SA Health

Allied Health Assistant Framework

September 2025

Allied and Scientific Health Office

Government of South Australia
SA Health

Contents

Acknowledgements

Statement of acknowledgement

We acknowledge and respect Aboriginal peoples as the state's first peoples and nations and recognise Aboriginal peoples as Traditional Owners and occupants of land and waters in South Australia. We pay our respects to Elders past, present and emerging.

The term ‘Aboriginal’ is used throughout this document as inclusive of people who identify as First Nations, Aboriginal, and/or Torres Strait Islander peoples.

Acknowledgement of Framework contributors

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Further, ASHO would like to acknowledge the generous contributions made by local health network members of the Allied Health Assistant Framework Development Virtual Advisory Group who provided early feedback and advice on framework content and concepts, and SA Health allied health staff more broadly who participated in the consultation and feedback process.

This Framework is adapted from a range of allied health assistant frameworks and resources, including but not limited to:

- Allied Health Assistant Framework (2020), NSW Government
- Allied Health Assistant Framework (2022) Office of the Chief Allied Health Officer, Clinical Excellence Queensland
- Allied Health Assistant NT Health Framework (*draft* 2024)
- Allied Health Assistants Policy, WA Country Health Service, Government of Western Australia (2025)
- Country Health SA Local Health Network Allied Health Assistant Framework (2018)
- Delegation Framework – Allied Health (2022), Office of the Chief Allied Health Officer, Clinical Excellence Queensland
- Supervision and Delegation Framework for Allied Health Assistants (2023), Victorian Government Department of Health
- Supporting and Developing the Allied Health Assistant Workforce (2015), Government of Western Australia
- Victorian Allied Health Assistant Workforce Recommendations (2023), Victorian Government Department of Health

A range of existing SA Health local health network based allied health assistant resources were also considered, including existing allied health assistant focused procedures, frameworks, clinical task instructions, and training/education modules. This content was highly valuable in supporting the overall direction and refinement of Framework development.

Definitions

Allied health assistant (AHA): A healthcare employee who carries out consumer-centred tasks delegated and supervised by an AHP, consistent with the AHA's demonstrated capability and competencies.

AHA capability: The aggregate skills, knowledge and abilities of an individual AHA to practice safely and effectively.

Allied health professional (AHP): A university-qualified healthcare professional who is not part of medical, dental or nursing professions. These professionals possess specialised expertise in preventing, diagnosing and treating a range of conditions and illnesses[1].

Applying a cultural lens: Within professional supervision, the process of explicitly considering and working towards the development of cultural awareness, capability and responsiveness in working with diverse groups.

Applying an Aboriginal cultural lens: A focused approach within the broader concept of the cultural lens, where cultural capability and responsiveness in working with Aboriginal people is specifically considered and developed, in recognition of the unique sovereignty, histories, and cultural realities of Aboriginal peoples.

Clinical governance: A systematic approach to maintaining, improving and safeguarding the quality of consumer care within a health system.

Clinical Task Instruction (CTI): A document that describes the background, best practice process, and competency assessment for AHA performance of a delegated direct clinical task. Some professional groups may use other terms for this document (e.g. entrustable professional activity in pharmacy).

Competency: Assessed capacity to apply the required knowledge, skills and abilities to successfully perform a task.

Cultural safety: Creating environments that are safe and welcoming for Aboriginal people, where cultural differences are acknowledged, respected and supported.[2] Cultural safety requires all people to undertake an ongoing process of self-reflection and cultural self-awareness and an acknowledgement of how these impact on interactions with others and service delivery.[3]

Delegation: A six-step process by which an AHP allocates a direct clinical task to an AHA who has demonstrated the competency required to perform the task.

Direct clinical task: Direct clinical interaction with a consumer (in-person or via telehealth), delegated by an AHP to an AHA and supported by a Clinical Task Instruction and Competency Assessment process.

Indirect tasks: Administrative, operational, and other non-consumer facing clinical tasks undertaken by an AHA in supporting care and consumer outcomes; assigned to an AHA and supported by training, workplace instructions, procedures or protocols.

Performance Review and Development (PRD): A formal, collaborative process between a supervisor and staff member to plan, develop and evaluate the staff member's work. The goal of the PRD is to improve individual performance, support career development and ensure the delivery of high-quality health services. Services may use different terms for this (e.g. development discussion).

Professional supervision: A formal, regular and structured opportunity centred around reflective practice, that supports and facilitates AHAs' personal and professional development within and beyond a clinical context.

Scope: The roles, functions, responsibilities, activities and decision-making capacity authorised to be undertaken in a position. An individual AHA's scope must align with the tasks and duties required of the position by the service, and the AHA's distinct capability to perform tasks safely and competently.

Service manager: Provides organisational oversight for clinical governance, team performance and quality service outcomes. In this framework, the term service manager encompasses a variety of position names used across SA Health, and will require interpretation by LHNs to align with local governance structures.

Task monitoring: The process by which an AHP provides clinical oversight of an AHA undertaking a task.

