Role Descriptors For Healthcare Professionals

The purpose of this document is to support and facilitate collaboration among families and healthcare providers, wrapping around the needs of the children in their care. Families and clinicians across Alberta have identified a **lack of role clarity as one of the largest barriers to quality care for children with a feeding or swallowing disorder.**

Eating, feeding, and swallowing (EFS) is an area of practice requiring a wide-range of skills and advanced training. As well, team composition and roles differ across the province depending on the team structure, client needs, discipline availability, and individual competencies. The result is variance in care for families and there is a need for greater role clarity to facilitate a collaborative, interprofessional approach.

Role Clarity is one of six required interprofessional collaborative competencies that must be integrated in all aspects of professional practice: patient and family centred care, role clarification, team functioning, collaborative leadership, communication & conflict resolution (CIHC 2010, AHS 2016). The Rehabilitation Conceptual Framework also guides providers in conceptualizing, designing and delivering rehabilitation services (AHS 2018).

CONT. →

"Roles are not clearly defined or communicated. Families wonder 'Who do I ask this question of? Who is responsible for each piece?"

– Parent

"Families are frustrated and receive different messages."

– Parent

"No one owns this in the health system. We need role clarity and education for service providers."

– Healthcare Provider

"We have silos within silos - even at the same location."

– Healthcare Provider

If operational leaders don't have knowledge of the discipline role and skills, they lack support and have unrealistic expectations placed on them."

– Healthcare Provider

Together with families, clinicians, AHS Health Professions Strategy & Practice (HPSP), AHS Co-ACT, and professional colleges, the PEAS Project has developed this guide for healthcare providers to:

- provide EFS clinicians with an **adaptable tool** to use as a way of highlighting, communicating, and clarifying overlaps and gaps within each individual team
- promote **interprofessional care**[1] by bringing together the unique perspectives of varied disciplines regardless of whether people work in co-located teams or are geographically spread out
- focus care team members on their **collective team competence** to address child and family centered goals for EFS
- provide a tool to **identify and cover gaps** in service (e.g. referrals or consultation with other care teams, training, recruitment, etc.)

1 Note: "A team-based or multidisciplinary approach to feeding and swallowing assessment in children is consistently recommended because of the complexity of dysphagia and to ensure care is coordinated appropriately." (CADTH, 2017, p. 20)

Where do we begin?

It is important to first acknowledge the value of the family as an integral part of the care team. EFS can be a highly emotional area for families whose children struggle with eating given its functional, nurturing, and cultural significance in our society. In addition, distinctions across the roles of various healthcare providers are often complex and context dependent. Each discipline brings a unique perspective and, though the tasks completed may be the same or very similar, the child and family benefit from the integration of these perspectives, especially in an area like EFS that involves so many different professionals in a variety of care settings.

To facilitate interpretation of this guide, please review the agreed upon principles of collaborative practice, overlapping scopes of practice supported by the Health Professions Act (HPA) and recognition of unique skills and perspectives in EFS intervention. The child and family are the focus of our collaborative efforts in light of the complexities mentioned.

