

Support Workers in Community Rehabilitation

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research
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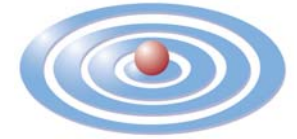


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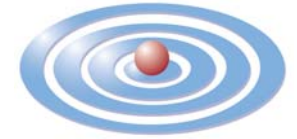
Background

- Centre for Allied Health Evidence in conjunction with Queensland Health conducted a systematic literature review on the use of support workers
- Inform the Queensland Health Community Rehabilitation Workforce Project



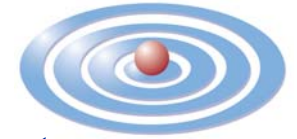
Background

- Increasing demand on healthcare
 - Ageing population
 - Evolving models of health care service delivery
 - Increasing stakeholder expectations
- New models of allied health education
 - Generic health care worker
- Chronic shortage of allied health professionals
- Support workers introduced to address these issues
 - Bridging the gap
 - Widening entry into health workforce



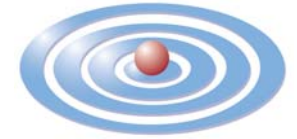
Introduction of support workers

- Origins in Crimean War 1854-1856
- Florence Nightingale acknowledged the value of nurses assistants
- Nursing auxiliary given formal recognition in 1955 (cheap labour!)
- HCA introduced in the 1980s to work under direct supervision of nurses



Ambiguity about support workers

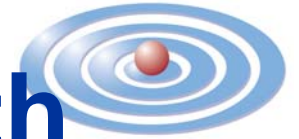
- Who are they and what they do?
 - Titles/roles/responsibilities vary depending on service & setting
- Ambiguity introduces variability
 - Training
 - Regulation



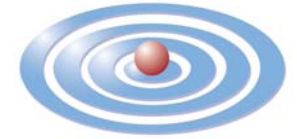
Support workers

- aka:
 - rehabilitation assistants/support workers
 - health care assistants/support workers
 - community rehabilitation team therapists
 - community health worker
 - A and B-grade nurses
 - nurse aide
 - care practitioners
 - care assistants
 - *therapy assistants (i.e. allied health)*
 - technical instructors
 - multidisciplinary health care workers
 - Aboriginal health workers

Support workers in health care



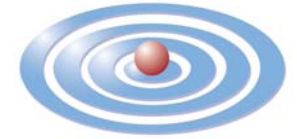
- No professional qualifications
- Varied training, mainly on-the-job
- Work delegated & supervised by qualified staff
- Support qualified staff to free up their time to perform clinical tasks
- Direct patient roles i.e. hygiene, nutrition
- Indirect patient roles i.e. housekeeping, maintaining stock, clerical duties



Issues

- Training requirements/standardisation
- Competency
- Supervision
- Regulation
- Clear role definition
- Career progression
- Role boundaries/‘turf wars’





Aim

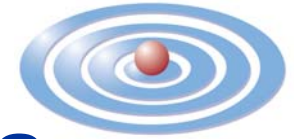
To systematically identify and review literature on utilisation of community based rehabilitation support workers

- allied health and nursing
- government and non-government
- rural and remote
- indigenous settings

