an opportunity for the AHP to model how to interact appropriately with children and parents to the AHAs, to observe the AHAs at work, and to review their skills and competencies.

In 2012, the *Active Lorikeets* screening tests and group sessions are routinely conducted by two AHAs working together. The program activities are set up in close consultation between the AHAs, OT and speech pathologist.

The *Active Lorikeets* team meet each week to hold a review and planning meeting. The program is also discussed at bimonthly paediatric team review meetings. The OTs, speech pathologists and supporting AHAs are located in the one office, which facilitates regular conversations and questioning. The AHAs are involved in the purchasing and organisation of equipment, and maintain the resource library materials and activities.

The current *Active Lorikeets* program coordinator is a Grade 2 AHA who commenced work at GLCH after completing her VCE and a Certificate III in Children's Services. She had decided not to pursue a career in the childcare sector and was not certain what direction her career should take. Through a relative, she secured a volunteer role at GLCH two days per week. Having volunteered at GLCH for over nine months, she was invited to apply for one of the AHA positions to support the *Active Lorikeets* program.

## Developing AHA competencies

The Grade 2 AHA received three months of intensive skills development with the AHPs, including observing client reviews and therapy sessions, assessment tools, administering tests and working with children and parents, one on one and in a group setting. Throughout this period, she was also supported in delivering the program by an experienced AHA. During 2011, she completed her Certificate IV in Allied Health Assistance, specialising in speech pathology.

She now coordinates the delivery of the *Active Lorikeets* program with the support of a new AHA with ten years fitness program experience, who has recently joined the GLCH team. The new AHA is continuing her on-the-job development and considering her options with regard to gaining further qualifications in allied health assistance.

Supervision and professional development for each AHA includes a monthly professional development meeting and a six-monthly review formalised through completion of a standard template to record development needs, career goals and individual work plans. The AHA team has a weekly meeting focused on information sharing to support their programs areas and, if necessary, to plan leave cover for each other.

The community health executive manager and the senior Grade 3 AHA have regular meetings regarding the AHA team and the management of their supervision. If individual issues arise, a three-way discussion is held and a course of action agreed, which is recorded in writing.

## Service and role review and improvement

Waiting times for speech therapy and OT appointments at GLCH have been reduced from 33.3 to 13.5 days and 30.1 to 8.3 days respectively, since the introduction of the *Active Lorikeets* program. A process is in place to ensure that one-to-one service delivery is now clearly targeted at those children with highest need. The *Active Lorikeets* program ensures that each child is receiving the most appropriate level of intervention.

Through the delivery of information sessions to teachers and parents, the program has gained visibility in the community and is highly regarded as a mechanism for assisting children's skill development. Referral pathways are now well established. Anecdotal evidence from primary schools indicates that more children are reaching school with the appropriate level of language and fine motor skills to manage the challenges of the early school years.

The *Active Lorikeets* program is now in its third year of operation and recurrent funding has allowed for its continuation. GLCH is planning to expand the service into childcare centres, primary schools and holiday programs.



# Supporting patients from rehabilitation to ambulatory care

## Goulburn Valley Health, Shepparton

Goulburn Valley Health (GV Health) has increased capacity in allied health services by employing allied health assistants (AHAs) across many program areas, including subacute care services, transition care programs and community services. The need to support patients in the community with complex needs has driven the recent development of a blended role, which capitalises on additional qualifications held by AHAs.



### Identifying a service need

At GV Health, AHAs have long been an integral part of the physiotherapy, occupational therapy (OT) and community rehabilitation centre (CRC) teams. Initially, the AHA role mainly involved support for the clinical team to manage equipment, order stock and undertake general administrative tasks. It was rare that AHAs were involved in direct clinical support activities outside of physiotherapy based programs.

In 2005–06, the Department of Health's Better Skills Best Care<sup>5</sup> strategy demonstrated potential roles for AHAs in supporting clinical service delivery. In parallel, GV Health received funding for a number of new and expanded sub acute ambulatory programs. These included the implementation of subacute care services (SACS) programs, transition care program funding and community programs, including new active service and self-management models and community interlink.

These changes, along with a growing clinical workload and the changing needs and preferences of patients, provided the mechanism for the GV Health allied health team to implement a broader service review in 2006–07.

The key objective for the service review project was to improve the existing service delivery model by expanding the AHA role to include a greater range of duties and activities, with the potential to create more AHA positions across a broader range of services and programs. Development of appropriate support structures and processes was needed to strengthen and sustain the recommended model within the organisation.

### Defining the AHA roles

As a result of the review, it was recommended that the role of the AHA in service delivery within GV Health be expanded to allow AHAs to work within their full scope of practice. This change required organisational recognition of the AHA role at a professional level, development of standardised working practices and implementation of formalised professional development.

A number of benefits would be realised through implementing these changes, including the development of a multi-skilled AHA workforce, increased efficiency and consistency in service delivery and quality of care, and the development of clear delegation processes and supervision structures. It was also recognised that a wider variety of opportunities for AHAs could potentially increase job satisfaction and staff retention.

<sup>5</sup> Department of Health Victoria



The CRC team and the physiotherapy manager, who has a long history of working with AHAs, took on the role of project manager to drive AHA workforce planning and implementation across the organisation. This involved development of a generic AHA position description, detailing the skills and knowledge required for the role, and the development of a formal orientation program, run within the subacute admitted service.

This provided a highly structured environment for AHAs to work closely with experienced allied health professionals (AHPs) while building further skills and confidence. The project manager was initially responsible for the line management of AHAs. This responsibility was later transferred to the managers in the disciplines and programs employing AHAs across GV Health.

Having developed structures to support the expanded AHA role, the next step was to identify the program areas that required new AHA positions to support service development or expansion.

## Implementing the AHA roles

In early 2007, the number of AHAs employed at GV Health was approximately three equivalent full time (EFT), working across physiotherapy, the CRC, OT and the Hospitals Admission Risk Program (HARP) Disease Management Team (DMT).

The project manager identified service needs that could be met by implementing new AHA roles. Many patients were coming to the CRC after extended admissions and suffering additional illness, such as pneumonia, after long periods in bed without mobility. Recovery times could improve by introducing earlier mobility activities in the acute wards, prior to patients moving into rehabilitation.

The creation of an AHA position to support program delivery provided a solution. Under the supervision of a physiotherapist, the AHA provided support in the acute ward for patients to undertake simple activities, such as sitting up out of bed with proper posture, undertaking easy arm exercises or walking in the corridor. The benefit of earlier intervention was soon realised in improved patient outcomes.

AHAs completing orientation within the subacute ward environment were also supported to rotate through other programs and disciplines. Pivotal in the change management to expand the use of AHAs in the organisation, was challenging AHPs who had not worked with AHAs, to identify activities that could successfully be delegated and supervised.

