

# TASK DELEGATION FRAMEWORK

**The purpose of this framework** is to provide overarching principles and guidelines to support and assist the process of safe and effective task sharing between Accredited Exercise Physiologists (AEPs) and other exercise professionals or members of the care team, including Accredited Exercise Scientists (AES), Allied Health Assistants (AHA) and/or Disability Support Workers (DSW). The framework is accompanied by resources and practical case study examples to assist the decision-making process to ensure clients receive the best support possible and achieve the best health outcomes.

This framework does not provide definitive answers as to whether or not allied health tasks can be delegated, or if exercise interventions can be assigned to another person. Instead, it identifies factors to consider, and the level of support and supervision required if tasks are shared. AEPs must use clinical judgement to determine what is appropriate in a particular situation.

**Note:** The term 'client' has been used throughout this document to refer to a consumer of exercise services, for consistent terminology. In some cases, the term 'patient', 'participant', or 'person' may also be appropriate in a particular service delivery.



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## ROLES IN DELIVERING EXERCISE INTERVENTIONS

It is important that AEPs understand and can distinguish between different roles in the care team when considering the scope of practice, qualifications, knowledge, and type of support required in providing allied health services to a client.

**Accredited Exercise Physiologist (AEP)** - are university-qualified allied health professionals who prescribe, deliver, and adapt movement, physical activity, and exercise-based interventions to facilitate and optimise health status, function, recovery, and independence. AEPs undertake a minimum of 4 years of equivalent study at an Australian Qualification Framework (AQF) Level 7 or above in clinical exercise physiology. They are also required to meet an extensive accreditation process that includes practicum experience in a range of settings and environments. [AEP Scope of Practice](#).

**Accredited Exercise Scientists (AES)** - are professionals who apply the science of exercise to design and deliver physical activity and exercise-based interventions to improve health, fitness, well-being, and performance. It is their role to assist in the prevention of injury and chronic conditions. At a minimum, they hold a bachelor's degree that meets the Australian Qualification Framework (AQF) Level 7 requirements with high-level training in exercise and sports science. An AES critically evaluates scientific evidence to design and deliver physical activity and exercise-based interventions to prevent injury, return to activity, manage risk factors for chronic conditions, promote participation, improve fitness and performance. It is also within the scope of an AES to deliver exercise-based interventions that have been prescribed by a health professional qualified in clinical exercise prescription (e.g., an AEP) for people with medical conditions, injuries, or disabilities. [AES Scope of Practice](#).

AES and Private Health: [Private Health \(essa.org.au\)](http://essa.org.au)

**An AES can also work as a sole trader provider or as an employee of a provider, offering direct support or working as an Allied Health Assistant.** For further information, see Compensable Work for AES: [https://www.essa.org.au/AES/Compensable\\_Work/AES/Compensable\\_Work.aspx](https://www.essa.org.au/AES/Compensable_Work/AES/Compensable_Work.aspx)

**Allied Health Assistant (AHA)** - works with and under the supervision and delegation of an allied health professional (AHP) to provide therapy and support to individuals and groups, to help protect, restore, and maintain optimal function, and promote independence and well-being. The level of supervision may be direct, indirect, or remote and is dependent on several variables related to the task, client, setting, AHA qualifications and competency, and level of risk involved.

See the table below for some examples of clinical and nonclinical duties that AHA can perform:

*Adapted from Allied Health Assistants and What They Do: A systematic review of the literature - Journal of Multidisciplinary Healthcare (2010).*

CLINICAL DUTIES	NONCLINICAL DUTIES
Coordinate and assist AHP in the operation of services	Administration, including clinical notes
Provide physical and social support to the client	Stock ordering/requisition
Administer clinical services and modalities	Prepare/maintain the environment
Transfer clients	Equipment maintenance
Communication with other care team members	Health promotion
Assist with mobility and gait	Monitor and update the healthcare-specific database
Provision of equipment	Reporting/statistics/database
Provide client education	Housekeeping
Prepare clients for treatment	Cleaning
Provide individual or group therapy that has been prescribed by an AHP	

Formal qualifications are available including Certificate III, Certificate IV, or Diploma in Allied Health Assistance.

Each state and territory's AHA framework identify different levels of qualifications and competencies. For further information see: <https://www.ahana.com.au/state-specific-information>

Some AHAs may have qualifications that allow them to do a broader range of tasks, such as a degree in Exercise Science, or Certificate IV in Fitness. Where AHAs have a broader range of qualifications, the AHP must have a good understanding of the competencies associated with these other qualifications. Please note the AEP's insurance will not cover an AHA to undertake activities using additional qualifications that are outside the AEP profession scope (such as massage therapy).

Within the National Disability Insurance Scheme (NDIS), AHA roles are also labelled Therapy Assistants. Two support levels of Therapy Assistants are included in the NDIS Pricing Arrangement and Price Limits 2022 - 2023<sup>2</sup>, as outlined below:

- » **Level 1** - can only deliver support under the **direct** supervision of an AHP.
- » **Level 2** - can deliver supports under the **indirect** supervision of the AHP but may require specific training in the needs of the client before they take responsibility for the delivery of the therapy.

The National Disability Insurance Agency (NDIA) does not specify any formal qualifications for AHAs, nor minimum training requirements for the two levels of assistance covered in the pricing guide.

Note: Allied Health Assistants must be covered by the professional indemnity insurance of the supervising allied health professional (or the allied health professional's or therapy assistant's employing provider).

Further information regarding Indemnity Insurance can be found here: [https://www.essa.org.au/Public/Professional\\_Standards/Insurance\\_FAQs.aspx](https://www.essa.org.au/Public/Professional_Standards/Insurance_FAQs.aspx)

**Disability Support Worker (DSW)** - provides care and support to people with a disability. They are responsible for a wide range of tasks that support client choice, optimising general health and wellness, physical comfort, social enrichment, and emotional well-being. They support individuals in function and participation in their home environment and in the community.