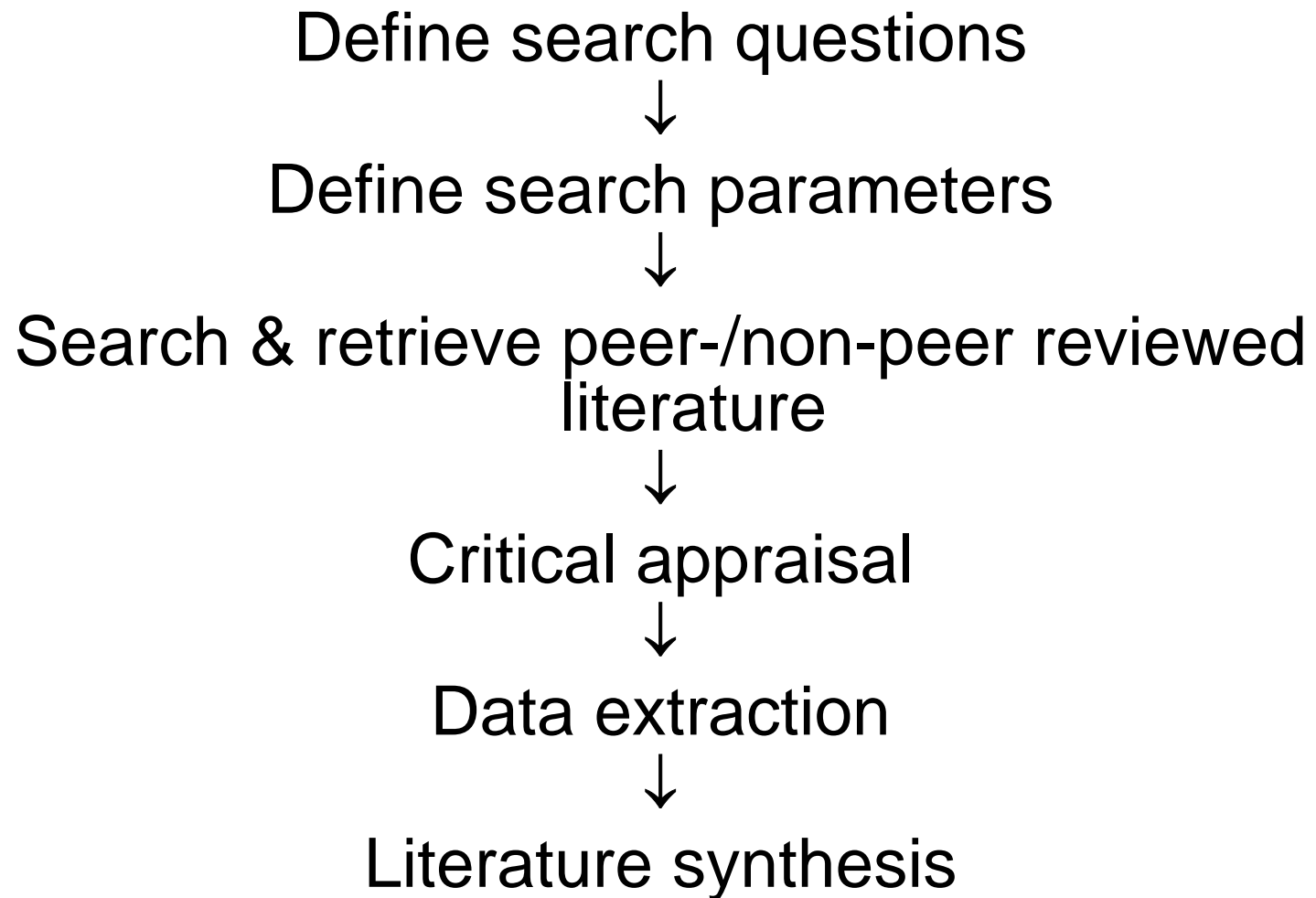


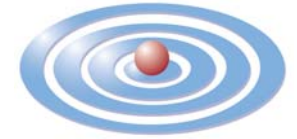
Research Questions

- What are the current & emerging roles of support workers?
- What models of service delivery are associated with these roles?
- What outcomes have been investigated?
- Is there evidence of effectiveness of roles/models?
- What competencies are required?
- What training is required?
- What training model is most effective?



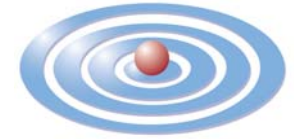
Systematic Review process





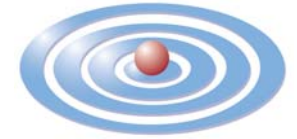
Results

- 84 publications included in the review
- Primary & secondary research
- Qualitative & quantitative
- Majority from the UK (N=51)
 - Issues of generalisability
- Majority related to nursing (N=41)
 - Issues of applicability to allied health



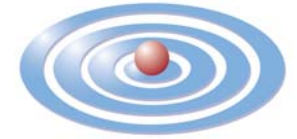
Direct roles

- Physical/social support of patient
- Administer clinical services/modalities
- Communication with patients
- Transfer/porter patients
- Assist with mobility/gait
- Patient education
- Provide equipment
- Supervise/assist exercises



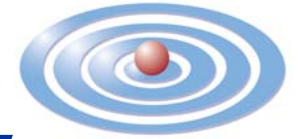
Direct roles

- Conflicting evidence regarding these roles
 - Interpret/plan/modify treatment
 - Assess/prescribe
 - Administer clinical services/modalities
- Potential emerging roles for support workers
 - Underpinned by appropriate training and regulation



Indirect roles

- Administration/clerical
- Stock ordering/requisition
- Prepare/maintain environment
- Communication with other staff
- Recording/statistics
- Answer phone
- Taking/preparing samples
- OH&S



Models of service delivery

- Delegation & supervision most common factors
- Worked independently less commonly (i.e. rural & remote)
- Multi-D or discipline specific
- Contributed to decision making process & process of care infrequently



What outcomes have been investigated?

Patient

Provider

Funder/
Manager

Service quality

Knowledge

Cost efficiency

Satisfaction

Skills

Service quality

Health

Attitudes

Staff

improvement

Competencies

recruitment/

ADLs

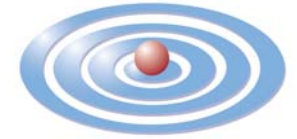
Efficiency

retention

Function

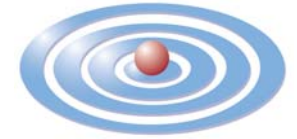
Job

satisfaction



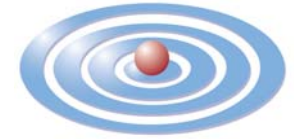
Evidence of effectiveness

- Patients seem to be happy!
 - More contact time
 - Pastoral care
- Improved health, ADLs/function and communication
 - Variably measured
- Improved time/resource/cost efficiency
 - Especially from a provider perspective
- Improved staff recruitment/retention/job satisfaction
 - Especially from a provider perspective
- Safety?
 - Poorly measured or reported



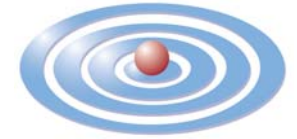
Competencies

- Generic
 - teamwork, OHS, communication, administration
- Specific to AH
 - assist/support/promote rehabilitation & client function, conduct classes, patient education, assessment, recording/ reporting



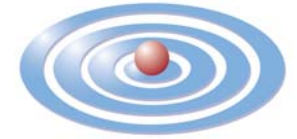
Training

- Common components
 - OHS, care skills/principles, communication, professional issues, manual handling
- Variable models dependent on local service needs
- Theoretical + practical
- Service quality, safety
- Supervisor training



Conclusion

1. Support workers potentially valuable
2. Clear role definition
3. Mix of indirect & direct roles
4. Appropriate delegation & supervision
5. Supervision models developed locally
6. Supervisor training
7. Documented accountability
8. Measure outcomes
9. Training to promote core competencies
10. Support the support workers



Final report

http://www.health.qld.gov.au/qhcrwp/docs/qh_final_report.pdf

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