Abbreviations

ASHO Allied and Scientific Health Office

AHA Allied Health Assistant

AHP Allied Health Professional

CTI Clinical Task Instruction

LHN Local Health Network

PRD Performance Review and Development

Introduction

Allied Health Assistants (AHAs)
An AHA is a healthcare employee who carries out consumer-centred tasks delegated and supervised by an AHP, consistent with the AHA's demonstrated competencies. AHAs may work within a single, multi-disciplinary or inter-disciplinary capacity, depending on service models and consumer need. AHA tasks typically involve a mix of direct clinical and indirect duties, together with AHPs delivering high quality allied health care to consumers.

Allied health professionals (AHPs) represent more than one third of the Australian health workforce. The workforce is growing rapidly as demand grows across the aged care, mental health, disability and other health sectors.[1]

SA Health recognises the benefit that an appropriately skilled and supported AHA workforce can bring to delivery of effective, responsive, consumer centred allied health services across a range of professions, clinical settings and sectors.

Effective utilisation of AHAs can benefit consumers by:
- Increasing access to timely and effective care, especially in community and rural/remote settings
- Improving consumer satisfaction by providing more individualised care and assistance
- Enhancing clinical outcomes through higher frequency and/or additional therapy and services

Effective inclusion of AHAs within services can benefit AHPs by:
- Increasing time and capacity for delivery of high complexity clinical tasks through delegation of less complex clinical tasks
- Increasing leadership and teaching opportunities whereby AHPs can teach, supervise and mentor AHAs
- Reducing time spent on administrative, operational and other non-consumer facing clinical tasks able to be assigned to AHAs

AHAs bring significant benefits to SA Health local health networks (LHNs) through:
- Collaboration and diversity, whereby AHAs bring different perspectives and experiences to teams
- Enhanced capacity, whereby AHAs assist to meet increasing service demands, and deliver new and innovative models of care
- Increased efficiencies whereby each team member's skills are used to better meet consumer needs.

Improved AHA workforce structures also provide greater support and opportunities for employment of Aboriginal people and diverse groups in allied health, both in AHA careers and as a pathway into allied health profession training and employment. Improved representation of Aboriginal people in the health workforce is a key strategy in improving the health outcomes of Aboriginal people and communities.[2] [4] Offering employment pathways for people from diverse backgrounds also supports the development of a workforce reflective of the South Australian community, in alignment with the Department of Health and Wellbeing's Diversity, Equity and Inclusion Strategy 2024-2026.[5]

The SA Health Workforce Strategic Directions 2022 recognises current critical allied health shortages, and promotes a focus on supporting AHPs to work at the top of their scope and implementing innovative models of care that support resource efficient, agile and responsive workforce practices.[6] AHA supported service delivery models are a key strategy in supporting these outcomes. Similarly, the SA Rural Allied and Scientific Health Workforce Plan 2021–26 identifies reviewing and embedding an SA Health Allied Health Assistant Framework as a key action to achieve the objective of developing attractive rural and remote allied and scientific health positions in regional South Australia.[7]

As SA Health continues to develop of AHA workforce models and structures, it is expected that further opportunities will emerge to expand the effective utilisation of AHAs.

Purpose

The SA Health Allied Health Assistant Framework has been developed to guide managers, clinical seniors, allied health staff and other relevant health professionals in the safe and effective employment and integration of the AHA workforce across LHNs.

The Framework aims to clearly define the roles and responsibilities of AHAs and AHPs in supporting AHA service delivery in SA Health. It guides how AHPs can effectively develop, assess, supervise and support AHAs, and appropriately delegate or assign direct clinical and indirect tasks. The Framework has potential to facilitate further expansion of the AHA workforce to support the efficient and timely delivery of allied health services.

A clear understanding of the AHA role, and recognition of the contribution they can make to consumer care and the organisation, can lead to improved consumer outcomes, innovative and efficient service development and increased job satisfaction for the AHA.

The Framework can be used by LHNs to:

- provide a structure that supports safe AHA practice, ensuring provision of high-quality healthcare that meets the needs of SA Health specific contexts
- assist AHAs, AHPs and service managers to better understand roles and scope of practice of the AHA workforce
- recognise and meet the training and development needs of AHAs, ensuring they are supported to undertake their roles
- support increased capability and value of the existing AHA workforce
- define AHA competency development and assessment processes and pathways
- support the inclusion of AHA positions within the development of allied health models of care and service design
- enhance awareness of AHP managers, clinical seniors and AHPs regarding their roles and responsibilities in AHA service models
- support AHPs to supervise and delegate safely and effectively to the AHA workforce
- inform a consistent approach in the development of new AHA positions.

Further guidance on service considerations when establishing/expanding AHA positions, or reviewing existing AHA positions, is provided in Appendix 1 and Appendix 2.

This Framework specifically relates to AHA-classified positions (as described in the Allied Health Professionals, Assistants and Psychologists Enterprise Agreement 2025[8]) that provide services within SA Health under the delegation and supervision of an AHP. This includes AHAs directly employed by an LHN, and those who may be sub-contracted by an access appointed AHP who provides services in an SA Health site. It does not extend to other support workers or ancillary employees employed outside of the AHA classification, however there is scope for key principles from this Framework to be utilised for these positions as deemed appropriate by LHNs.