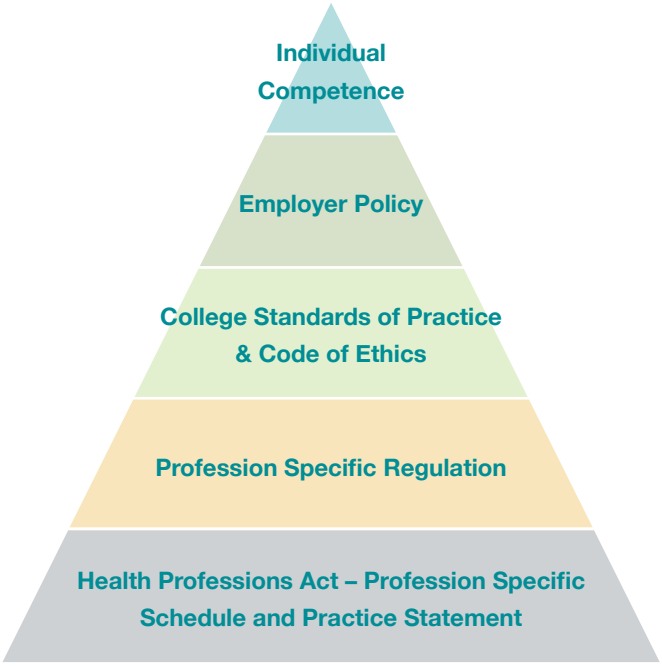

FIGURE 1: SCOPE OF PRACTICE

Scope of Practice

Scope of practice (Figure 1) is broadly defined for each profession within the profession-specific schedule of the Alberta HPA. The HPA contains a "practice statement" for the profession and is further defined by the restricted activities that each profession is authorized to perform. The HPA requires all regulated health professional colleges to set educational and practice standards for registered members. Scope of practice is further guided by the standards of practice, code of ethics and other guiding documents from the College outlining the expectations for delivery of professional services, including the performance of restricted activities. Employers may enable or limit professional scope of practice through employer policy or other practice support documents.

Professional regulation also requires that individual practitioners recognize when patient or client care requirements exceed their own level of competence. When this occurs, there is an obligation to consult with or refer the patient to other professionals whose expertise will better meet patient care needs. This is a key component of patient centered care that demands interprofessional collaboration. Accordingly, the standards of practice for regulated professions typically contain

statements obligating regulated members of the profession to practice collaboratively with others on the team (including unregulated providers) and in the patient's best interest. One purpose of the HPA is to allow for non-exclusive or overlapping scopes of practice. It guides our recognition that no profession has exclusive purview over a specific skill or activity and different professions may provide the same health services.

Regulating authorities may further define scope of practice through approval of competency profiles, which serve as the basis for curriculum taught in educational programs. Credentialing exams based on the competency profile are then used to validate knowledge and competency to practice the regulated profession. Not all professions have competency profiles, however many do.

Overlap

Some aspects of EFS practice are shared based on competency and the boundaries of scope of practice. "Many roles will overlap between disciplines; the identification of who is best positioned to care for a specific patient or perform a specific role is a combination of role, competency and context. A truly collaborative team, understanding the roles of each profession and the individual strengths of each team member will ensure that the right care is provided by the right provider at the right time" (AHS, 2015). In a joint presentation from the Alberta College of Occupational Therapists (ACOT) and Alberta College Of Speech-Language Pathologists & Audiologists (ACSLPA) to the PEAS Roles & Implementation Working Group on June 6, 2019, the co-presenters shared the following affirmations related to overlapping roles:

> *"The HPA and the Profession Regulations lay out the practice statement. The intent was not to have exclusive scopes of practice or practice statements, so* ***there is a lot of overlap between professions*** *within Alberta and that overlap extends far beyond feeding and swallowing."*
> *– Sandy Nickel, Director of Professional Practice, ACSLPA*

> *"When it comes to feeding and swallowing or any activity really, it depends on the individual competencies, which will vary. If more than one person is competent to do the same activity then a* ***discussion around this needs to occur in the spirit of collaborative practice****."*
> *– Marianne Baird, Registrar, ACOT*

Overview of Roles in EFS

While some EFS practices and activities are shared across roles, each discipline contributes a unique perspective and skill set that is necessary to optimize outcomes for the child and family. Team competence and a collaborative approach to care are critical. Roles within an individual team are defined by the needs of the child and family, context, skills and experience of individual team members. Variability in practice depends on team composition and levels of advanced knowledge. Each discipline approaches this work with a different lens. When the disciplines come together, around the needs of the child and family, we achieve excellent quality care.

The following diagram (Figure 2) shows the core team members often involved in EFS, with the child and family in the center of the care plan and process. Please note that additional team members important to the overall care of a child and family will become involved as needed.