The project manager supported AHPs to speak to colleagues in organisations already working with AHAs, to investigate tasks and activities that could potentially be delegated to an AHA, with appropriate supervision approaches and models.

As the project gained momentum, AHPs from other areas of the hospital identified opportunities to delegate tasks to AHAs. Those who had not used AHAs before gained confidence from working with AHAs for a few hours each week, realising the benefit of having additional time to focus on higher level activities, such as patient assessment and specialised therapy.

Over time, disciplines such as dietetics, and OT and program streams, particularly in community outreach programs, introduced AHA roles where they had not previously existed.

## Implementing AHA roles in ambulatory care programs

Alongside the creation of AHA roles in the hospital setting, AHAs were also finding a significant place in supporting ambulatory care programs. In 2007, GV Health received funding to initiate the Transition Care Program (TCP)<sup>6</sup>. The initial TCP team involved a manager, a physiotherapist and an AHA, supporting three bed-based placements at Mercy Health's Shepparton aged care facility and four home-based placements in the Greater Shepparton region.

The first Grade 2 AHA held additional qualifications, including a Certificate IV in Nursing and a Certificate III in Fitness, with experience in the acute hospital setting, supporting a team to deliver cardiac and pulmonary rehabilitation, where for optimal recovery, many patients required continued support as they returned home, with a significant proportion of this support delivered through the TCP.

A move into a role supporting continued rehabilitation in the community setting was a rational progression. The AHA transitioned to working part time in the TCP team, while continuing part time in the rehabilitation ward. The new role supported the supervision of clients undertaking physiotherapy and OT exercise programs requiring repetition, two or more times per week.

Service demand has continued to grow due to increasing referrals from a broader geographical region, and the implementation of the Geriatric Evaluation and Management (GEM) in the Home (GITH)<sup>7</sup> and restorative care programs<sup>8</sup>. By 2009, the service was supporting 22 home and bed-based places with ten staff, including care coordinators, physiotherapists, OTs, an administrative assistant, manager and two AHAs.

The AHAs deliver services to patients in their homes or residential care placements once or twice between weekly AHP reviews, according to the tasks delegated to them and as documented in a written exercise plan. At the end of each day, the AHAs provide feedback on patient progress and AHPs make changes to care plans as required.

For patients with a high level of complexity, AHPs and AHAs will undertake a session together so that direct supervision of delegated tasks can occur, such as speech therapy or dietetic support, including speech exercise practice, dietary supplement delivery and weighing. AHAs are also involved in equipment set up and education, supported by the AHPs.

Case conferences occur weekly with the ambulatory aged care programs (encompassing TCP, GEM in the Home and Restorative Care). The AHAs are expected to actively contribute to a discussion of each patient's progress, including articulating goals that the patient has identified. A meeting between the AHP and AHA follows, to assign patient caseloads and prioritise work for the coming week.

## Implementing a team assistant role

As the program progressed and the AHA role developed, AHAs within these programs identified a potential need for both allied health assistance and basic nursing care. Some patients would present with medication questions, or medical conditions that required monitoring, including wounds, incontinence, blood pressure and blood sugar issues.

Management decided to create a blended AHA and enrolled nursing role to more holistically manage the needs of these patients and, as many of the AHAs at GV Health were also registered enrolled nurses, such a role was feasible. Having one person address the broader needs of patients would increase efficiency in care delivery and potentially improve patient outcomes.

---

6 The objective of TCP is to deliver a range of services, including physiotherapy, OT, nursing and personal care to support older patients after a hospital admission to optimise their functioning and independence, to return home rather than to residential care.

7 GEM in the Home is a GV Health-specific program.

8 Restorative care supports clients 50 years and over who have had an orthopaedic event requiring non-weight-bearing rehabilitation and support for up to 12 weeks. GEM in the Home is aimed at improving function of clients in their homes, in order to prevent admission to an aged care facility or hospital.

A position description for a team assistant role was developed in 2011. The position requires qualifications in allied health assistance and enrolled nursing (including holding current registration), to be employed by GV Health at the same level as an enrolled nurse.

The position currently reports to a team coordinator within aged ambulatory care programs who is a registered nurse. Clinical supervision is shared between allied health and nursing staff, based on the care being delivered. The majority of the care delivered is in allied health.

Orientation and continued professional development is supported within the AHA organisational framework. Casual and rotating staff are usually AHAs, rather than team assistants. In this case, their work is limited to the AHA scope of practice.

## Developing AHA competencies

A key element in supporting AHAs to complete appropriate qualifications and providing continued professional development opportunities for AHAs, has been to partner with the local registered training organisation (RTO), Goulburn Ovens Institute of TAFE (GOTAFE). Through this partnership, GOTAFE has offered course content for certificate qualifications in allied health assistance to support the development of a skilled workforce.

In return, GV Health AHPs have developed and delivered discipline-specific units as part of these courses, and GV Health has supported clinical placements for GOTAFE students, coordinated by an experienced AHA.

Continued professional development has been integral to the success of the AHA role at GV Health. Content development has been responsive to the needs of AHAs and program areas. Examples of recent professional development activities include a workshop in normal movement with an expert AHP, and a malnutrition and food handling series relevant to patient support in the hospital and community settings.

## Service and role review and improvement

In 2012, GV Health has approximately 15 EFT AHAs or team assistants across eleven disciplines and program streams. The team assistant role is in place in programs supporting patients with more complex needs and requiring allied healthcare and some nursing support. These currently include the aged ambulatory care programs and HARP DMT.

These positions are funded through a range of funding streams including the Transition Care Program, SACS and the hospitals acute and subacute funding allocations.

By increasing the size of the allied health workforce with AHA positions, GV Health has successfully expanded and optimised services to meet growing demand within the community. The allied health team will continue to review the needs of both patients and the community, shifting resources or adjusting approaches as needed, within the constraints of program budgets and the changing workforce landscape.

# Implementation of a remote supervision model

## Omeo District Health

Omeo District Health (ODH) has been able to expand the delivery of physiotherapy services, paediatric speech development and community exercise programs, through recruitment of an experienced Grade 3 allied health assistant (AHA). This locally based AHA supports implementation of individual and group programs, and is supervised directly and indirectly by allied health professionals (AHPs) during and between their fortnightly visits to the remote mountain location.



## Identifying a service need

Omeo is a small rural community located in a geographically isolated alpine region of Victoria. The population of the district is approximately 1,500, distributed across the four townships of Omeo, Swifts Creek, Ensay and Benambra. The nearest regional centre is Bairnsdale, population 11,000, located over an hour and a half's drive down a winding mountain road.