The Framework is intended to be used as a guide to flexibly meet the needs of the broad variety of services and settings within SA Health. It should be used in conjunction with:

- 'Understanding the SA Health Allied Health Assistant Framework' online training course on iLearn
- Clinical Task Instruction (CTI) template (Attachment 1)
- Essential Competency Instruction and Assessments (Attachments 2, 3 and 4)
- Resources listed through this document

Where SA Health AHAs are providing services within externally funded programs (e.g. National Disability Insurance Scheme, Aged Care sector), associated program standards and requirements in addition to those outlined in this Framework must also be met.

AHA qualification requirement

AHA education pathways are strongly linked to qualifications and experience. The Allied Health Professionals, Assistants and Psychologists Enterprise Agreement 2025[8] describes the minimum qualifications required to employ AHAs across AHA position classification levels. Table 1 summaries the education and task/skill requirements across these levels.

Table 1: Summary of education and task/skill requirements across AHA classification levels[8]

AHA Classification	Education Requirements	Tasks and skills
AHA1*	No formal qualifications. May possess Certificate 1 or 2 in Allied Health.	> Undertake activities which require application of basic AHA practical skills and knowledge. Work routines are established with limited scope for interpretation. Works under close direction and clinical supervision of an AHP.
AHA2	Possess or be undertaking a Certificate III in AHA or equivalent	> Undertake the full range of AHA1 clinical support tasks. Work flexibly across a range of therapeutic and program related activities. Some scope for use of limited discretion in skill application and varied method by agreement with the AHP. May be required to assist AHA1 in their daily activities.
AHA3	Certificate IV in AHA or equivalent	> Undertake advanced AHA functions under direction of an AHP. May use discretion in the application of skills. High level communication and interpersonal skills. > May be required to assist in supervision of daily activities of AHA1 and AHA2 including allocation and monitoring of work, determining priorities and providing on the job training and mentoring.
AHA4	Certificate IV in AHA or equivalent	> Undertake a broad range of tasks that require specialisation and/or detailed knowledge or training. > May maintain items by ensuring their operations within established standards, design and develop specific equipment, and contribute to recording, consulting and preparing reports. > May provide supervision, coordination and leadership of a small team at a health site. > With support from AHPs, may undertake training of less experienced AHAs.

***** Level 1 AHAs will automatically progress from AHA1 to AHA2 within 6 months of appointment (unless subject to a performance management plan) or on successful completion of Certificate in AHA, whichever is sooner.

Some AHAs have qualifications and experience other than a Certificate in Allied Health Assistance. The following guidance supports matching an appropriate AHA classification to an applicant or employee's qualifications and experience:

- ASHO provides guidance on assessing an individual's AHA qualification equivalency, detailing endorsed alternative Certificate III and Certificate IV qualifications and providing direction on assessing other qualifications and relevant prior workplace experience.[9]
- Undergraduate students undertaking the 2nd, 3rd or 4th years of an allied health profession degree are also eligible for equivalency to a Certificate III or Certificate IV in Allied Health Assistance, with the AHA classification to be determined by the LHN based on the position description and merit-based process undertaken for the position applied for.

- Some AHAs commenced working in SA Health prior the introduction of a minimum qualification requirement for AHAs in 2017. A grandparent clause was introduced to acknowledge their recency of practice and ability to continue employment with SA Health as an AHA.

Regardless of their qualifications or experience, an AHA must always work within the scope of the AHA position in which they are employed.

The above qualification pathways give way to two main cohorts of AHA employees:
- 'Career AHAs' with, or working towards, a certificate or equivalent qualification.
- Undergraduate AHPs working as AHAs until graduating with an allied health degree.

Service planning should consider the optimal mix of career and AHP student AHAs to support flexible, efficient service delivery.

Pillars underpinning successful AHA service models

Mutual respect
Central to AHA service models is the assertion that "*allied health assistants contribute significantly to the delivery of quality allied health services and will continue to emerge as an important part of the care landscape*".[10]

Mutual respect amongst all team members is key to the successful integration of AHAs into teams and services, where the contribution and experience of individuals is respected, valued and promoted. Mutual respect is a key factor in effective healthcare teams, supporting:
- collaborative work towards a shared team vision and goal(s)
- provision of high quality and safe consumer care
- capacity to openly communicate, particularly with respect to raising issues or concerns
- contribution to innovative service development.

Team culture and processes must ensure AHAs:
- are empowered to understand and describe their competence and learning needs
- can make valuable contributions into consumer care
- are supported to identify appropriate development opportunities to meet their individual learning needs
- participate in, or lead quality improvement initiatives, depending on classification and experience
- are represented at appropriate service and leadership meetings.

Communicating with consumers
It is best practice for consumers to be provided with information by the AHP about the involvement of an AHA in their care, including the role, scope and the nature of tasks the AHA will undertake with the consumer. Information should include the benefits of having an AHA involved in providing therapy (i.e. increased therapy dosage, increased access to services, reduction in geographical barriers, reduced wait times), and provide the opportunity for the consumer to share queries or concerns. An AHA should clearly identify themselves and their role when interacting with the consumer. This timely, open communication assists in building a positive therapeutic relationship between the consumer and the healthcare team.