There are no specific education levels or entry criteria for DSWs, however, certain roles may require certificate or undergraduate training. Formal qualifications are available, including but not limited to Certificate III in Individual Support (Disability); Certificate IV in Disability; or Bachelor of Applied Science (Disability).

DSWs work within clearly defined parameters and their work is determined by the needs of the client. As part of their role, DSWs may also support the client with allied health tasks that the AHP, client, or decision maker has identified as appropriate<sup>3</sup>.

Disability Support workers can be encouraged to undertake AHA studies and develop AHA skills to further advance their careers.

**Note:** For both allied health assistants and disability support workers, the position description they are employed with defines the role and scope of practice within the work environment.

## TASK SHARING MODELS

This section defines and describes three models that AEPs can use when collaborating with others to provide safe and quality client services in the delivery of exercise interventions. These three models include task handover, task delegation, and task allocation. In all models, the AEP develops the treatment plan and is responsible for identifying which aspects of the treatment plan are appropriate for handover, delegation, or allocation to another person.

### Potential benefits of task sharing

Safe and appropriate task sharing may benefit the healthcare organisation or business, healthcare professionals, and clients as outlined below.

#### For clients:

- » increased opportunities and treatment options
- » improved compliance for exercise and increased opportunity to meet exercise recommendations
- » improved client outcomes due to increased adherence
- » better self-management and increased self-efficacy
- » more support available for clients in regional and remote locations by having local AHAs supervised by an AHP through telehealth

#### For healthcare professionals (i.e. AEPs):

- » AEPs have more time to carry out more complex tasks and work with higher needs clients
- » AEPs receive more support for clinical and non-clinical tasks
- » provides opportunities for the AEP to supervise AHAs and develop delegation and leadership skills

#### For organisation/business:

- » freeing up AEPs to focus on high-level clinical assessment and services
- » reduces the current long waiting lists for AEP services
- » improved efficiency of service delivery
- » increased workforce capacity
- » increased potential for business diversification

## TASK HANDOVER MODEL

**Task handover:** the process by which an AEP transfers some or all aspects of an exercise intervention to an AES. The AES is responsible and accountable for the aspects of the intervention they have agreed to take over.

**Note:** This model is specific to AES because it is within the scope of an AES to deliver exercise-based interventions that have been prescribed by an AEP for people with medical conditions, injuries, or disabilities. AES also hold appropriate professional indemnity insurance, either personally or through a third party (such as an employer) and do not work under the supervision or accountability of the AEP.

It is recommended that the AES also has their own public liability insurance (usually combined into one policy with professional indemnity). Public Liability provides cover for bodily injury and property damage that does not result from the provision of the professional services, such as slips and trips, and damage to property.

### Accountability in task handover

#### AEP

- » AEPs are responsible for developing the treatment plan and determining if it is suitable for an AES to deliver some or all aspects of the exercise intervention.
- » The AEP must ensure that the handover is not prohibited by legislation, regulation, or funding restrictions (e.g., AEP services funded under Medicare, DVA, or Workers' Compensation schemes).
- » The AEP must gain client consent for the handover and include the client in the handover process.
- » AEPs must provide a detailed handover of the prescription to the AES to ensure safe, high-quality client services.

#### AES

- » AES are responsible for carrying out the aspects of the treatment plan they have agreed to and operating within their scope of practice
- » AES should seek guidance from the AEP or refer the client back to the AEP if client conditions or symptoms change

## Handover guidelines

**Step 1:** AEP uses clinical judgement to decide if it is safe and suitable to handover some or all aspects of the exercise intervention to an AES. Considerations might include complexity of the exercise intervention, complexity of the client's health conditions, variability of client response to the exercise intervention, and experience of the AES.

**Step 2:** The AEP gains client consent for handover (informed and written).

**Step 3:** AEP provides verbal and/or written handover to AES including client history, goals, treatment plan, expected outcomes and timeframes. The use of a structured handover template can help to provide a framework for communicating the minimum information content for handovers. The template should be adapted to suit local workforce environments and culture, and the purpose of the handover.

**Step 4:** The AES delivers the prescribed exercise intervention (no supervision is required) and records detailed case notes ([Professional Resources - Clinical & Non-Clinical Practice \(essa.org.au\)](https://www.essa.org.au)). AEP and AES maintain open lines of communication.

**Step 5:** AEP reviews client outcomes as per the treatment plan (if indicated).

**Note:** This framework includes appendices which are specific to delegation, however, they can also be used as a guide in the process of a task handover. See [Appendix 1: Risk Assessment Tool](#), [Appendix 2: Competency Checklist](#), [Appendix 3: Delegation Agreement](#), and [Appendix 5: Checklist for Accepting Tasks](#)



## Case Study 1: Task Handover to AES

### BACKGROUND

Sandra (72yr old female) was referred to an AEP to assist her with her declining mobility and back pain. The client also had a history of depression, hyperlipidaemia, hypertension, and asthma. All health conditions were stable and controlled with medication.

Sandra's goals were to better manage pain, be able to walk the dog along the beach for 60 minutes and be able to perform housework tasks more easily.

Sandra attended a clinical assessment with the AEP, who developed the treatment plan and designed the exercise program. AEP deemed it to be safe and suitable for Sandra to perform the exercise program under the supervision and guidance of an AES who works for the same organisation as the AEP.