From 2000, allied health services at Omeo District Health (ODH) have been funded through a Commonwealth Rural Primary Health Service (RPHS) grant, available to rural and remote communities with less than 5,000 residents, through the Department of Health and Ageing.

The community healthcare delivery program is funded under the RPHS with a review of the service agreement and budget breakdown every three years. The funding model is flexible enough to respond to community need within the appropriate service provision model and according to the availability of appropriate service providers. Access to occupational therapy (OT), physiotherapy and speech pathology services was provided through this program.

In Omeo, there was a documented need to expand the delivery of physiotherapy services, provide additional support to coordinate intake across all allied health services, and increase resourcing for established programs that were supported by part-time staff, particularly in the areas of paediatric services and community exercise programs.

In late 2009, an experienced AHA moved to the district and expressed interest in undertaking an AHA role at ODH, if a position became available. The community care manager responsible for liaison with the RPHS took advantage of this opportunity.

As part of the three-yearly review in late 2009, a business plan was developed that proposed changes to the service delivery model for physiotherapy, and implementation or strengthening of additional programs required in the Omeo district. The business case demonstrated that a number of identified gaps could be addressed by employing a skilled and experienced AHA to support service and program delivery.

The proposal was agreed to and funding was secured for a Grade 3 AHA four days per week (0.8 EFT), commencing in the 2010–11 financial year.

## Defining the Grade 3 AHA role

A position description was developed for this multidisciplinary AHA role to allow the successful candidate to work with a range of AHPs to deliver services and programs as required. The key objective for the role was 'to support the provision of therapy programs, health promotion programs and patient record keeping, under the direction of the Omeo District Health community and allied health staff'.

The position description was developed utilising a range of relevant documents, including the AHA scoping project<sup>9</sup>, Better Skills Best Care Stage 1 pilot projects (2005–06)<sup>10</sup> and position descriptions developed by other organisations.

The key program areas identified for the AHA role included supporting delivery of individual and group programs for patients of all ages across a range of settings. Under AHP direction and remote supervision, the AHA would assist with many local programs. Responsibilities include:

- supervision of group exercise programs in a gymnasium
- assisting patients in the acute facility with rehabilitation exercises and activities
- facilitating language development groups at primary schools
- assisting with organised health promotion programs and activities
- undertaking routine screening and monitoring of patients
- facilitating the Kindy Gym program
- fitting and issuing equipment (for example, crutches) under remote supervision
- delivering and installing standard home-based equipment under an AHP's direction
- transporting patients to and from treatment sessions or other activities.

Duties also included a range of administrative tasks such as assisting with intake documentation for new patients, maintaining medical records for existing patients and undertaking routine tasks on behalf of AHPs (typing, mail outs, filing, photocopying and laminating, organising appointments for AHPs, and maintaining and organising equipment).

The breadth of the new role required someone who could work with minimum supervision, who had high-level communication and interpersonal skills, and who could prioritise and organise their own workload. The role was designated a Grade 3 AHA.

The successful applicant was an experienced AHA who had obtained a Certificate IV in Allied Health Assistance qualification. ODH supported the AHA to obtain a Certificate III and IV in Fitness (personal training). The AHA had more than twelve years of experience across three health and community services, supporting a range of physiotherapy and occupational therapy programs in the acute, rehabilitation and aged care settings.

## Direct and remote AHA supervision

The initial focus of the new AHA role was to support the delivery of physiotherapy programs for individuals and groups. This required implementation of a remote supervision model for the locally based AHA, working with oversight from a visiting Gippsland Lakes Community Health (GLCH) physiotherapist.

The physiotherapist visits ODH for two consecutive days each fortnight to assess and review all patients, supported by the AHA. The physiotherapist prepares exercise programs, demonstrates technique and discusses the goals and intervention parameters for each patient with the AHA, to ensure that patients are effectively supported to continue their programs.

<sup>9</sup> Healthcare Management Advisors Pty Ltd, 2009, Allied health assistants final report.

<sup>10</sup> Department of Health, Victoria

A comprehensive review and handover of each patient is pivotal for successful management of patients between physiotherapist visits. Patients often undertake their prescribed exercise programs with the AHA twice or more between physiotherapist visits.

The community care manager, a practicing occupational therapist, line manages the AHA on a day-to-day basis, providing practice guidance, overseeing her professional development and reviewing her performance in collaboration with the AHPs with whom she works. The community care manager is also responsible for allocating general and administrative tasks in support of allied health services.

The physiotherapist is responsible for supervision of the AHA in delivery of all physiotherapy services. Between the physiotherapist's fortnightly visits, the AHA follows written care plans and documents patients' progress in the notes.

During regular phone calls, the AHA and physiotherapist discuss patient issues, address clinical questions and adjust plans as a result of changes in a patient's health status. Open communication between the physiotherapist and AHA ensures full understanding of what is happening, and facilitates timely and appropriate responsiveness to patient needs.

An alternative mode of communication was also trialled between GLCH and ODH as part of an AHA-supported telehealth pilot. The AHP and AHA were able to conduct remote consultations and hold patient case discussions using audiovisual software loaded on laptop computers. This technology may provide future opportunities for rural and remote communities to effectively communicate and, as a result, to improve service delivery and clinical oversight.

## Developing AHA competencies

In addition to physiotherapy services, ODH identified a range of programs that could be delivered with AHA support. The AHA was keen to be involved in new programs and explore new professional development opportunities. ODH recognised the contribution the AHA had brought to the organisation since commencing in the role, including providing additional services in the district.

Having a qualified and highly skilled AHA who also holds qualifications in fitness has facilitated the establishment and commencement of much-needed health and fitness programs in Omeo. Weekly gentle exercise programs have now been implemented in Benambra and Swifts Creek, and a community gym has recently been set up at ODH. The AHA has facilitated the development of community membership guidelines, gym assessment procedures and fitness programs.

Increased paediatric services were also needed in the district. A visiting speech pathologist required an assistant to support delivery of a school-based speech development group. Having not previously worked with a speech pathologist, the AHA relished the opportunity to develop skills in a new area.

By working closely together initially, the AHA was quickly able to develop the skills she needed to support delivery of the group program. She now assists with twice-weekly delivery of the structured speech program at Omeo primary school. The speech pathologist directly oversees the program by undertaking double-up sessions with the AHA, and remotely supervises via phone and email between visits.

The AHA represents the ODH team as a member of the High Country Early Years Action Group.

Membership of this working party includes the ODH OT, visiting speech pathologist, and childcare, kindergarten and schools representatives, who work collaboratively to support community development of early years services in the district.