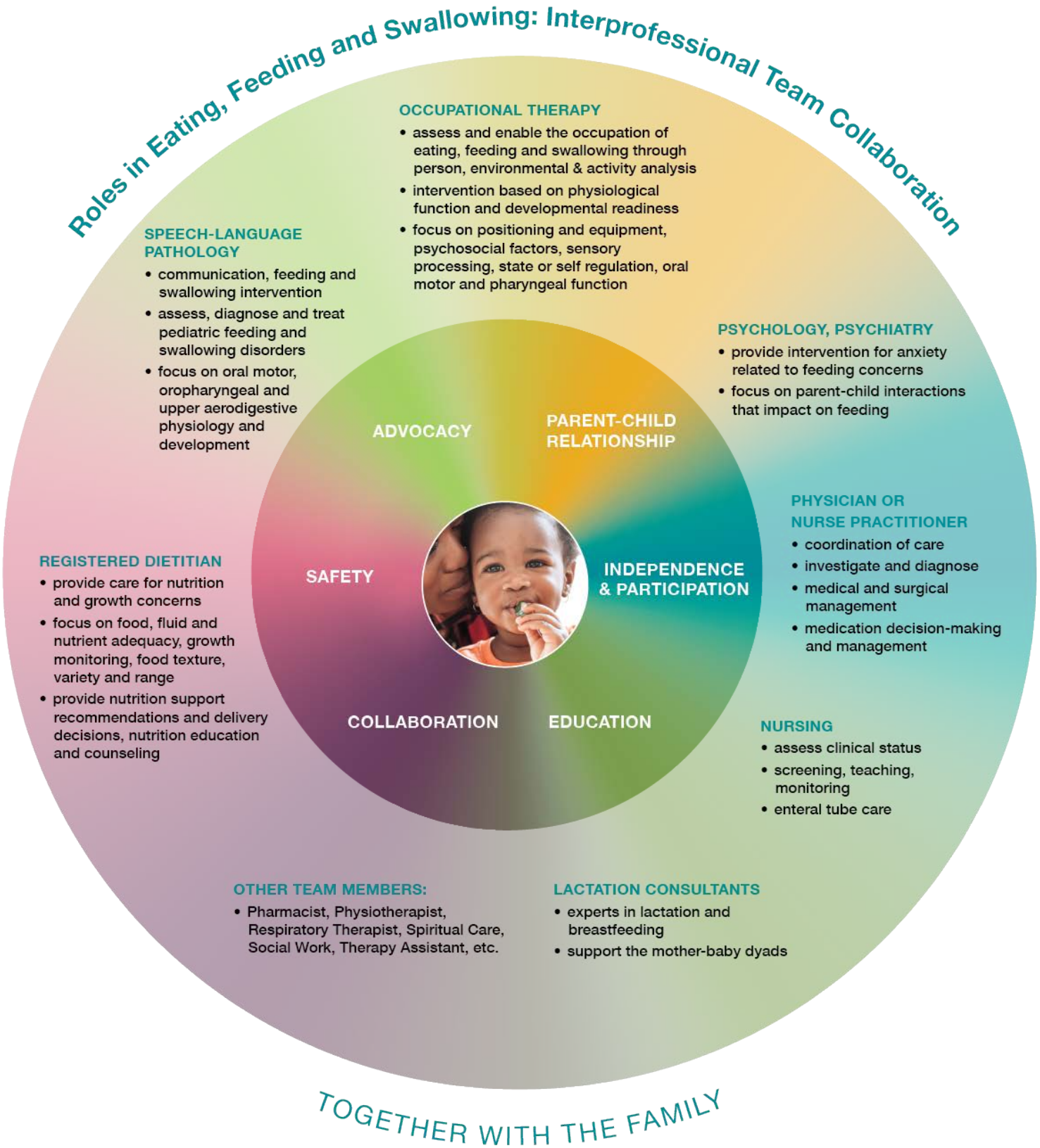
Roles in Eating, Feeding and Swallowing: Interprofessional Team Collaboration
OCCUPATIONAL THERAPY
• assess and enable the occupation of eating, feeding and swallowing through person, environmental & activity analysis
• intervention based on physiological function and developmental readiness
• focus on positioning and equipment, psychosocial factors, sensory processing, state or self regulation, oral motor and pharyngeal function
SPEECH-LANGUAGE PATHOLOGY
• communication, feeding and swallowing intervention
• assess, diagnose and treat pediatric feeding and swallowing disorders
• focus on oral motor, oropharyngeal and upper aerodigestive physiology and development
PSYCHOLOGY, PSYCHIATRY
• provide intervention for anxiety related to feeding concerns
• focus on parent-child interactions that impact on feeding
ADVOCACY
PARENT-CHILD RELATIONSHIP
SAFETY
INDEPENDENCE & PARTICIPATION
COLLABORATION
EDUCATION
PHYSICIAN OR NURSE PRACTITIONER
• coordination of care
• investigate and diagnose
• medical and surgical management
• medication decision-making and management
REGISTERED DIETITIAN
• provide care for nutrition and growth concerns
• focus on food, fluid and nutrient adequacy, growth monitoring, food texture, variety and range
• provide nutrition support recommendations and delivery decisions, nutrition education and counseling
NURSING
• assess clinical status
• screening, teaching, monitoring
• enteral tube care
OTHER TEAM MEMBERS:
• Pharmacist, Physiotherapist, Respiratory Therapist, Spiritual Care, Social Work, Therapy Assistant, etc.
LACTATION CONSULTANTS
• experts in lactation and breastfeeding
• support the mother-baby dyads
TOGETHER WITH THE FAMILY