### HANDOVER PROCESS

- » AEP gained Sandra's informed and written consent to handover
- » AEP provided verbal handover to AES, including expected outcomes and timeframes
- » AEP provided face-to-face handover with Sandra present
- » AEP documented handover notes in Sandra's file using clinical notes software
- » AES delivered the prescribed strength training program twice a week to Sandra and recorded session notes in clinical software program
- » (AES does not require supervision from AEP to deliver the exercise program)
- » the AES and AEP maintained open lines of communication to discuss Sandra's progress and any modifications to the program
- » AEP reviewed and re-assessed Sandra every 6 - 12 weeks and discussed the outcomes and treatment plan with the AES

**OUTCOMES**

Improved objective client outcomes as listed below:

<b>INITIAL ASSESSMENT (SEPTEMBER 2022)</b>	<b>MOST RECENT (FEBRUARY 2023)</b>	<b>COMMENTS</b>
<b>BP</b> - 145/85, <b>HR</b> - 82bpm	<b>BP</b> - 130/75, <b>HR</b> - 78bpm	Reduction in resting BP and HR
<b>Height</b> - 165cm, <b>Weight</b> - 111kg, <b>BMI</b> - 40.8	<b>Height</b> - 165cm, <b>Weight</b> - 92kg, <b>BMI</b> - 33.8	Reduction in BMI
<b>Body Fat%</b> - 53%	<b>Body Fat%</b> - 49.2%	Reduction in body fat %
<b>RMR</b> - 1463	<b>RMR</b> - 1659	Increase in resting metabolic rate (RMR)
<b>Visceral Fat</b> - 18.5%	<b>Visceral Fat</b> - 15%	Reduction in visceral fat
<b>Grip Strength:</b> Right = 21kg, Left = 24kg	<b>Grip Strength:</b> Right = 23kg, Left = 26kg	Increase in grip strength bilaterally
<b>Sit to Stand</b> = 10reps	<b>Sit to Stand</b> = 13reps	Increase in LL endurance
<b>Balance:</b> SL EO L = 3sec, SL EO R = 3sec	<b>Balance:</b> SL EO L = 20sec, SL EO R = 30sec	Improvement in balance
<b>VO2 Peak</b> = 18.7ml/kg/min	<b>VO2 Peak</b> = 23.1ml/kg/min	Increase in cardiovascular fitness

## TASK DELEGATION MODEL

**Task delegation** - the process by which an AEP identifies appropriate allied health task(s) to be performed by an AHA who is deemed capable. The AHA performs the task(s) under the supervision and accountability of the AEP. The level of supervision required depends on several variables related to the task, client, setting, qualifications, competency of the AHA, and level of risk involved.

**\*The task delegation model is applicable to AES if they are employed as an AHA.**

Delegating clinical tasks to AHAs is an effective strategy for the efficient and timely delivery of allied health services<sup>4</sup>. Research indicates that AHAs can impact positively on client health outcomes (without impact on client safety) when they provide evidence-based therapy, such as interventions aimed at increasing physical activity<sup>5-11</sup>. As such, healthcare organisations and businesses should consider how AEPs can effectively utilise AHAs and delegate appropriate tasks (clinical and non-clinical) safely and effectively.

### Accountability in task delegation

#### AEP

- » AEPs are responsible for developing the treatment plan and determining when a review of the plan is appropriate
- » AEPs are accountable for delegating allied health tasks and have a legal responsibility to determine that the AHA has the:
  - i. knowledge and skill level required to perform the delegated task, and
  - ii. the appropriate level of supervision and feedback in the performance of that task
- » AEPs are responsible for supervising and supporting the AHA, and for monitoring the implementation of activities they have delegated
- » AEPs are responsible for evaluating the outcomes of the delegation

#### AHA

- » the AHA is accountable for deciding to accept (or decline) delegated tasks and for ensuring that they have the appropriate skill, knowledge, and judgement to accept the delegation
- » AHAs are responsible for fully understanding what is expected of them regarding tasks being delegated and raising concerns if they feel they do not have the necessary skills to do a task
- » AHAs are responsible for their actions in carrying out delegated tasks and operating within their scope of practice

## Delegation process

**Step 1:** AEP identifies suitable task(s) for delegation including Risk Assessment ([Appendix 1](#))

**Step 2:** AEP provides task instruction including Competency Check ([Appendix 2](#)) & Task Delegation Agreement ([Appendix 3](#))

**Step 3:** The AHA decides whether or not to accept the task ([Appendix 5: Checklist for Accepting Tasks](#))

**Step 4:** The task is administered by the AHA – under appropriate AEP supervision (e.g., direct/indirect/remote)

**Step 5:** AEP reviews client outcomes as per the treatment plan

### STEP 1

## AEP identifies suitable task(s) for delegation

The primary motivation for delegation should be to serve the best interests of the client. This includes the consideration of client safety, ongoing physical activity promotion, self-management, and capacity building, as well as financial management.

- » the AEP uses clinical reasoning and decision-making processes to decide whether to delegate a task and is responsible for this decision
- » as a part of the decision-making process, risks and risk mitigation strategies associated with the safe and effective performance of the task should be considered, developed, and communicated to the client and the AHA
- » Before delegating tasks, the AEP should consider:
  - › The global risk of delegation - see [Appendix 1: Risk Assessment Tool](#)
  - › The level of training, skills, and competencies of the AHA - see [Appendix 2: Competency checklist](#)
  - › Accountability and liability factors
  - › The potential outcomes if a task is not delegated

The AEP needs to consider that the client should have the choice to do something that involves a level of risk, ensuring that they are empowered to make their own choices, understand, and live with the consequences (known as 'dignity of risk').

- » Tasks can be delegated when the AEP assesses that the client outcomes can be met, and the risks can be managed adequately.
- » Clinical tasks that are not appropriate to delegate include those that:
  - › The AHP is not competent to perform the task themselves or to delegate the task

- › The AHA is not competent to perform the task
- › The client does not consent to the delegation
- › Are prohibited by legislation, regulation, or funding restrictions, for example, a delegation of AEP services under Medicare, DVA, or Workers' Compensation schemes

If risk mitigation strategies are inadequate and the task is not deemed appropriate to delegate, then the AEP should not delegate the task. In this instance, recommended follow-up could involve communicating with the client, carer, family, and/ or support coordinator; advocating for appropriate allied health services to achieve the client's goal(s); and advocating for greater skill development and training for AHAs.

