The feasibility of the role of the Allied Health (AH) assistant in the rural health delivery model – A survey of AH assistants employed in the rural health delivery model

for

The Ministry of Health
(Rural Innovation Funding 2007)

Author: Martin Chadwick
Contact: Robin Steed

New Zealand Institute of Rural Health
9 Anzac Street
Cambridge

This report was funded by the Ministry of Health Rural Innovation fund. The report content is the intellectual property of the Ministry of Health. All use of material must acknowledge MOH funding and intellectual property ownership. November 2007.

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Appendix One

1.0 Background

In the first half of 2007, a project was undertaken to explore the feasibility of the role of the Allied Health (AH) assistant in the rural health delivery model. This project involved a literature review which highlighted the changing skill mix in delivering healthcare with themes identifying areas that need to be clarified with the implementation of service models utilising assistants. Themes included delegation of tasks, supervision of the assistant and professional oversight, and the need for AH professional staff to be adequately prepared for any change in skill mix.

A second part of the project consisted of a series of interviews focusing on this topic. Interviews focused on the geographic areas represented by the District Health Boards (District Health Boards) of Otago, Taranaki, Waikato and West Coast. Interviewee's included representatives of AH professionals, AH educators, AH professional societies/associations, AH funders, Primary Health Organisations, AH registering bodies and AH managers. Themes emerging from the interviews confirmed the themes of the literature review, as well as the concepts of "unburdening" the AH professionals, and allowing the AH professionals to fulfil a greater scope of practice.

The project report concluded with a scope of practice for the AH assistant which focused on the ability of the assistant to provide supportive tasks for the AH professional, and to provide the prescriptive portions of care to the patient. Concepts of delegation, supervision and professional oversight are also reviewed.

The conclusion of the project realised that while there had been exploration of the potential role of the AH assistant from AH staff, and AH managers and funders, there had not been an exploration of individuals who currently filled AH assistant roles, and how their experiences may correlate with the original piece of work. This forms the extension of this project, to explore the AH assistant perceptions of their role

2.0 Method and Results

The geographic region of the Waikato was selected for further exploration. Waikato was selected as the District Health Board aside from the main tertiary campus at Hamilton, also maintains four rural hospitals in Thames, Tokoroa, Te Kuiti and Taumarunui. All of the rural hospitals employ AH assistants which were the target population. A survey was developed to identify:

- If the AH assistant was involved in providing clinical care
- The expectations they have of the AH professional when they are providing clinical care
- What the AH professional should expect from them in providing clinical care
- What is an appropriate level of supervision
- What constitutes good delegation of care
- Who is responsible for the care for the patient

The survey was delivered to the four AH assistants working in the rural hospitals, and once completed were delivered to the primary investigator for collation and analysis. (See appendix I)

Surveys were received back from all rural hospitals, constituting a return rate of 100%. All of the AH assistants who completed the survey identified that they were involved in providing aspects of clinical care. Basic analysis was via "inductive thematic analysis." Due to the small sample size the investigator did not need to develop a specific coding strategy, rather there was the ability to translate themes between the surveys.

There was agreement amongst the respondents that they expected the AH professional to provide clarity with regards to what was expected of them, and if they were to complete an exercise programme, that this should be communicated to them via multiple formats i.e. described, written and demonstrated.

With regards to what they believed the AH professional should expect from them, there was again clear agreement from the respondents that they viewed themselves as being there to assist the AH professional, and that they should demonstrate competence in their role and the tasks that they carried out.

The question that explored supervision returned the greatest variety of responses with no clear themes emerging. While not explicitly reported, the responses did suggest that they were grappling with the issue of understanding boundaries, how to identify them, and how in turn to involve the AH professional if they believe they have crossed the boundary of providing safe and appropriate care.

Delegation also drew a variety of responses with the predominant theme centring on clarity of the tasks that are being handed to the AH assistant to be carried out. This was also reflected in the next question were all respondents clearly articulated the understanding that the AH professional had ultimate responsibility for the care that is provided, but that care was provided via a team approach.

3.0 Discussion

The initial phase of this project focused on AH professionals, their educators, their relevant professional societies, those who managed them, and those who funded their services. By distilling the relevant literature, there was the ability to undertake a focused interview process in clarifying the role of the AH assistant with a scope of practice developed from this process. This is represented diagrammatically in figure 1.