Consumers may withhold their consent to receiving services from an AHA if they choose; if this is the case, the AHP should clearly explain any associated implications and/or risks of this decision (e.g. delayed, reduced or adapted services).

Orientation and induction
A timely, comprehensive and systematic orientation/induction must be completed to facilitate appropriate clinical governance from the beginning of an AHA's employment. As well as standard orientation to the LHN, this should include relevant information on:

- organisational policies, procedures and protocols
- AHPs employed within the team
- models of care and funding streams in which care is provided
- administrative requirements
- scope and boundaries of the AHA position
- AHP delegation process
- AHA professional supervision
- infrastructure requirements including cross-site orientation, vehicle use, safety (i.e. bushfire plans etc)
- reporting lines (line management, professional supervision, team structure)
- mandatory training requirements.

Orientation and induction may be supported by a checklist and timeline of what is to be covered, by whom and by when. It may be appropriate to draw on other team members (including AHPs and more experienced AHAs) to support the orientation process as required.

Both the service manager and professional supervisor responsible for a newly employed AHA should establish an understanding of their existing skills, knowledge, abilities and competencies at the commencement of their employment (as outlined in Section 3 AHA competency: training and assessment). This facilitates the matching of appropriate scope to the AHA, and an understanding of further development and support required.

Newly employed AHPs must also receive orientation to the utilisation of AHAs in the service, including a clear understanding of AHA position scope, AHP delegation processes and professional supervision arrangements. The ‘Understanding the SA Health Allied Health Assistant Framework’ online training course on iLearn is available to support AHA and AHP orientation.

Section 1: Clinical governance

Strong clinical governance supports delivery of health services which are safe, effective and constantly improving. SA Health services are accountable for ensuring compliance with relevant quality and safety standards (i.e. National Safety and Quality Health Service Standards, Aged Care Quality Standards and/or National Disability Insurance Scheme Practice Standards), in addition to workplace health and safety standards. The SA Health Clinical Governance Framework for Allied Health Professionals provides guidance regarding the minimum clinical governance requirements to assume delivery of safe, effective, high quality continuously improving health services.[11]

The governance of the AHA workforce is guided by the following key principles:

- service managers, AHPs, and AHAs have a clear understanding of their responsibilities and accountabilities in AHA training, development, delegation and supervision
- operational and professional responsibilities of AHA positions are clearly described in organisational structures and position descriptions.

Governance is further supported when the broader service has a clear understanding of AHA position requirements in relation to:

- service/operational management
- professional supervision
- task delegation and monitoring.

The Framework supports strong clinical governance by clearly delineating roles of management, supervision and delegation which:

- enables AHAs to safely and competently practice, supporting delivery of safe and effective clinical care
- recognises the need to meet the training and development required for AHAs to undertake their roles
- enhances the understanding of service managers and the allied health workforce regarding their roles and responsibilities.

Appropriate governance for AHA positions is supported through clear documentation of management, supervision and reporting relationships. In small teams, roles and responsibilities may be undertaken by the same staff member (e.g. service manager may also be the professional supervisor). In multidisciplinary AHA positions, task monitoring and clinical direction provided by AHPs must correspond with the discipline-specific components of the AHA position.

In instances where AHP staffing is reduced (e.g. position vacancies) and there is reduced capacity to provide management, supervision, delegation and task monitoring to AHAs, local contingencies to ensure AHA support, quality care delivery and clinical risk management are required. This may include but is not limited to:

- ceasing recruitment to new AHA positions until recruitment to AHP roles is achieved to ensure staffing availability for AHA orientation, onboarding and support
- ceasing the delegation of AHA tasks if appropriate allied health clinical governance and task monitoring cannot be provided

Accountabilities and responsibilities when working with AHAs

The concepts of accountability and responsibility of AHAs and AHPs are vital to supporting appropriate and safe AHA service provision. Accountability is defined as owning the result or outcome of the action. Responsibility is defined as completing the required task and/or following the rules or instructions.

Service managers, senior AHPs, workload supervisors (where present), professional supervisors, delegating AHPs and AHAs each have their own accountabilities and responsibilities, as outlined below. Broader health service accountabilities include ensuring compliance with quality and safety standards including consumer safety, clinical governance, workplace health and safety and health care equity. This includes adhering to any additional governance, delegation and supervision requirements relating to AHA service provision into disability and aged care sectors.

Table 2 outlines the roles, accountabilities & responsibilities required when working with AHAs.