## STEP 2

### AEP provides task instruction

- » The AEP must provide instructions that include all relevant information, so that the task can be undertaken safely, including:
  - › Clear instructions of the required task, client characteristics, and anticipated outcomes
  - › The procedure to be followed when undertaking the task
  - › Guidance on how to manage any anticipated risks
  - › When and how further advice should be sought from the AEP
  - › Specific information that is required to record client outcomes (e.g., subjective and objective information)

### Client consent and documentation

- » Keep a record of client consent to work with an AHA - informed and written
- » The delegation instruction needs to be documented in client notes/ file. Developing a handover template promotes uniformity in the documentation. See [Appendix 3: Task Delegation Agreement](#), for an example only
- » Written instructions need to detail the nature of the task together with whom, when, and where the task is to be conducted
- » Written communication is recommended for task delegation for several reasons, such as:
  - › Helping to ensure client care is delivered appropriately
  - › Providing clarity about responsibility for clinical activities should it be required in the future

**STEP 3****The AHA decides whether to accept the task being delegated**

- » The AHA needs to have a clear understanding of their responsibilities when accepting delegated tasks and seek clarification where required. See [Appendix 5: Checklist for accepting a task](#)
- » The AHA should raise concerns if they feel they do not have the necessary skills to do a task being delegated to them
- » The AHA may decline the task if they do not possess the training and competency to implement the task safely or if there are other barriers or risks to implementing the task

**STEP 4****The task is administered by the AHA - under appropriate AEP supervision (e.g., direct/indirect/remote)**

- » The AEP is responsible for supervising the AHA to ensure client safety and that desired client outcomes are achieved
- » Key elements of effective supervision include<sup>3</sup>:
  - Monitoring:** a process of ensuring the delegated task is being completed safely and capably in the manner required
  - Direction:** provides advice on the course of action to be taken
  - Guidance:** shows the way for effective learning through visual/verbal/manual/mechanical aids
  - Support:** provides supportive feedback, nurtures, reassures, and protects, enabling a person to gain skills and confidence
- » Before delegating an activity, the AEP must know how they will supervise the activity they are delegating. They should consider:
  - › what supervising strategies they will use
  - › how regularly they will supervise the activity
  - › what mode of communication they will use to supervise the activity (for example, face-to-face, phone, videoconference, etc)
  - › documentation, risk identification and mitigation
  - › a plan for escalation and indicators for when AEP input is required for safe and effective client support

Clinical supervision may be direct, indirect, and/or remote:

Direct clinical supervision occurs when the supervising allied health professional:

- » Works alongside the AHA
- » Observes and directs the AHA's activities
- » Provides immediate guidance, feedback, and intervention as required

Indirect clinical supervision occurs when the supervising allied health professional:

- » Works on-site and is easily accessible but may not be in direct view of the AHA while the activity is being performed
- » Is readily available within the same physical area or easily contactable (i.e., by phone) should the need for consultation arise
- » Designates an alternative contact person (should the need arise) if they will be unavailable

Remote clinical supervision occurs when the supervising allied health professional:

- » Is located some distance from the AHA
- » Is immediately contactable and accessible to provide direction, support, and guidance as required (e.g., phone or video-conferencing)

The lines of responsibility and accountability must be clearly articulated and well-documented when using remote supervision.

Telehealth services provide supports to participants in remote locations. For example, an AHA might deliver services in regional and remote locations under the supervision of an AEP based in a different location. This might require some extra considerations in recruiting, training, supporting remote AHAs, and telehealth technology and training.

**The level of supervision required depends on several variables related to the task, client, setting, qualifications, competency of the AHA, and level of risk involved.**

## Factors that influence monitoring

*Adapted from the Queensland Government (2022). Office of the Chief Allied Health Officer. Delegation Framework – Allied Health<sup>12</sup>.*

FACTOR	CONSIDERATIONS
<b>Task</b>	<ul style="list-style-type: none"> <li>» The complexity of the task</li> <li>» Risks associated with the task</li> <li>» Predictability of task outcomes</li> <li>» The frequency that the task occurs in the service</li> </ul>
<b>Client</b>	<ul style="list-style-type: none"> <li>» The complexity of the client's presenting health condition</li> <li>» Stability of the client's health condition</li> <li>» Potential impact (positive and negative) of the delegated task on the client's condition</li> <li>» Other client factors, e.g., behaviour cognition, communication, engagement</li> </ul>
<b>Treatment plan</b>	<ul style="list-style-type: none"> <li>» How recently the task was added to the clients' plan (i.e., initial or review)</li> <li>» The frequency of the task will be performed as part of the treatment plan</li> </ul>
<b>Setting / Environment</b>	<ul style="list-style-type: none"> <li>» Access and proximity to the delegating AEP</li> <li>» Frequency of contact with the delegating AEP</li> <li>» Access to other health professionals, or other support infrastructure, e.g., mobile phone, first aid kit, defibrillator</li> </ul>
<b>Team</b>	<ul style="list-style-type: none"> <li>» AHA's education, knowledge, skills, and competencies</li> <li>» AHA's experience in undertaking tasks in similar contexts and with clients with similar needs</li> <li>» AEP's training and experience in delegation practice</li> <li>» AEP's knowledge, skills, and competency in performing the task</li> </ul>

Supervision is an important skill for all allied health professionals. AEPs should consider participating in professional development activities to develop and refine their supervision skills as required.

### Feedback

- » Giving feedback is a critical component of supervision. The AHA needs to understand what is going well and what requires improvement. Being aware of their actions enables them to become more effective in their interactions or improve their performance.
- » The goal of feedback is to identify strengths and gaps in skills to develop agreed action plans to improve performance. Feedback loops should also involve clients.

**STEP 5****Review of client outcomes**

The AEP reviews and documents the outcomes of the task and evaluates the decision to delegate the task based on the outcomes. The AEP determines the need for ongoing client care, including the requirement for additional assessments and interventions. If suitable, the AEP provides a new delegation instruction, thereby repeating the process.