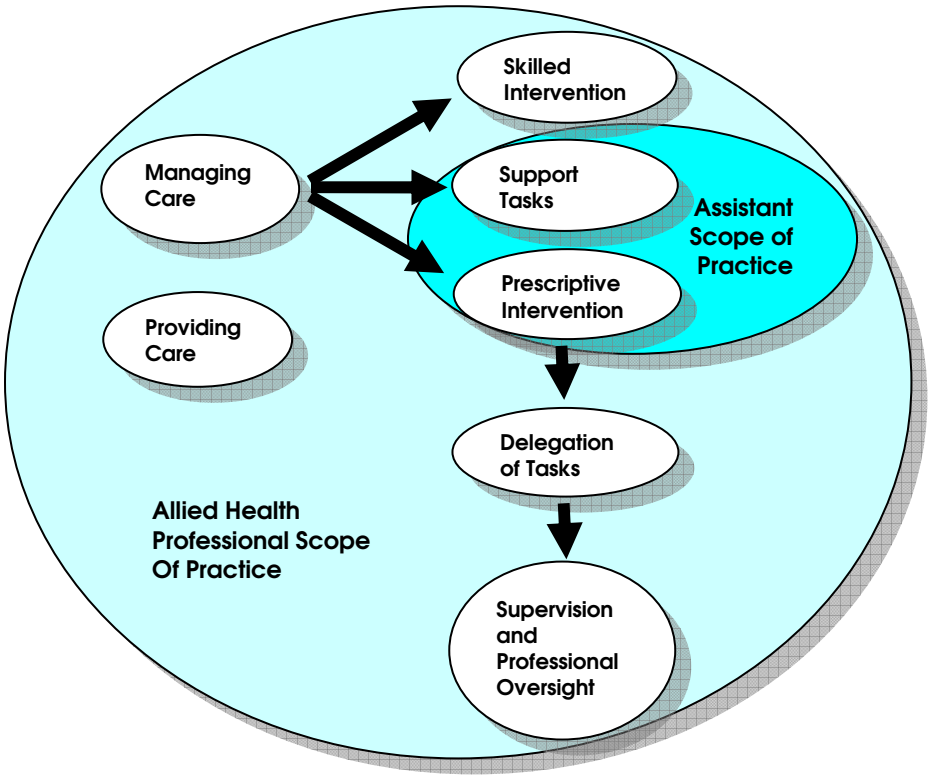

Figure 1. The Scopes of Practice of the AH professional and assistant

The AH assistant scope of practice is focused on providing support tasks to the AH professional and to provide aspects of clinical care that are prescriptive in nature. In order for this to be functionalised, there is the need for the care to be delegated in an appropriate fashion, and for there to be appropriate supervision and professional oversight of the care being provided.

The survey of rural AH assistants confirmed that this is a workable model. Overall the survey confirmed that AH assistants has a good understanding of their scope of practice and that they operated under the guidance and supervision of the AH professional. What was highlighted however was that there is still a general lack of understanding as to what contributes to clear delegation of tasks and the associated supervision required for the tasks that are being provided.

Where the potential for resolution of this issues lies remains unclear. Upon review of the initial stages of this project, and compared against the results of the survey, there are two plausible contributing factors. The first is that AH professionals are not routinely taught as a part of their training the skills that are required in order to support a successful therapeutic partnership between the AH professional and the assistant. The focus of their education remains on providing care, and until there is a shift to the skills in managing care, this will potentially continue to be an issue. The second factor is that there is no uniform training that an AH assistant undertakes to take on the role. The result is that the training is wholly on the job. This then contributes to a situation of variability in how AH assistants are utilised, and the expectation that they have coming into a role. Interestingly this was raised as a point during the survey process, in that there was an expressed desire to see more formalisation around the training that is offered to AH assistants.

4.0 Summary

As a continuation of the project to investigate the feasibility of the AH assistant in the rural healthcare environment, a follow up survey was conducted targeting AH assistants. The survey targeted the population of AH assistants employed in the rural hospitals of the Waikato district. A 100% return rate was obtained from the survey process. The survey confirmed the scope of practice model that was proposed in the initial stages of the project with the AH assistants demonstrating good understanding of their scope of practice. What was highlighted was the continued lack of clarity around the concepts of delegation of tasks and supervision. While not validated, it is proposed that this lack of clarity is a result of minimal education of AH professionals during their training as to how to work with AH assistants, and the differences between providing and managing care. Another proposed contributor to this issue is the lack of formal training available to AH assistants to reinforce expectations around the role.

Appendix I

In 2007, the New Zealand Institute of Rural Health investigated the feasibility of the role of the Allied Health Assistant in the rural environment. This investigation identified several areas that the Institute would like to explore further via survey. Please answer each question fully and to the best of your ability. Thank you for your time completing this survey.

1. Do you routinely assist the physiotherapist or occupational therapist in providing aspects of clinical care?

   Yes ☐ No ☐

2. Please list what you expect from the physiotherapist/occupational therapist to help guide you in providing clinical care:

3. Please list what you believe the physiotherapist/occupational therapist should expect from you to help guide them in providing clinical care:

4. What do you believe is an appropriate level of supervision of the assistant in providing clinical care?

5. When patient clinical care is delegated to you, what do you believe needs to be in place for this delegation to work well?

6. Who do you believe is responsible for the care provided to the patient, and why?

7. Any other comments relating to the role of the assistant?