FIGURE 2

PEAS Tasks within Full Scope

With this overview in mind, local teams can use the more detailed PEAS Tasks within Full Scope Chart that follows to facilitate greater role clarity at the local level. A literature review conducted by AHS HPSP had the following guidance for healthcare professionals as they engage in conversations with one another regarding roles:

> *"The use of validated tools and resources to foster role clarity is recommended. Some face-to-face facilitation may be required as the concept of role clarity is complex and needs to be introduced in a consistent and non-threatening way. Building capacity for role clarity facilitation at the **local level** is also recommended to ensure **developing comfort with role overlap** and ongoing role clarity education specific to the operational area. A **detailed description of each profession** involved in the provision of health services is required as a reference. Each description must include reference to the specific regulation and standards of practice for that profession. Efforts to understand the role and spectrum of expertise of each team member is essential to ensuring the delivery of collaborative patient focused care" (AHS 2015).*

The following PEAS Tasks within Full Scope Chart outlining full scope of practice for the professions, is not meant to be prescriptive, but rather it is to be adapted and used to help facilitate these important conversations about role clarity within various EFS teams. Checkmarks (✓) indicate clinical activities that are within the **maximum scope** of a given discipline based on college regulation and do **not** imply that an individual staff member will have these particular skills. Rather, team member roles will vary depending on job description and individual competence. Working through the Chart will ideally enable and support all clinicians to fully contribute to team competence and to work together in addressing the needs of each child and clinical context.

DISCLAIMER: Recognizing that scope of practice is approved by college regulation in **no way** removes the responsibility of the employer or individual to ensure individual competence and adequate training and competency.

Steps

Note: Before working on the chart, it is recommended that teams complete a **Team Charter** (see Team Charter Primer) to establish collective team goals and a collaborative, child and family centred approach.

1. **Download the PEAS Tasks within Full Scope chart here:**

   click to view and download the chart

2. **Hide or Add columns of the chart depending on your team's composition** (e.g.: perhaps your team does not have access to a Social Worker)

3. **Consider the skills required to serve your client population.** The skill requirements may vary based on your context (e.g., Community Rehabilitation versus Acute inpatient services)

4. **Team members remove or adjust checkmarks (✓) within their discipline's column** depending on their role and areas of individual competence. This can be done independently, in discipline groups, or collectively so long as all of the columns are eventually assembled into one team chart. Also consider access to virtual team members as appropriate to your setting. If there are any discrepancies needing further input or clarification, please contact your local team Discipline or Clinical Lead, and, or AHS HPSP Discipline Lead.

(Tip: hovering over a cell with a red triangle in the corner will pop-up additional information. The PEAS Clinical Practice Guide also provides greater detail and guidance for most EFS intervention).

5. **Meet together as a team to:**

   i. **Discuss areas of overlap.** Talk about surprises, concerns, and questions, as well as the unique perspective and skills that team members bring. Use your Team Charter principles and focus the team on developing safe processes and optimal care plans from a child or family perspective while also considering local factors such as your specific population, available resources, etc.

   ii. **Discuss gaps in service** and recommendations for how to cover these areas (e.g.: referrals or consultation with other care teams or professionals, training, recruitment, etc). Identify who is responsible for exploring and, or acting on these recommendations.

iii. **Adjust the chart to reflect how your team has determined it will function.**

6. **Try it out** with a commitment to solicit feedback in a few months. Remember to also ask families for their input. What is their perspective, goals, and how do they want to be involved in their care as a contributing team member?