## Case Study 2: Task Delegation to AHA

### BACKGROUND

Clare has a C5 Incomplete Spinal Cord Injury (Asia Impairment Score C). She had been attending weekly Exercise Physiology since her discharge from the hospital to continue her rehabilitation and manage her health and well-being.

#### Clare presented with:

- » Impaired motor function in trunk and lower limb
- » Impaired sensation and proprioception below the level of injury
- » Impaired hand function

#### Mobility and transfers:

- » Uses manual wheelchair for all mobility
- » Lift transfer from wheelchair to bed
- » Standing pivot transfer wheelchair to car

#### Risks Identified:

- » Risk of skin injury during transfer
- » Autonomic Dysreflexia
- » History of shoulder and elbow pain

#### Clare's NDIS Goals are:

1. Participate in activities to better manage mental and physical health
2. Decrease body weight to make transfers easier
3. Assist with cooking and cleaning duties

### CONSIDERATIONS

- » Clare has limited opportunity for exercise outside of supported therapy as she requires assistance for the setup of all exercises and uses gripping aids to assist with upper limb exercises. She has previously trialled the use of support workers for completion of the Home Exercise Program but did not enjoy exercising in a home environment, did not feel comfortable accessing a community gym and wanted to continue to access equipment in a purpose-built facility.

- » Clare requires the prescription of an exercise program by an AEP.
- » Clare has nil cognitive, communication, or behavioural concerns.
- » Clare presents with a stable condition and rarely requires adjustments to the program. However, she requires hands-on assistance and adaptive equipment to participate in exercise.
- » AEP identifies that Clare would benefit from more frequent exercise and would be safe to perform the prescribed program under the supervision of AHA.
- » Consider re-allocation of funds to maximise services by using AHA for delivery of exercise program.

### NDIS funding:

- » NDIS Funding available: Improved Daily Living - equivalent to 60 hours of Exercise Physiology
- » The AEP, Clare and Support Coordinator discussed Clare's goals, exercise recommendations and available funding
- » All parties agreed that it would be safe and suitable for Clare to perform the exercise program under the supervision and support of the AHA

Re-allocation of funds to maximise services to NDIS Participant:

- » AEP services: 1 hour exercise prescription + 1 hour (non-clinical) written Guidelines + 1 hour handover and competency check with AHA + 3 hour reviews every 8-12 weeks + 1-hour Therapy Report for NDIS Plan Review = 7 hours of AEP services
- » AHA services: 1 hour handover and competency check with AEP + ongoing exercise delivery 3 x week (45 mins per session) x 45 weeks

**Note:** According to the NDIA it is appropriate for the provider to bill for the time spent by both the AHP and the AHA. This arrangement can represent value for money for the participant compared to the alternative of all supports being delivered by the AHP.

## DELEGATION PROCESS

1. The AEP prescribed the exercise program, provided detailed task instructions, and risk management plans.
2. The AEP completed a handover session and signed off on all competencies with AHA and Clare. Clare, AHA, and AEP all signed the agreement form.
3. The AHA delivered the exercise program 3 x week under the indirect supervision of the AEP. The AHA maintained clinical notes in the electronic medical record and provided intermittent progress updates to AEP on a weekly basis.
4. The AEP reviewed and updated the program every 8-12 weeks as indicated.

**OUTCOMES**

- » Clare increased her weekly exercise participation from 1x/week to 3x/week.
- » Clare was able to decrease her weight by 7kg.
- » Clare increased her independence with transfers due to increased strength and endurance. She travelled interstate twice during the year and was able to complete transfers on the plane, self-propel manual wheelchair in the airport, and manage transfers in the hotel environment.
- » AEP was more available to perform clinical assessments and programming for new and/or high-risk clients.
- » AHA developed skills and confidence in exercise delivery under the guidance of the AEP.

## TASK ALLOCATION MODEL

**Task allocation:** occurs when the AEP identifies aspects of the exercise prescription that can be supported by a DSW (or carer). The AEP provides training (if required) and then transfers the task recommendations and the responsibility to the line manager.

**Line manager:** the person to whom a DSW (or carer) reports to. Their title may vary depending on the setting. This may be the employer, support coordinator, or self-managed client.

**Self-managed clients:** when a NDIS plan is managed by the recipient of the plan, instead of a provider or the NDIA.

A self-managed client has specific roles and responsibilities as part of their NDIS self-managed plan. In disability services, self-managed clients are like line managers and are responsible for: choosing and arranging their supports; ensuring that the relevant invoices for their supports are paid in a manner that is consistent with their provider service agreements; storing appropriate records and receipts for supports provided, claimed, and paid; reporting to the NDIA or the department on how they spend their funds<sup>3</sup>. For self-managed clients under the age of 18, the line manager is generally the parent or guardian.

In disability services, DSWs are a great resource to support clients to be more active. AEPs can work safely, effectively, and collaboratively with DSWs to assist in meeting client goals. In some cases, a DSW will be able to help a client to undertake their exercise routine prescribed by an AEP. They can motivate, reduce fear of movement, help clients understand their program, and provide prompts, etc.

### Accountability in task allocation

#### AEP

- » The AEP is accountable for the client's treatment plan and identification of allied health tasks that can be allocated to others (i.e., aspects of the exercise prescription).
- » In the process of task allocation, the AEP is responsible for:
  - i. clear communication and documentation to support the effective transfer of the exercise prescription
  - ii. providing training for the DSW (if required) to safely supervise and support the exercise prescription
  - iii. providing recommendations to the line manager, as **once the treatment plan is transferred, the line manager becomes accountable and responsible for the decision to allocate the task**

## DSW

- » The DSW must fully understand what is expected of them in relation to the tasks that are allocated. They should raise their concerns with their line manager if they feel they do not have the necessary skills to do a task being allocated to them.
- » DSWs are accountable for delivering the task safely and effectively within the scope of their role. They should seek the support of their line manager if they are concerned about the client or their safety.