## Service and role review and improvement

The implementation of a Grade 3 AHA role at ODH has supported local delivery of many programs and services that would otherwise not have been possible in this small community in the high country. The key to the success of this model has been the ability to recognise and employ a candidate with the qualifications, skills and drive to support service delivery under remote supervision.

A robust supervision structure and a clear definition of role, in conjunction with the experience and confidence of the AHA, has resulted in effective program delivery for the community.

The flexibility of a multidisciplinary Grade 3 AHA position has allowed the role to develop and respond to changing service needs, while providing diversity and professional development opportunities for the AHA.

The AHA has reported very high job satisfaction as a result of the wide variety of tasks and working to the full scope of the Grade 3 AHA role. She likes planning and organising her work independently, working flexibly around the availability of the AHPs within the supervision framework and governance structures of ODH, the standard group session times and the needs of individual patients. She particularly enjoys the significant patient contact and seeing the difference that her role makes to the lives of people in her community.

The increased responsibility of the Grade 3 role has been a big positive for her, balanced with the support she receives from her manager, visiting AHPs and other colleagues at ODH. She is hoping to build a stronger network with other AHAs across the Gippsland region, participate in regular professional development activities via teleconference, and perhaps use the portable videoconference software currently being trialled.

ODH has successfully delivered high-quality physiotherapy services through employing an AHA to support a visiting physiotherapist, with a combination of direct and remote supervision practices. Even with changes in personnel, the ODH team is keen to continue to deliver the programs, with AHAs providing ongoing support to AHPs to meet the service needs of the local community.



# Supporting patient-centred care at Casey Hospital

## Southern Health

At Casey Hospital, allied health assistants (AHAs) play a vital role delivering integrated care by following the patient journey through four disciplines in acute and subacute settings, working under the supervision of physiotherapists, occupational therapists (OTs), speech pathologists and dietitians. Casey Hospital has established a Grade 3 AHA position that encompasses a clinical role supporting multidisciplinary patient care and a leadership role supporting Grade 2 AHAs, students and allied health professionals (AHPs).



## Identifying a service need

In 2004, the establishment of the new Casey Hospital presented senior allied health managers with a unique opportunity to design a service model and facility that has improved multidisciplinary care. In developing and maintaining this model, AHPs remain committed to implementing best-practice care guided by research. The one allied health department with shared offices where staff work together supports a strong multidisciplinary culture within the hospital.

Five AHAs at Casey Hospital (3.5 EFT) support a team of 60 AHPs working across a range of settings, including emergency, acute, subacute and women's and children's services. Each multidisciplinary AHA has a caseload of patients they provide care to, for all the AHPs involved in the patient's care. The AHA is able to develop a rapport with their patients, understand their needs, monitor and advocate on their behalf, and keep the AHPs informed of their progress and emerging needs.

## Defining the Grade 3 AHA role

Under the *Better care for older people* initiative, Southern Health was able to fund a 12-month Grade 3 AHA position with a focus on minimising the functional decline of older people.

As the Grade 3 AHA position was found to be effective in meeting patient need, when the funding ceased, a pre-existing Grade 2 AHA position was reviewed and reclassified as a Grade 3 position. The scope of the reclassified role was expanded and redesigned to meet both the clinical needs of patients within the acute and subacute environments, and to strengthen leadership support available to AHAs.

Currently, the position incorporates:

- a **clinical role** that includes:
  - utilising screening tools when indicated by the outcome of a global screen that supports AHP assessment of the patient
  - identifying patients who would benefit from participation in functional maintenance or activities of daily living (ADL) groups
  - assisting in the completion of food charts and supplement consumption of high-risk patients identified by the dietitian
  - undertaking discharge support home visits, installing appropriate equipment and ensuring appropriate social supports are in place to support a patient's transition home
  - leading socialisation activities to promote emotional health and wellbeing.



- **a leadership role** supporting Grade 2 AHAs within the team as a mentor, monitoring and managing patient workflow and demands on the team, and coordinating the AHA weekend service
- **assisting with orientation** of Grade 1 AHPs and AHA students around the role AHAs play in the hospital setting, and demonstrating ways of working in a multidisciplinary manner with patients to support learning needs identified by the supervising AHP
- **supporting and managing quality improvement initiatives** that the AHAs have responsibility for.

## Scoping the role

At Casey Hospital, the development of the Grade 3 AHA role was part of a broader piece of work initiated by the Allied Health Executive to identify the roles and competencies required of AHAs working at Grade 1, 2 and 3 levels. A working party of clinicians defined the knowledge, clinical skills, interpersonal skills, supervision requirements, administrative tasks, quality and patient equipment tasks that AHAs at each level could have responsibility for. This resulted in the development of a skills matrix.

The *Better care for older people* project coincided with the opening of a 16-bed general medical ward at Casey Hospital. Funding for the Grade 3 AHA was achieved through the *Better care for older people* project, which provided an avenue to develop, implement and evaluate a new model of care through the creation of the first Grade 3 AHA role at Casey Hospital. The focus of the role was guided by the main outcome of the project – minimising functional decline.

As part of the governance of this new position, a working party with representation from each AHP discipline was convened to scope and articulate the competencies required in the new Grade 3 role. A skill development program was then developed, incorporating elements from physiotherapy, OT, dietetics and speech pathology, to support the AHA to acquire the necessary skills and knowledge for particular roles in each discipline area and within the multidisciplinary team.

The competencies identified were consistent with the roles outlined in the skills matrix. AHPs at Grade 2 or above monitored and supported the Grade 3 AHA to attain these competencies, prior to undertaking the tasks independently.

## Implementing the AHA role

In establishing the Grade 3 AHA role, Southern Health sought to recruit someone who had completed a Certificate IV in Allied Health Assistance, had three to five years experience at Grade 2 level, had worked with AHPs across a range of disciplines, had a commitment to patient-centred care, an interest in supporting quality initiatives and the capacity to play a key leadership role in supporting the AHA team.

The person currently in the role has had eight years experience working within acute and rehabilitation environments in outer and inner Melbourne health services, with interests in neurological conditions and women's health developed in previous roles.

The AHA was attracted to the role as she had the relevant qualifications and was keen to move forward in her career. The Grade 3 role provided her with career progression and she was attracted by the prospect of mentoring and leading other AHAs.