7. **Regularly revisit your chart** to orient new team members and to adjust it as needed.

(Suggestion: update this chart yearly. Possibly set an annual reminder to update the document and facilitate discussions about professional development and mentorship opportunities).

Case Studies

Aerodigestive Clinic

The AHS Aerodigestive Clinic in Edmonton sees children with complex feeding and swallowing disorders. The clinic includes an SLP and physician specialists who see a child or family together as a team, as well as independently during a single clinic visit. While there were initial growing pains and even resistance among team members, there was a willingness to try out this integrated model of care. After seeing the results of their collaborative team efforts to create one plan for the child or family, they have become champions of this integrated model of care since starting the clinic in 2012. Their evolution as a team has allowed families to see all of the disciplines needed in their child's complex care, appreciating the uniqueness of each team member's role, while having **one** integrated, safe, collaborative care plan for their child.

As a result, the family is not left to determine how to integrate the various recommendations of siloed disciplines, which would be considered the least safe approach for their child's healthcare needs.

> *"It was kind of a frustrating situation because every time [our child] would get a cold, we would end up in hospital for 2-3-4 days as well as have daily symptoms. We had done some sleep studies and had been seen through Respirology, but they were all separate appointments. When we got into the Aerodigestive Clinic it was amazing because we just got to see everyone together and they got to see us one-on-one where they would just talk to us about symptoms that related to their specialty and then they all met that morning as a group and made a plan."*
>
> *- Parent*

Medicine Hat Regional Hospital (MHRH)

"The Medicine Hat Regional Hospital Eating, Feeding and Swallowing discipline managers and staff came together in 2013 due to staff concerns expressed related to confusion about scope of practice while delivering EFS services. The process to meet and build consensus on how our disciplines function at this site took time, as this was uncharted territory. It was important to the staff and managers that we had better clarity on roles based on past confusion. We looked at the sustainability of this service when providers moved from unit to unit or were taking on different positions. Every time we review a team's functioning on various units or sites, we often look at roles first. This then allows for respect for the various roles. This work can be complicated and touchy, but it depends on each team's composition. We all needed to review our scope of practice and then look at overlaps to determine what we were comfortable doing as a team. We learned so much together. There were aspects of service we discovered to better serve the family (e.g., education services). Wayfinding was improved, as we all had a better understanding of where to transition a child/family (acute services, community services, outpatient services, public health, allied health, etc).

We wanted to discover who was the most appropriate person to do this task, on our particular team, for the safety of the infant or child. Each team documented their decisions on a chart for transparency and clarity. It built our understanding of when to involve another discipline, pending the roles decision. After reaching consensus on discipline functions at MHRH, team members and managers expressed greater satisfaction with their delivery of service to infants/children/families. We continue to review and update our role charts on a regular basis as the team changes over time and new questions arise."
– MHRH Staff

References

Canadian Interprofessional Health Collaborative. (2010) A National Interprofessional Competency Framework. Retrieved from: http://www.cihc-cpis.com/publications1.html

Alberta Health Services. (2016) Collaborative Practice Principles Supporting Patient and Family Centred Care. Retrieved from: https://insite.albertahealthservices.ca/Main/assets/tms/hpsp/tms-hpsp-collaborativer-practice-principles-supporting-patient-family-cc.pdf#search=collaborative%20competencies

Alberta Health Services. (2018) Rehabilitation Conceptual Framework. Retrieved from https://insite.albertahealthservices.ca/Main/assets/tms/prs/tms-prs-prov-rehab-conceptual-framework.pdf#search=rehab%20conceptual%20framework

Alberta Health Services. (2015) Role Clarity in Interprofessional Collaborative Teams: A Review of the Literature. Health Professions Strategy & Practice. Retrieved from: https://insite.albertahealthservices.ca/main/assets/tms/hpsp/tms-hpsp-role-clarity-lit-review.pdf.

CADTH. (2017) Feeding and swallowing assessment services for pediatric populations in Canada: Service provision, practice models, and assessment tools. Environmental Scan; no.61. Retrieved from https://www.cadth.ca/sites/default/files/pdf/ES0306_Feeding_Swallowing_Assessment%20Services.pdf.