## Line manager

- » The line manager who employs the disability support worker is accountable for the DSW's performance and their ability to safely and effectively complete the allocated task.
- » Line managers need to ensure the DSW works within their scope of practice according to their position descriptions.
- » Line managers must also provide appropriate training and upskilling, and professional development opportunities and make recommendations for the ongoing support of allied health tasks that are provided by the allied health professional<sup>3</sup>.

## Example Allocation Process

**Step 1:** AEP identifies suitable task(s) that can be allocated to the DSW – [Appendix 1 & 2](#): Risk Assessment Tool & Competency Checklist

**Step 2:** AEP transfers the task to the line manager – [Appendix 4](#): Task Allocation Agreement (including escalation plan)

**Step 3:** The DSW decides whether to accept the task – [Appendix 5](#): Checklist for Accepting Tasks

**Step 4:** The task is administered by the DSW under the supervision and accountability of the line manager

**Step 5:** AEP reviews client outcomes as per the treatment plan

## Case Study 3: Task Allocation to DSW

### BACKGROUND

Greg sustained an incomplete spinal cord injury (C3 Asia Impairment Score C) secondary to a 1.5M fall from a retaining wall with associated acquired brain injury, bilateral intramedullary femoral nails.

#### Clare presented:

- » with significant neuropathic pain below the level of injury, hypersensitivity in LL and UL
- » with a history of 2x pressure injuries (Sacral and Ischial)
- » with a R) finger flexor contractures and use of day and night splints
- » underweight (BMI 16)
- » with spasticity in UL, trunk, and LL

#### Mobility and transfers:

- » using a power wheelchair with chin control for mobility indoors, attendant controlled for community access
- » using a hoist with two-assist for all transfers
- » assistance for all personal and domestic activities of daily living

#### Greg's NDIS goals are to:

1. be able to communicate with friends and family
2. feel safe in the home
3. better manage pain and spasticity with daily movement

### CONSIDERATIONS

- » Greg lives in a Specialist Disability Accommodation (SDA) and has 24-hour care provided by disability support workers. He requires daily completion of home stretching, and active assisted exercises to maintain his joint range and manage his pain.
- » Greg requires in-home supports as taxi travel exacerbates pain and spasticity.
- » Greg requires the prescription of management programs by an AEP, Physiotherapist (PT), and Occupational Therapist (OT).
- » Once the treatment program has been established, DSWs can be trained to safely deliver the prescribed therapy.
- » Utilisation of DSWs to deliver therapy programs is the most cost-effective strategy for ensuring Greg gets the recommended exercise.

- » Greg is >5 years post-injury and his programs are targeted to the maintenance and management of his pain and spasticity.
- » Greg requires hands-on assistance and adaptive equipment to participate in the exercise program.
- » It is not clinically reasonable for NDIS to fund Allied Health Professionals to deliver ongoing, long-term care and supports for Greg's management.

#### **NDIS funding available:**

- » Core Supports funding for 28 hours per day (24-hour care + 2 hours of 2:1 supports AM and PM)
- » Capacity Building (Improved Daily Living) – To be distributed between PT, OT, AEP, and Speech Therapist.

The Allied Health treatment team (AEP, PT, OT, Speech Therapist, Dietitian), Greg and Support Coordinator discussed goals, management recommendations, and available funding. The team decided that the Allied Health Professionals will set up a multidisciplinary care manual and provide training to two care provider companies.