Table 2: Roles, accountabilities and responsibilities in working with AHAs

Role	Accountabilities	Responsibilities
AHP Service Manager (May be an executive director, service director, program manager, profession manager)	Providing organisational oversight for clinical governance, team performance and quality service outcomes. Ensuring the AHA and AHP(s) receives the required training and supports to support safe and effective care within the defined AHA position scope.	> Service planning, resourcing, performance monitoring and reporting. > Workforce planning, performance and standards, human resources functions (recruitment, selection, reclassification, leave). > Oversight of model of care, including local AHA delegation model. > Provide day to day management of team. > Ensure compliance with externally funded program requirements (e.g. National Disability Insurance Scheme, Aged Care) where relevant. > Conduct (or appropriately delegate to line manager) regular performance review and development (PRD) for AHA as per SA Health policy. > Hold financial and line management delegation responsibilities for the team or service.
Senior AHP	Provide oversight of the AHA scope to ensure effective and safe clinical service delivery.	> Define tasks within scope to be completed by the AHA, with consideration of position-specific clinical governance and risk factors. > Provide clinical expertise to support clinical governance and guide development and monitoring of the AHA model of care. > Ensure AHA provided services are aligned to clinical best practice. > Support the AHA to engage in education and development opportunities, including access to and participation in professional supervision. > Support recruitment and selection of AHAs, and their orientation to the service.
Workload supervisor (Optional role, suited to multi-d teams where AHA receives delegated tasks from multiple AHPs. May be AHP, or an appropriately skilled AHA4)	Coordinating and overseeing appropriate AHA workload on a day-to-day basis.	> Work with AHA to ensure workload is appropriate and manageable. > Assist AHA to prioritise workload, particularly in multidisciplinary and interdisciplinary teams where delegated tasks may come from various professions > Liaise with delegating AHPs regarding AHA capacity.

Role	Accountabilities	Responsibilities
Professional supervisor (May be AHP, or an appropriately skilled AHA4)	Providing reflective practice supervision that supports AHA skill and competency development.	> Support supervision, mentoring and capability building. > Facilitate reflective practice supervision. > Contribute to the AHA's PRD. > Use organisational process to support supervision relationship i.e. supervision agreement, elective professional supervision elements.
Delegating AHP	Implementing and monitoring best practice AHA delegation processes.	> Deliver safe, effective clinical services through effective AHA delegation. > Have clarity regarding own role and delegation accountabilities. > Contribute to AHA training and development via feedback, guidance and mentoring. > Provide oversight of consumer management, including diagnosis, management and discharge plans within their scope of practice. > Only delegate tasks within own scope, and which they are competent to plan and implement. > Understand the individual scope of the AHA, and only delegate tasks within this scope. > Provide mode and frequency of task monitoring and clinical direction to support safe AHA care delivery. > Evaluate and integrate task outcomes into ongoing consumer program or intervention plans. > Provide feedback to AHA on performance to inform professional development planning and service-led skills development. > Develop and maintain own delegation competence, supported by completion of the 'Understanding the SA Health Allied Health Assistant Framework' online training course on iLearn, and supplemented by professional supervision, orientation/induction and other local resources. > Respect and reinforce delegation competence via modelling AHA practice boundaries.
AHA	Safely delivering consumer care aligned to AHP delegation instructions and defined individual scope. Provide information to delegating AHP to support clinical care planning and evaluation of delegation.	> Only accept delegated tasks within defined individual scope. > Apply clinical and operational guidelines and procedures. > Seek clarification, additional information and support from the delegating AHP or other practitioner as appropriate to support task quality and safety. > Comply with documentation requirements. > Provide feedback and/or outcome of task to delegating AHP as instructed. > Contribute to consumer care planning and coordination within scope. > Actively participate in own development, including PRD, education, training and professional supervision. > Undertake activities that support quality improvement and team operational performance (matched to AHA classification work level definitions). > Develop and maintain a clear understanding of own responsibilities in delegation, supported by completion of the 'Understanding the SA Health Allied Health Assistant Framework' online training course on iLearn and supplemented by professional supervision and other local resources.

Position descriptions

Position descriptions are a key governance element within an AHA service model. Accurate AHA position descriptions that outline the key skills, experience and responsibilities are essential in communicating to both AHA and AHP staff the key AHA position deliverables. AHA position descriptions should clearly outline reporting lines relating to operational management, professional supervision and task delegation and monitoring.

SA Health position descriptions are to be based on AHA specific work level definitions, as outlined in the Allied Health Professionals, Assistants and Psychologists Enterprise Agreement 2025[8], and the key responsibilities associated with the position. AHA position description templates are available on the ASHO website and can be used as basis for development of local position descriptions. Position descriptions can be reviewed by service managers to address changes in service provision and demands (e.g. as part of the PRD process).

Section 2: AHA scope and tasks

Scope refers to the roles, functions, responsibilities, activities and decision-making capacity authorised to be undertaken in a position.

AHAs can work across a diverse range of clinical and geographical settings, and with different allied health professions. The scope of an AHA position must supplement, not replace, AHP services. As non-autonomous practitioners, AHAs must always work under the overarching supervision and delegation of an AHP. While the boundaries of AHA scope will be consistent across SA Health, the scope of individual AHA positions will vary between settings and services and may change over time, influenced by:

- service needs and risks
- AHP workforce capability and capacity
- AHA education, experience, competency, and capability
- legislation, policy, guidelines, and standards. This includes those developed by some profession associations or registration boards[12, 13, 14]
- the classification of the position, and the corresponding work level definitions (as per the Allied Health Professionals, Assistants and Psychologists Enterprise Agreement 2025)[8]
- Code of Ethics for the South Australian public sector[15].