## Supporting change management

Over the last eight years at Casey Hospital, the AHA role has been nurtured in a supportive environment under the strong leadership of managers with responsibility of developing the multidisciplinary model of care. Managers have worked towards establishing a strong model of care supported by a range of systems and structures including:

- **a culture that values AHAs' contribution** to patient care and recognises them as a discipline that supports integrated care. The Grade 3 AHA role has supported development of the AHA team as a discipline. With a strong leadership component mentoring Grade 2 AHAs and managing AHA workloads, the role has been important in fostering a sense of ownership and professionalism within the team. AHAs are encouraged to take responsibility for managing the referrals they receive and their clinical and group activity workloads, and facilitating good communication with the other allied health team members. The Grade 3 AHA supports the AHAs to work to their full capacity within their roles.
- **regular AHA team meetings and professional development programs** that provide the opportunity to discuss issues and identify emerging professional development needs. Each month, one of the AHPs involved in the supervision of the AHAs attends their meeting to provide support and guidance on any issues that emerge. Bi-monthly professional development opportunities are developed to respond to identified learning needs. AHAs are also invited to attend the broader AHP development sessions.
- **regular case conference and handover meetings**, which enable them to gain an understanding of patients' clinical needs and treatment goals, and establish the priority order for patients to be seen. The Grade 3 AHA subsequently supports AHA team members to timetable the care they will provide on a regular basis to patients. A priority matrix (based on client need) was developed by managers and clinicians, which is used to support effective decision making and guide AHAs when demand from across all the allied health disciplines within the team exceeds capacity.
- **clear role definitions and position descriptions** for Grade 2 and 3 AHAs. Particular effort was made to structure and define the Grade 3 AHA role, so that both AHPs and AHAs have a very clear understanding of the scope of practice of the role. Recognising that the roles of Grade 2 AHAs are varied, processes have been established requiring AHPs to provide written referrals for all Grade 2 AHAs, to ensure treatment plans and parameters of practice are clearly understood. Over time, each allied health discipline has developed a range of templates to support the prescription of common treatment activities.
- **creation of a buddy system**, linking each AHA with another AHA. They work together under the supervision of an AHP for a period of time to gain an appreciation of each other's roles, so that they are able to backfill for each other should one of them take leave or if they need assistance managing their workload.
- **establishment of a team of AHPs responsible for AHA supervision**, consisting of senior representatives from physiotherapy, OT, dietetics and speech pathology, with expertise from acute and subacute wards. The AHA supervisor team meets every two months to discuss developments, changes and issues relating to AHA needs.
- **regular supervision sessions for each AHA** with a senior AHP they work closely with. The AHA supervisor is rotated in line with the AHA rotations through acute and subacute to ensure appropriate expertise. Each AHA has a designated supervisor from one discipline who rotates with them. AHAs can discuss discipline-specific needs with the discipline supervisor or referring AHP.
- **Partnership with Swinburne TAFE** that provides Certificate IV in Allied Health Assistance training at Southern Health as required.

## Service and role review and improvement

AHPs report that the use of AHAs has lead to:

- improved efficiency as more routine tasks are delegated to AHAs, which enables the AHPs to focus on more complex treatment activities
- clinicians experiencing increased job satisfaction as AHAs take on more of their routine tasks
- better client health outcomes resulting from coordinated care and support.

In a busy hospital environment, having the one multidisciplinary AHA caring for a patient enables that AHA to spend time establishing rapport, understanding their needs, monitoring their progress, advocating on their behalf and ensuring that supervising AHPs are kept informed of their progress and emerging needs.

AHPs also note that patients often confide information they have not shared with busy clinicians. As the AHAs build rapport with the patient, they can bring issues to the attention of the team and ensure they are addressed.

The multidisciplinary allied health model of care at Casey Hospital is viewed by the management team as being very effective in strengthening outcomes for patients. An aspiration is that over time the model will be implemented at other campuses. However, it is recognised that progress will be slow, as the key enabler (having all allied health team members sharing joint facilities) is not common at all campuses.

The challenge will be to look for opportunities to strengthen multidisciplinary care and create new AHA roles as positions become vacant or growth funding emerges.

# Improving outcomes for patients through malnutrition screening

## Swan Hill District Health

The creation of a Grade 1 allied health assistant (AHA) role with both dietetics and health promotion has enabled Swan Hill District Health to address the significant issue of malnutrition in their patient population. The role also provides support for health promotion activities and offers an opportunity for young people to experience an allied health career. This case study focuses on the development of the dietetics component of the new role.



### Identifying a service need

Recent research has shown malnutrition to be a risk factor in hospital settings for increased rates of complication and length of stay, greater probability of readmission to hospital post-discharge, increased risk of mortality and higher hospital costs.<sup>11,12,13</sup> The prevalence of malnutrition has been reported to be as high as 20 to 50 per cent of hospital patients.<sup>14,15,16</sup>

In 2009, based on the growing body of evidence, the Dietetics Association of Australia recommended as best practise the routine screening of hospital patients, using a validated malnutrition screening tool. It also recommended that awareness, identification and treatment of malnutrition be increased across the continuum of care in Australian healthcare facilities.<sup>17</sup>

The number of patients being referred to dietitians at SHDH for early review was shown to be very low in relation to those potentially at risk of malnutrition. Malnutrition screening is important for patients in reducing the risk of poorer health outcomes and the associated increases in hospital resource utilisation.

In June 2008, new Australian Coding Standards enabled health services to claim additional funding under new Diagnostic Related Group (DRG) codes for the management of malnutrition in association with certain cases, based on the level of complexity. SHDH identified this as an opportunity to potentially access funding that would recover the costs associated with undertaking routine screening activities.

In 2009, Monash University dietetics students on placement at SHDH undertook an audit of patients admitted to the acute wards, in order to identify the number of patients at risk of malnutrition who should be referred to the dietitian for review. This data was compared to patient referrals based on existing processes. This was to determine if the Australian Coding Standards change presented an opportunity to secure sufficient additional funds to support a position that would undertake routine screening activities.

11 Goiburu ME, Goiburu MM, Bianco H et al. 2006, 'The impact of malnutrition on morbidity, mortality and length of hospital stay in trauma patient', *Hospital Nutrition*, vol. 21, no. 5, pp. 604–610.

12 Correia MI, Waitzberg DL, 2003, 'The impact of malnutrition on morbidity, mortality, length of stay and costs evaluated through a multivariate model analysis' *Clinical Nutrition*, vol. 22, no. 3, pp. 235–239.

13 Chima CS, Barco K, Dewitt ML et al. 1997, 'Relationship of nutritional status to length of stay, hospital costs and discharge status of patients hospitalised in the medicine service' *Journal of the American Dietetic Association*, vol. 97, no. 9, pp. 975–978.

14 Kubrak C, Jensen L, 2007, 'Malnutrition in acute care patients: A narrative review', *International Journal of Nursing Studies*, vol. 44, pp. 1036–1054.

15 Alberda C, Graf A, McCargar L, 2006, 'Malnutrition: Etiology, consequences and assessment of a patient at risk', *Best Practice and Research Clinical Gastroenterology*, vol 20, pp. 419–439.