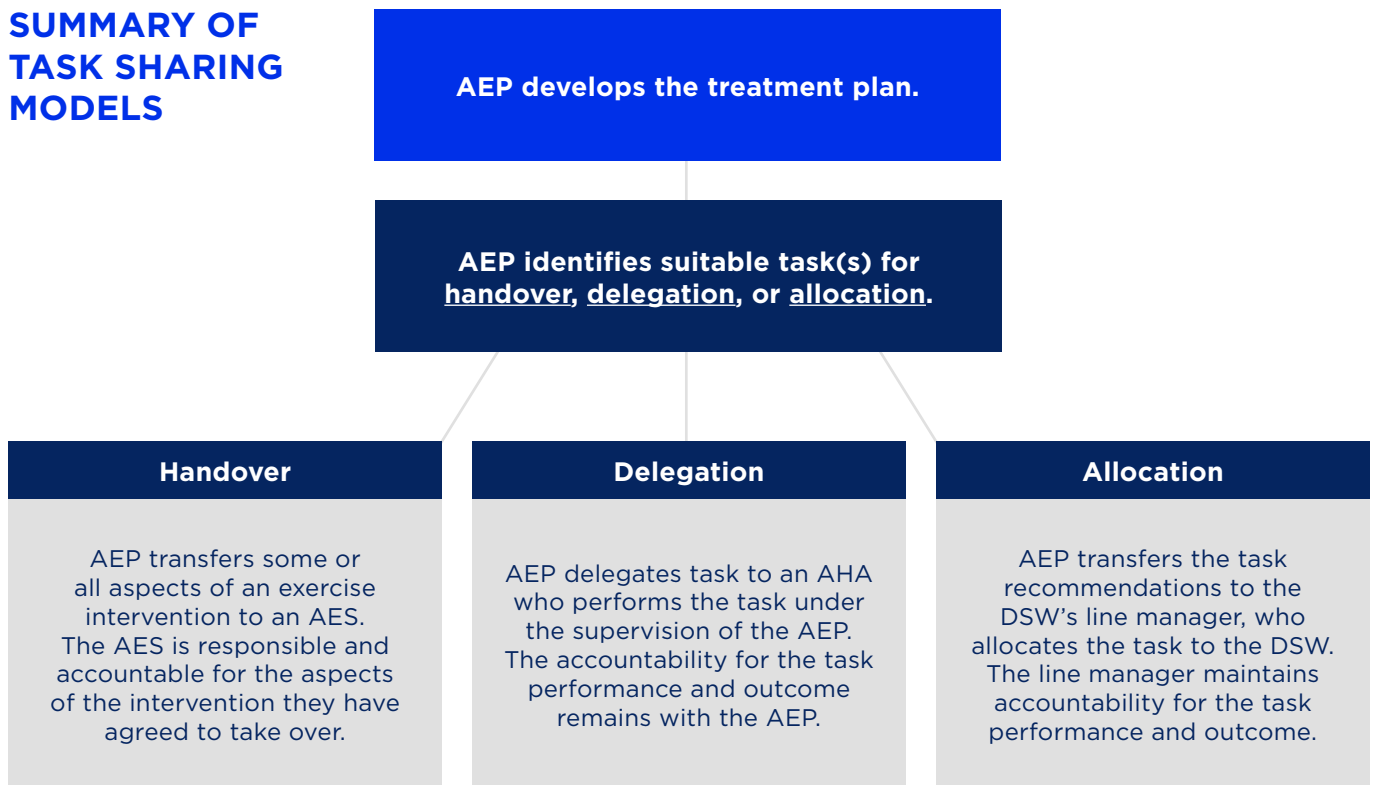
#### **ALLOCATION PROCESS**

- » AEP completed an assessment, and prescription of assisted technology (MOTOmed).
- » AEP contributed to Multidisciplinary Care Manual with written programs with detailed instruction and risk management plans.
- » AEP completed 2 x handover sessions with DSWs and Greg with sign-off on all competencies.
- » The training provided was recorded on Greg's iPad to create a training resource for future DSWs.
- » Lead DSW was observed training a new staff member and signed off as confident and competent to complete future training.
- » The Care Provider has now been allocated the responsibility of overseeing the delivery of care as outlined in the Care Manual and training of new DSWs.
- » Care manager is to contact the allied health team for review in the case of injury or illness or if there are any significant changes to Greg's care arrangements.

#### **OUTCOMES**

- » Greg has been able to complete daily stretching, strengthening, hand therapy, and MOTOmed cycling programs for the past 6 months
- » Greg has only had 1 hospital admission in the past 6 months (5 in the 6 months prior)
- » Greg has increased his weight by 2.3kg
- » Greg reports improved sleep due to decrease tone and spasticity at night
- » Greg reports significantly improved mood and quality of life since having the supports he needs in his home

## SUMMARY OF TASK SHARING MODELS



## TRAINING MODEL

In some instances, an AEP is asked to provide training for a task that has been or will be, assigned to a DSW by the line manager.

### Accountability in the training model

- » The AEP is accountable and responsible for the training content and evaluation of trainees after the training.
- » If directed by their line manager, DSWs must attend and actively participate in appropriate training, education, or instruction for their professional development and upskilling in tasks for client support.
- » **Accountability and responsibility for that task remain with the line manager once training has been completed.**
- » Line managers must be aware that the provision of training by an AEP does not automatically imply the capability of a DSW to perform a certain task to support a particular client. The line manager must judge if the task is appropriate to be assigned.

## THE ROLE OF THE CLIENT

The client has a central role in directing and managing their treatment goals and services through active communication with their health care team<sup>3</sup>. The client has a right to:

- » Select staff to provide their allied health services.
- » Determine how they receive their services, including when and where.
- » Receive good quality evidence-based practice.
- » Make decisions about their allied health services.
- » Participate in active and supported decision-making (as relevant).
- » Disclose or withhold information at their discretion, including consent for communication between providers.

## THE ROLE OF COMMUNICATION

All members of the care team require good communication and interpersonal skills to provide safe and high-quality services to clients.

The client should be at the centre of communication and decisions and can determine the interaction between service providers. Clients have a right to make informed decisions and express their choice and preference<sup>3</sup>.

Clear and considered communication should occur:

- » When delegating or identifying a task for allocation.
- » When transferring accountability for a task.
- » During supervision.
- » When providing feedback about the implementation of a task.
- » When discussing a client's progress.
- » When delivering training.

DSWs are a highly casualised, part-time workforce. The communication challenges they face might include:

- » Variable staffing and workforce turnover.
- » The involvement of multiple organisations in providing services to clients.
- » Limited time to communicate due to competing requirements and workloads.
- » The need to work within a client's NDIS funding.
- » Working in various locations (community, homes, schools, workplaces).

Developing a clear process for communication and consistent points of contact will improve the ability to communicate and, therefore, address issues early. When working with a DSW, it is important to ensure they know to whom, where, and how to raise questions, and requests for review and address concerns.

The AEP can use the following strategies to assist with setting up clear communication links and reporting lines:

- » Ensure the client is at the centre of the conversation and the treatment plan.
- » Provide clear guidance around the issues of concern.
- » Know whom to transfer the allied health task and who will accept responsibility for the task, which is appropriately documented.
- » Give clear recommendations on how and whom to follow up with if issues arise.
- » Provide clear methods of communication, feeding back outcomes to support staff, client, family, and management as appropriate.
- » Discuss communication loops.

The health literacy of the client and their family must be considered in relation to communication and service provision. The client is required to provide consent for communication between health providers, so their understanding is critical.

## CONSIDER POTENTIAL OUTCOMES OF INACTION

The AEP should consider the potential outcome for the client if a task is not delegated or allocated to another care team member. This may be in relation to available funding for allied health tasks, and the client's request, goals, and needs. However, all tasks delegated or allocated should have risk and risk mitigation plans, whether informal or formal, with clear and accessible communication and documentation. Where the decision is made not to proceed, it is necessary to document this. If delegation or allocation of tasks is deemed best practice, however, environmental factors prevent this, based on the decision-making factors involved, recommendations for resolution should be provided to the client, decision maker, support coordinator, and/or line manager.

## TIPS FOR EFFECTIVE TASK DELEGATION FROM EXPERIENCED AEPs

- » Know when it is appropriate, and not appropriate to delegate. If you feel that a client's presentation is too complex, severe, or episodic go through the Administrative Appeals Tribunal (AAT) process and advocate for funding in line with the client's needs.
- » Develop a skills matrix to help align the needs of the participant with the skills of the therapist.
- » Ensure communication channels are open, and the practitioner is reviewing the client at clinically relevant time intervals.
- » If you are concerned about liability, talk with your insurer to get clarity on your rights, responsibilities, and obligations.
- » Slowly decrease AEP supervision during a handover while the client builds trust and rapport with the AES, AHA or DSW.
- » Provide clear communication of the treatment plan, involving expected outcomes, as well as the concept of integration.