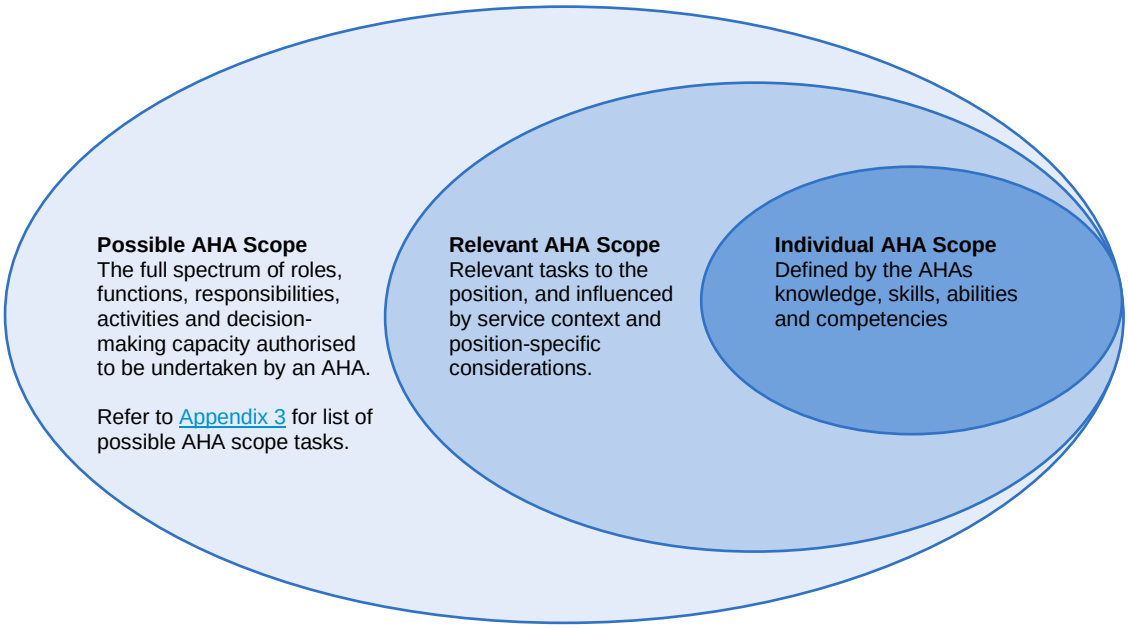
Services must have processes in place to:

- monitor the practice of each AHA to ensure they are operating safely and competently within their individual scope
- support AHAs to practice within their individual scope
- periodically review the relevant scope of AHAs within their service to ensure it is matched to service need.

Determining individual AHA scope

The scope of an AHA position must be matched to the setting and individual employed in the position. Not all tasks that are within the possible scope of an AHA will sit within the identified relevant AHA scope for a given setting, or be safe and appropriate for every individual AHA to undertake (Figure 1).

Figure 1: Representation of AHA possible, relevant and individual scope



Possible AHA scope
Possible AHA scope refers to the full spectrum of roles, functions, responsibilities, activities and decision-making capacity authorised to be undertaken by an AHA. It is the responsibility of each service to determine which aspects of possible scope are relevant to be undertaken by AHAs in a given context.

A list of tasks within the possible scope of an AHA in SA Health is provided in Appendix 3.

Relevant AHA scope
Relevant scope refers to the AHA tasks and duties required of a position within a service. It will be influenced by LHN policy, program requirements and allied health profession-specific guidelines, and must account for position-specific considerations associated with clinical risk and governance.

The relevant scope must be reflected within the AHA position description. An AHA's classification, corresponding work level definition, and formal qualifications must also align appropriately to the relevant AHA scope.

Relevant scope can be defined by identifying service-specific high frequency, high value tasks that an AHA may perform to support delivery of quality allied health care. These will comprise of direct clinical tasks, and indirect tasks.

Direct Clinical Tasks: Direct clinical interaction with a consumer (in-person or via telehealth).

- Delegated by an AHP to an AHA (refer to Section 4: delegation of direct clinical tasks):
  - the AHA accepts responsibility for carrying out the task in accordance with the training, education and delegation instructions they receive from the AHP. They must provide timely communication to the delegating AHP regarding the performance and outcome of the task.
  - the AHP retains responsibility for clinical decision making, and accountability for clinical outcomes and consumer care.

- Supported by a Clinical Task Instruction (CTI).
- Examples include:
  - assisting and supervising consumers with transfers, mobility, and activities of daily living
  - assisting consumers to access socio-economic supports
  - delivering AHP prescribed intervention or therapy programs in person or via telehealth
  - administering a standardised risk screening tool.

Indirect Tasks: Administrative, operational, and other non-consumer facing clinical tasks supporting care and consumer outcomes.

- Assigned to an AHA:
  - the responsibility for performing the task passes to the AHA.
  - the accountability for ensuring the AHA has the appropriate training and support to safely perform tasks sits with the service manager or senior AHP (depending on the task type)
  - the degree of task monitoring by an AHP will be proportional to the risk associated with the task
- Supported by training, workplace instructions, procedures or protocols.
- Examples include:
  - preparing and cleaning therapy spaces and equipment
  - managing and reporting on stock and equipment levels
  - liaising with other service providers and support agencies
  - collecting consumer demographic information using a proforma
  - preparing resources under instruction of an AHP.