16 McWhirter JP, Pennington CR, 1994, 'Incidence and recognition of malnutrition in hospital', *British Medical Journal* vol. 308, pp. 945–948.

17 Watterson C, Fraser A, Banks A et al. 2009, 'Evidence-based best practice guidelines for nutritional management of malnutrition in adult patients across the continuum of care', *Nutrition and dietetics*, vol. 66, S1, p. 534.

Over a two-week period, the students used a validated, standardised Malnutrition Universal Screening Tool (MUST) to screen as many admitted patients as possible on the acute wards. As a result of screening 68 patients from a total of 101 admitted patients, 21 patients (31 per cent of 68) were found to be at risk of malnutrition, whereas only two patients (2 per cent of 101) had been referred to the dietitian independently by other hospital staff.

Of the 21 patients identified using the MUST, subsequent evaluation of the DRG (Diagnostic Related Group) coding demonstrated that the associated cost weightings (WIES – Weighted Inlier Equivalent Separations) increased for seven patients, which in turn attracted significant additional funding.

## Defining the Grade 1 AHA role

Through the audit, the dietetics department had collected sufficient evidence on the effectiveness of screening in identifying additional patients with malnutrition, to illustrate the need for the service. The impact of this activity on funding codes demonstrated sufficient justification for creating a new role to support systematic screening of hospital patients.

A business case based on the identified service need was developed to seek approval for recruitment of an AHA to specifically support malnutrition screening.

The business case proposed piloting the AHA role for a six-month period for three hours each morning, five days per week. The proposal included details of the impact of additional dietetic referrals in attracting increased DRG funding to support the position. The SHDH executive gave approval for the pilot, with a requirement to measure and report the outcomes achieved in both clinical and funding terms.

At the same time, the Health Promotion Department identified a need for additional resources as a result of staff changes and increased demand that could be met by funding an AHA-level position for 15 hours per week.

The creation of a dual dietetics and health promotion AHA role was proposed to address the needs of both departments. A position description was developed for a Grade 1 AHA, detailing the responsibilities of the role and clear objectives to address the needs of both departments.

The key objective for the role in dietetics was to assist the dietitians in the provision of screening of nutritional status, diabetes screening and monitoring of dietary therapy interventions for hospital inpatients. The role within the Health Promotion Department was in administration and intervention support, including reception duties, data collation, and assistance with implementation of interventions.

As a secondary objective for the role, the chief dietitian was keen to create an opening into allied health and potential impetus for long-term career development.

## Piloting the AHA role

Applicants with a range of backgrounds applied for the position. As a result of the interview process, a university student who had recently deferred their studies was recruited to fill the Grade 1 AHA position.

The AHA received on-the-job training and supervision by the ward dietitian. This initially involved the AHA shadowing, then being supervised and observed, as she developed the required skills. The key areas for development were to interact confidently and appropriately with patients to administer the standard questions in the MUST tool, including scoring and recording the outcomes as directed.

Based on the MUST scores, patients assessed as having a score of two or more (at high risk of malnutrition) were referred for immediate review by the ward dietitian. The AHA was directed to follow up those at medium risk (with a score of one) to document dietary intake for their next meal on the ward, in order for the dietitian to assess the need for dietary intervention.

At the end of the six-month pilot period (which ran from July to December 2010), the results of the routine nutritional screening of new admissions by the dietetic AHA were analysed.

A total of 429 people admitted to SHDH were screened in the six-month period. Of those, 122 (29 per cent) were found to be malnourished with a further 25 (5 per cent) at risk of becoming malnourished. An advanced DRG classification for 11 of the 122 patients attracted significant additional funding for their management.

The results of an evaluation of the six-month pilot demonstrated that the AHA was able to appropriately administer the MUST tool to screen patients and provide the collected information to the dietitian for follow up. Sixty-five per cent of all referrals for dietitian review resulted from the AHA undertaking the MUST screen.

The outcomes of the pilot convinced the SHDH executive of the value of continuing the AHA role and agreement to continue for a further 12 months was granted. Ongoing collection and reporting of program outcomes was a requirement.

## Implementing the AHA role

The AHA position was funded for a further 12-month period from January to December, 2011. The role demonstrated continued success in screening to identify and refer patients at risk of malnutrition. On review of the data from this period, proportionally similar numbers of patients as for the initial six-month pilot were identified and referred.

Additional information regarding the profile of SHDH patients assessed as at risk of malnutrition is now available, based on the dataset collected over a full year period. Strategies to address both the causes and social circumstances that increase the incidence of malnutrition continue to be identified as a result of an ongoing focus on nutritional assessment.

The AHA role was subsequently approved to receive ongoing funding for 2012 and is planned to continue as long as demonstrable benefits are achieved.

The current AHA, who commenced in February 2012, is a student who has completed a health science undergraduate degree and is interested in specialising in either dietetics or health promotion at the end of her 12-month position. She and the ward dietitian share an office and work closely together. Working collaboratively as a team is key to the success of the SHDH AHA role.

As the position is Grade 1 level, the AHA works under the direct supervision of the ward dietitian. The dietitian reviews the AHA's work and discusses patient related issues.

The MUST is a structured screening tool that provides clear guidance for the AHA to administer questions and structured guidelines for dietetic review. The supervision structure and co-location with the ward dietitian facilitates frequent questioning and open discussion. Regular catch-up times are scheduled and utilised.

Review of completed screening checklists by the dietitian with the AHA each morning ensures that screening has been completed and is documented correctly.

Regular catch-up sessions in the more common disease entities (for example, diabetes), has facilitated greater understanding of the context for screening activities. Careful assessment of prior knowledge of the AHA has ensured an appropriate focus for her skills development.

## Service and role review and improvement

Role requirements are reviewed on an ongoing basis and changes have been made over time.

The AHA now starts work earlier, to facilitate the completion of MUST checklists and review of all identified patients by the ward dietitian prior to the lunch meal on the day of admission. Clinics for the ward dietitian have also been moved to afternoons to facilitate availability for immediate patient review in the morning.

Additional activities being considered include screening in pre-admission clinics to ensure screening of as many patients as possible. Standard screening questions to identify patients with allergies or intolerances have recently been added to the MUST questions administered by the AHA. Malnutrition management and AHA protocols have been written to describe the steps involved in the nutritional screening procedure.

The AHA also contributes to other initiatives, such as red meal tray and food service audits, conducted by the ward dietitian.

Education of all staff in malnutrition as a risk factor for poorer health outcomes and requirement for active management is and will remain a key focus for the dietetics department. The routine completion of patient-screening checklists in the acute ward has assisted in raising nursing and other staff members' awareness of the prevalence of malnutrition in the acute care setting.