- » Communicate with the client throughout the delegation or handover process, so they know what to expect and can be involved in the process.
- » Involve the AES, AHA or DSW early and arrange face-to-face handover if possible.
- » Communicate effectively during handover and schedule follow-up appointment for AEP review.
- » Clear communication with your client around how the delegation will work and discussions with them are vital so that everyone is on the same page and understands the processes.
- » Ensure all task instructions and agreements are in writing.

## USEFUL RESOURCES

The Allied Health Assistants Good Practice Guide: <https://jobsqueensland.qld.gov.au/wp-content/uploads/2022/08/workability-aha-guide.pdf>

Supervision and delegation framework for allied health assistants and the support workforce in disability: <https://www.health.vic.gov.au/sites/default/files/migrated/files/collections/policies-and-guidelines/a/allied-health-in-disability---supervision-and-delegation-framework.pdf>

## APPENDICES

Please note that the purpose of the appendices below is to provide some examples only. It is advised that you create templates to match your own environmental and business needs.

1. [RISK ASSESSMENT TOOL](#)
2. [COMPETENCY CHECK](#)
3. [TASK DELEGATION AGREEMENT](#)
4. [TASK ALLOCATION AGREEMENT](#)
5. [CHECKLIST FOR ACCEPTING TASKS](#)

## APPENDIX 1: RISK ASSESSMENT TOOL

Adapted from The Allied Health Professions' Office of Queensland January (2016). Allied health assistant framework.<sup>19</sup>

FACTOR	CONSIDERATIONS	RISK ASSESSMENT Lower risk ↔ Higher risk	COMMENTS
<b>Task</b>	Complexity	Low complexity ↔ High complexity	
	Technical demands	Limited requirements ↔ High requirements	
	Variability of task outcomes/ client response to the task	Low variability ↔ High variability	
	Consequence of harm	Negligible ↔ Serious, irreversible	
	Likelihood of harm	Low likelihood ↔ High likelihood	
	Barriers or restrictions to the task being delegated/ allocated	Nil barriers/restrictions ↔ extensive and persistent barriers/restrictions	
<b>Client</b>	The complexity of healthcare needs	Limited complexity ↔ High complexity	
	Risk of deterioration	Low risk ↔ High risk	
	Other client factors (age, behaviour, etc)	Negligible impact ↔ high impact	
<b>Treatment plan</b>	Stage of the treatment plan	Review/established ↔ Initial stage of the plan	
	Frequency task is delivered in the treatment plan	High frequency ↔ Low frequency	
<b>Environment</b>	Access to supervision, support, and direction	Highly accessible ↔ Limited or delayed access	
	Environment and situational factors	Highly appropriate ↔ not appropriate	
<b>Care team</b>	AHA/DSW: task training and competencies	Relevant training ↔ No training	
	AHA/DSW: task experience	Highly experienced ↔ No experience	
	AEP: delegation practice	Highly experienced ↔ No experience	
	Team: local delegation model	Highly developed ↔ not developed or implemented	

**Identified risks:**

**Risk mitigation strategies:**

## APPENDIX 2: COMPETENCY CHECK

**Client name:** .....

**AHA /DSW name:** .....

**Task description:** .....

CHECKLIST	COMMENTS
Is the AHA / DSW familiar with the client?	
Is the AHA/ DSW familiar with the task?	
What task-specific training has the AHA/DSW undertaken to be deemed competent?	

**Is the AHA/ DSW competent to perform the task?** .....

**AEP Signature & date:** .....

## APPENDIX 3: TASK DELEGATION AGREEMENT FORM EXAMPLE

Client name	
Client background	
Client goals	
Client treatment plan	
The task identified for handover	
Task details	
Reason for task delegation	
Potential risks identified	
Risk mitigation strategies	
Criteria for escalation (cease therapy, review client)	
Plan for escalation	
AHA name	
Task-specific training completed	
Supervision plan	
Recommended AEP review date	
AEP name, signature, and date	
AHA name, signature, and date	
Client name, signature, and date	

## APPENDIX 4: TASK ALLOCATION AGREEMENT FORM

Client name	
Client background	
Client goals	
Client treatment plan	
The task identified for allocation	
Task details	
Reason for task allocation	
Potential risks identified	
Risk mitigation strategies	
Criteria for escalation	
(cease therapy, review client)	
Plan for escalation	
Task-specific training completed	
Recommended AEP review date	
AEP name, signature, and date	
DSW name, signature, and date	
Line manager name, signature, and date	
Client name, signature, and date	

## APPENDIX 5: CHECKLIST FOR ACCEPTING TASKS

Adapted from VIC Govt. Supervision and delegation framework for allied health assistants and the support workforce in disability<sup>3</sup>.

Client name: .....

Assistant /DSW name: .....

Task description: .....

**Ask yourself the following questions before accepting a task that is delegated/allocated to you. This will help determine if you require training and will help you perform the task safely and correctly.**

SELF-ASSESSMENT CHECKLIST	YES/NO
Do you understand what you are required to do?	
Do you understand why you are completing the task?	
Do you have the skills to perform the task delegated to you?	
Is this task within the scope and job description of your role?	
Are you confident in performing the task?	
Are you aware of how the client will respond while performing the task?	
Do you feel comfortable with the client's safety if you were to perform the task?	
Do you have the right resources to complete the task?	

- » If you answer **NO** to any of these questions, **do NOT** accept the task. Discuss your concerns with the allied health professional and/or your line manager.
- » You might need to discuss your concerns with your client to explain why you cannot complete a task they have requested.
- » It is appropriate to seek training to ensure you can support clients safely and effectively.

Assistant/DSW signature and date: .....

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