Tasks within the relevant scope are to be defined by appropriate senior allied health decision makers. This may include the executive director, service director, team leader, manager, professional lead or senior AHP, with input from other AHPs and experienced AHAs. In doing so, the clinical risk and governance associated with the following position-specific factors must be considered:

- *Degree of allied health clinical governance*
  The robustness of clinical governance structures and resources (including AHP4 and above), and availability of senior allied health clinical leaders to define and ensure appropriate utilisation and support of AHA positions.
- *Depth, breadth and complexity of tasks*
  The depth, breadth and complexity of tasks within the relevant scope will vary. AHA scope in a multi-disciplinary position must be carefully considered and monitored in recognition of the complexity of performing and maintaining competence in tasks across multiple professions and settings. Specific characteristics of the consumer population must also be considered, including clinical complexity, clinical stability, age, and behavioural factors.
- *Degree of task monitoring from AHPs*
  The level of task monitoring and clinical direction provided by AHPs on a day-to-day basis must align to the AHA's classification, knowledge and experience, and the complexity of the position. Simple and routine tasks require less frequent monitoring than complex and non-routine tasks. The AHA's scope may change where direct task monitoring and clinical direction is less available.
- *Degree and mode of professional supervision*
  AHA scope must be proportionate to the availability of appropriate professional supervision. Supervision provided should align to the AHA's classification, knowledge and experience, and complexity and breadth of the position. Whether supervision is in-person, hybrid or remote should also be considered. The AHA's scope may change where in-person professional supervision is less available.
- *Capability of the delegating AHP(s)*
  - Appropriate delegation of tasks by an AHP is a fundamental component of AHA service provision. AHPs must never delegate a task to an AHA that they, themselves, are not competent in performing. It is also incumbent upon delegating AHPs to understand their responsibilities and accountabilities when delegating a task to an AHA, including knowledge of the competencies required of the AHA to effectively perform the task, and task documentation, monitoring, and communication processes. AHPs must receive suitable training and support to develop and maintain sound delegation practice. This is supported by the 'Understanding the SA Health Allied Health Assistant Framework' online training course on iLearn.

A decision-making tool to assist in determining if a task should be included within the relevant scope of the AHA position is provided in Appendix 4.

Individual AHA scope
Individual AHA scope refers to the specific tasks and duties that will be undertaken by the individual in the AHA position, considering their distinct capability to perform tasks safely and competently.

An individual AHA's capabilities will be underpinned by skills and knowledge acquired through nationally recognised training courses (e.g. Certificate in Allied Health Assistance or equivalent), and complemented by experience, ongoing service-led and formal education, and competency-based training and assessment.

When defining individual scope, the service manager and senior AHPs must establish that the AHA has acquired the necessary:

Knowledge, skills and abilities:
Foundational: understanding of delegation principles and profession roles, AHA boundaries and professional conduct, obtaining consumer consent, confidentiality, working in teams, written and verbal communication, Aboriginal cultural capability and responsiveness, and working with diverse communities.

Position specific: may include health literacy/terminology, use of specific equipment, responding to challenging behaviours, understanding of consumer demographics, and IT capability.

Essential competencies: underlying competencies an AHA must demonstrate prior to independently undertaking any direct clinical tasks. All AHAs must demonstrate the essential competencies of:

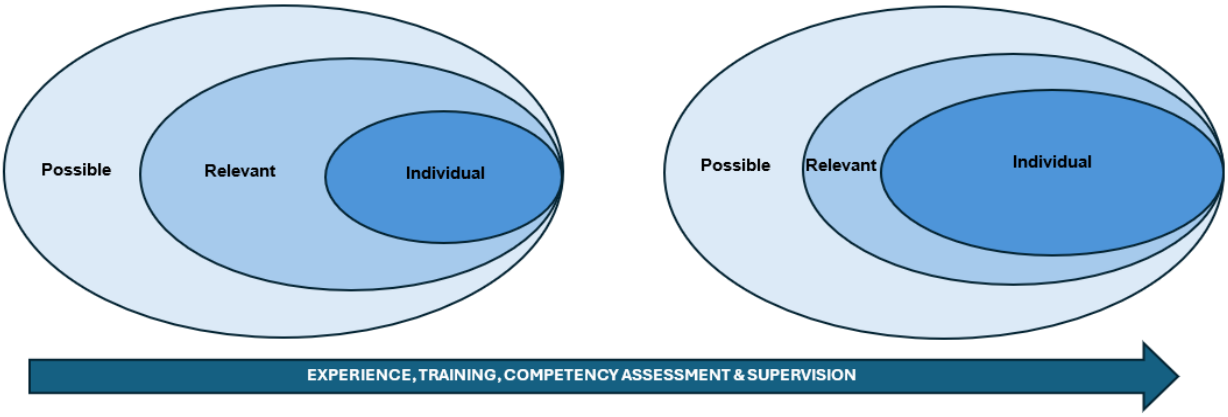
- Clinical documentation
- Clinical handover
- 'When to stop' a task

Task competencies: competency in direct clinical tasks and indirect tasks identified as within the AHA's relevant scope.

Mechanisms to determine and support an AHA's knowledge, skills and abilities are outlined in Section 3: AHA competency: training and assessment. Support for training, education and development is required where an AHA has not yet developed the knowledge, skills and abilities required to perform a task identified within the relevant scope of their role.