The objective for the role in providing an opportunity for a local person to experience the AHA role and explore a career in allied health has already been successfully achieved. The AHA involved in the initial pilot program enrolled at university and is now in the second year of study for a Bachelor of Nutrition and Dietetics.



# Improving care outcomes in speech pathology

## Barwon Health

The speech pathology department of Geelong Hospital, with the support of the McKellar Centre (a rehabilitation facility), has established an allied health assistant (AHA) role to support the early rehabilitation of patients with dysphasia, dysphagia or a laryngectomy, throughout their journey across acute and rehabilitation environments.



### Identifying a service need

Allied health professionals (AHPs) at Geelong Hospital and the McKellar Centre identified the benefit of active early rehabilitation for patients with dysphasia and dysphagia, who are waiting for a rehabilitation bed, as well as the need for additional treatment for patients with a laryngectomy in the acute outpatient setting.

The long-term aim in establishing an AHA role within the acute setting is to support speech pathologists in the active early rehabilitation of appropriate patients and to strengthen continuity of support to patients as they move to a rehabilitation setting.

The six-hour AHA position was created with the support of the McKellar Centre. At the time, the role was created, the AHA was working one day as a ward clerk and four days as an AHA at the McKellar Centre. She now works full time as an AHA across the two sites.

### Defining the AHA role

The manager of the speech pathology department at Geelong Hospital recognised that other allied health departments and the McKellar Centre were utilising AHAs, and saw an opportunity to strengthen speech pathology service capacity through the employment of an AHA.

At the same time, an experienced AHA at the McKellar Centre was interested in expanding her role to provide earlier rehabilitation for patients. The AHA's supervisor at the McKellar Centre supported her in pursuing this opportunity.

The funding for this position came from existing resources within the speech pathology budget. A business case was submitted and senior management supported the development of the position. The approach was to establish a part-time position, measure the impact of the role, and if successful, develop a business case to expand the role.

### Scoping the role

Senior speech pathologists from the McKellar Centre, with significant experience in managing and working with AHAs, supported the acute speech pathology team to scope the AHA role within the speech pathology department at Geelong Hospital.

Speech pathologists undertook an audit over the course of a week in February 2010 to identify activities that could be undertaken by an AHA. The range of these activities included clinical activities, quality improvement and administrative tasks.



To maximise the benefit of the AHA's time in the speech pathology department, the role was carefully scoped. While opportunities to support clinical care were identified in the audit, it was agreed that, at this early stage, the role would primarily support the development of clinical processes and systems.

## Implementing the AHA role

The AHA has worked at the McKellar Centre for 18 years as a speech pathology AHA, and brought considerable experience supporting speech pathologists in neurorehabilitation care to the acute setting.

The AHA's role within the rehabilitation setting involves:

- providing one-on-one treatment to inpatients in accordance with treatment plans developed by the speech pathologist
- facilitating inpatient communication groups
- facilitating the Geelong Dysphasia Support Group for outpatients and their carers.

The acute AHA role has primarily focused on supporting the speech pathology department to strengthen its clinical processes and systems.

In particular, the role has involved:

- **clinical care**, including the development of generic aids to support patients on the wards to communicate with their healthcare team and provide one-on-one interventions with patients who have had a laryngectomy, in accordance with the treatment plan developed by an AHP
- **clinical system support** to ensure electronic communication equipment is serviced and in working order, and to develop and maintain systems to monitor equipment on loan to patients
- **administrative support**, including ordering stationery and resources (such as thickened fluids, dry mouth spray and progress forms), organising storage, and filing reports and discharge summaries.

A senior speech pathologist from the McKellar Centre supported the speech pathology team at Geelong Hospital to understand the scope of the AHA role, supervision and delegation requirements, and to develop an implementation strategy for the new role as the team had not previously worked with an AHA.

The team worked together to establish and implement systems to support the role, including development of a project request form (to request AHA time) and a project log to prioritise current and future AHA workload commitments and to monitor progress.

Initially, the senior speech pathologist visited the acute team half a day a month to assist the AHA to adjust to her role in a different clinical environment, and to support the AHPs to develop confidence in supervising and delegating tasks to the AHA.

Regular supervision sessions are provided across both campuses by the same senior AHP from the McKellar Centre. Additionally, each AHP working with the AHA provides supervision relating to the relevant clinical or project-based activity.

The AHA participates in relevant professional development program sessions for speech pathologists (which gives her greater insight into clinical approaches), attends the journal club (to hear about the latest approaches in care) and attends the team's business meetings.

At each team meeting, the AHA project log is reviewed, so that everyone is clear about work priorities. Adjustments are made where required.

## Service and role review and improvement

The AHPs at Geelong Hospital have been supportive of the AHA role, with feedback that the support provided by the AHA has improved clinical systems and allowed AHPs to focus more on higher level tasks.

In particular, the role has allowed AHPs to delegate a range of administrative and clinical support activities, which has meant that AHPs can provide individual therapy to more patients. A recent review showed that the AHA is spending 14 per cent of her time supporting patients, 16 per cent of her time ordering supplies for patients with dysphagia and 57 per cent of her time in administrative activities.

The AHA's role in developing generic communication boards and maintaining equipment has significantly improved patients' ability to communicate effectively with all hospital staff, and family and friends, during their hospital stay.

The manager of the speech pathology department recognises the important contribution that the AHA role has made to the effectiveness of the department. The next step is to build a business case to expand the AHA position and progress the long-term aims of implementation.

Expanding the AHA position and increasing the AHA's hours will enable the AHA to play a greater clinical role, increasing the proportion of time spent directly supporting the early rehabilitation of patients, particularly those with dysphasia and those who have had laryngectomies, as well as developing specific communication aids to support individual patients.

AHPs believe that strengthening early rehabilitation support to patients while on the acute wards may contribute to improved rates of recovery.

# Supporting the Serious Mental Illness Laughter and Exercise program

## Northeast Health Wangaratta

The Serious Mental Illness Laughter and Exercise (SMILE) program supports people with a chronic mental illness to reduce risk factors associated with developing a co-morbidity such as diabetes, heart disease or hypertension. The program is supported by a Grade 3 AHA who delivers a fitness program under the direction of a physiotherapist in a rehabilitation environment.



### Identifying a service need

AHA roles in the Subacute Ambulatory Care Service (SACS) at Northeast Health Wangaratta have changed significantly over the last ten years. Initially, AHAs worked within the specific allied health disciplines of physiotherapy and occupational therapy, delivering exercise-based programs and supporting equipment programs, along with associated administrative tasks. The AHAs supported patients with less complex needs, which enabled the allied health professionals (AHPs) to monitor patients with more complex needs and who required individual manual therapy.

As multidisciplinary allied health teams were developed, AHPs in other disciplines were able to explore with more experienced AHPs how to go about effectively delegating tasks and supervising AHAs.

In 2010, the Hospital Admission Risk Program (HARP), which works alongside the SACS at Northeast Health Wangaratta, identified that 45 per cent of their active patient load were people with chronic and complex needs requiring mental health interventions.

The HARP team was aware that research demonstrates that people with a severe chronic mental illness are:

- more likely to be overweight with a tendency for obesity
- at higher risk of diabetes, heart disease and hypertension
- more likely to have a lower life expectancy.

As a HARP initiative, managers selected a Grade 2 physiotherapist and a Grade 3 AHA to work with the mental health nurse from HARP to develop SMILE, a healthy lifestyle program to reduce avoidable hospital admissions and emergency department presentations, and to improve health outcomes and equitable access to health services program.

### Developing the SMILE program

The allied health team that works across the HARP and SACS programs at Northeast Health Wangaratta has a strong history of AHA involvement in program design and supporting patients in group settings. However, addressing patient needs associated with chronic mental illness was unfamiliar.

The program development team identified the importance of developing a greater understanding of the needs of patients with a mental illness. Management supported the AHA to attend a two-day mental health first aid course and a four-day course in anxiety and depression.

As a consequence, the AHA became aware that their approach in coaching patients with anxiety and depression would need to be different from the way they coached clients in mainstream exercise programs to 'sweat it out'. The AHA and team realised the key to success was to make the classes fun, help patients to set realistic goals and do the best they could on any given day.

With this knowledge, the team designed a program that would support participants to lose weight, improve cardiovascular fitness, increase healthy food choices, reduce smoking levels and improve quality of life.

To prepare all staff, access to professional development was offered to support the HARP and SACS team members to better understand the needs of patients with a chronic mental illness, and to build their confidence in working with patients with a mental illness.

The sixteen-week SMILE program provides a once-a-week gym-based exercise instruction class to a group of six to eight patients. Patients can achieve their fitness goals by using the gym equipment, which includes free weights, treadmills, exercise bikes, a stationary rower and multi-station weights machine.

The physiotherapist supervises the delivery of the program. Other AHPs, including a dietician, podiatrist and quit smoking facilitator, attend sessions throughout the program to provide education and support to participants to develop and maintain a healthy life.

Mental health case managers, carers and family members are all encouraged to attend, to offer additional support and motivation for participants. Maintaining a consistent and welcoming environment has been an important factor in maintaining active participation in the group.

## Defining the Grade 3 AHA role

The SMILE team (including the mental health nurse, physiotherapist and AHA) undertakes an assessment of each patient's needs and the physiotherapist develops a treatment plan. The AHA then develops an exercise program for each patient, which the AHP reviews. While each session has learning goals for the group related to healthy lifestyle, the AHA works on an individual basis with patients to support them in working to achieve their particular goals.

Many patients were initially anxious and reluctant to attend the SMILE program, as it involved visiting a new facility. Strategies to support and encourage patients to participate in the program were developed. For example, if the patient lacks initial confidence in attending a group, the AHA works with the patient on a one-on-one basis until they feel confident attending.

One of the key aims of the program is to facilitate a patient's behavioural change by establishing exercise as part of a daily routine. In doing so, patients are supported to look beyond the program itself and establish routines that will support them to maintain a healthy lifestyle, such as joining a local gym or exercise group. The AHA works with patients on these longer-term goals, and will attend local gyms or exercise groups to support their transition to a mainstream setting.

The AHA works with the patient to gather information that is fed into the SMILE team assessment process, including taking weight and waist girth measurements, and getting the patient to take the six-minute walking test.

Following the treatment plan developed by the physiotherapist, the AHA develops an individual exercise program based on particular goals, having regard to any contraindications identified by the physiotherapist. The physiotherapist then reviews the exercise program and, if any modifications are required, the program is revised.

The AHA has a key role in ensuring patients quickly become familiar with the gym and feel at ease. Their role also involves:

- undertaking pre-assessment activities that support the assessment of each participant
- identifying how patients are feeling and the exercise level they are comfortable with on the day
- monitoring the room and supporting individual participants with their exercises as required
- leading components of the group exercise program
- evaluating individual patient achievements compared with their exercise goals and supporting evaluation of the program
- ensuring patients maintain their fitness level by supporting them to participate in regular exercise at local community facilities at the conclusion of the program.

## Developing AHA competencies

In partnership with the local TAFE, Northeast Health Wangaratta has supported all its AHA team members to gain Certificate IV in Allied Health Assistance qualifications. With increased qualifications, the AHA roles have evolved from largely administratively based roles to roles that are now almost exclusively clinical.

The move to a more client-centred model of multidisciplinary care, with each client having a single AHA who works with them to help achieve their goals, establishes good rapport and provides them with consistent and coordinated support, has been well received by clients.

From a management perspective, having AHAs able to work across a range of disciplines provides greater workforce flexibility. As AHAs have developed skills working with a range of professionals, they have the flexibility to backfill for other AHAs while on leave or when a position is vacant.

Managers have assisted AHPs to identify how to effectively utilise AHAs and, over time, have supported AHAs to develop a greater clinical focus in their roles, by supporting the transfer of administrative roles to administrative team members.

The culture of the organisation is one where AHAs are regarded as key members of the clinical team and are expected, and actively encouraged, to contribute in case conferences and one-on-one discussions with AHPs. AHAs attend the twice-weekly multidisciplinary case review meetings.

Recently, AHA roles have expanded to include gathering information for an initial needs identification, which assists AHPs in undertaking assessments. Having a full understanding of patients' needs and care objectives supports AHAs to work effectively with them.

## Service and role review and improvement

The first SMILE pilot had a total of 17 patients participating with an attendance rate of 70 per cent. An evaluation of the pilot found that as a result of participating in the program, 65 per cent of patients' blood pressure decreased, 6 per cent reduced their antihypertensive medication, 59 per cent decreased their resting heart rate, 88 per cent improved their six-minute walk test results, 35 per cent reduced body weight, 24 per cent maintained body weight and 53 per cent reduced waist measurements, with three participants declining to have their waist measured. Of the six participants who smoked, one ceased, one reduced their intake and three were contemplating quitting.

As part of the evaluation, the managers identified that SMILE fitted more appropriately within the SACS program than the HARP program. As a result, resources were reallocated within the SACS program to accommodate SMILE.

The SMILE program is currently in its third year. In response to a recent program evaluation, the structure of the program has changed to allow patients to join the program as soon as they have been assessed, instead of having to wait until the start of a new course. They can also continue attending the program while they are inpatients on the mental health ward. This 'open' structure is strengthening timely access to the program and resulting in increased participation rates.