The individual scope will evolve over time particularly as the AHA develops knowledge, skills abilities and competencies to match the relevant scope (Figure 2).

Figure 2: Representation of individual AHA scope evolving to more closely align to relevant AHA scope over time



Each individual AHA's scope must be documented and communicated to provide a clear understanding of roles and boundaries to all team members, and as a mechanism to maximise the value of the AHA within the team and minimise clinical risk (an example template is provided in Appendix 5).

Individual AHA scope should be regularly reviewed (e.g. during the PRD process) by the service manager and senior AHPs to ensure it remains congruent to both the service needs, clinical governance, clinical risk and the individual recruited to the AHA position.

Activities outside of scope for AHAs

Activities that require the integration of high-level clinical knowledge, clinical decision making, and clinical skill sets are not consistent with an AHA's training and cannot be included in the scope of an AHA. This includes:

- clinical interpretation of referrals
- planning of assessments (e.g. determining information to be collected, activities to be undertaken)
- interpretation of assessments to provide diagnosis
- clinical decision making to determine suitable interventions
- development, negotiation or modification of goals, programs and intervention plans with the consumer without consultation with an AHP (including type, frequency and duration of services)
- prescribing equipment or aids
- prescribing or recommending medication or radiology interventions
- providing counselling
- discharge planning, including making decisions about discharging clients or referring to other services.
- providing high clinical risk treatments or interventions, or undertaking invasive procedures (e.g. administering local anaesthetic, debriding wounds)
- any activity beyond the standard clinical scope of an AHP.

An AHP may delegate direct clinical tasks to an AHA as part of consumer assessment and intervention processes, such as collecting information, administering a standardised tool, performing a measure or test, or providing a prescribed intervention (e.g. provision of education, supplying or modifying a piece of equipment). However, the AHP retains accountability for delegated tasks including ensuring standards are maintained; and the responsibility for task outcome analysis and integration, and conveying their clinical diagnosis and intervention plan to the consumer.

Section 3: AHA competency: training and assessment

Competency-based training & assessment supports safe and effective practice, and increases understanding of the individual AHA's capabilities within the team. It directly informs the support and development required by an AHA to undertake the position, and the AHA' s PRD.

It can further support:

- enhancement of the individual AHA scope
- reducing repetition in future training and assessments
- transferability of AHA skills across positions and settings
- greater confidence in the capabilities of AHAs
- lifelong learning and development in AHAs.

Understanding existing competency

An AHA's existing level of competency must be understood by their service manager and relevant senior AHP(s). This will initially occur through the recruitment process. It will be influenced by:

1. Whether the AHA has completed a Certificate III or IV in Allied Health Assistance (or another equivalent qualification), and the units of study undertaken. Awareness of the training an AHA has undertaken supports maximal application of the AHA's knowledge, skills and abilities in a clinical context.

   Education providers are responsible for assessing the competence of students against national competency standards. It is reasonable to assume that an AHA has the required level of competence for routine tasks associated with each unit of study undertaken to achieve their Certificate. Competency standards for all units undertaken as part of the Certificate III and IV in Allied Health Assistance are available from training.gov.au. The core units required of both Certificates[16, 17] include:

   - Interpret and apply medical terminology appropriately
   - Communicate and work in health or community settings
   - Work with diverse people
   - Assist with an allied health program
   - Recognise impact of health conditions
   - Apply basic principles and practices of infection prevention and control
   - Participate in workplace health and safety.

   Additional units required of the Certificate IV in Allied Health Assistance[17] include:

   - Respond effectively to behaviours of concern
   - Support relationships with carers and family
   - Facilitate the empowerment of people receiving support
   - Implement and monitor compliance with legal and ethical requirements
   - Implement and monitor infection control policies and procedures.

   AHAs undertaking a Certificate IV in Allied Health Assistance are also able to undertake units to develop competencies for specific professions.

   Further consideration must be given to clearly understanding the competencies achieved by AHAs who have completed a recognised equivalent qualification, or who are part way through their formal training.

   It is expected that AHAs will need service-led, position-specific training and experience, in addition to completing formal education, to be competent and confident in AHA tasks that sit within the relevant scope of the position.

2. What previous roles and responsibilities the AHA has held and clinical environments they have worked or undertaken placement within, including direct clinical tasks they have demonstrated competency in.

3. Whether the AHA has undertaken any previous on-the-job training or professional development relevant to their current position.

Competency development and assessment

AHA competency in indirect tasks and the necessary skills, knowledge and abilities required of the position is to be developed and supported through:

- orientation to position, profession, service and LHN
- mandatory training
- workplace instructions, procedures, and protocols
- general or service-led professional development
- role modelling by AHPs and more experienced AHAs.

Assessment of the AHA's performance of indirect tasks, and their demonstration of the necessary skills, knowledge, and abilities specific to the position, may be required at the discretion of the service.

Essential AHA competencies are the underlying competencies an AHA must demonstrate prior to independently undertaking any direct clinical tasks. They are an integral part of the onboarding process for new AHAs working in SA Health.

They are assessed via an Essential Competency Instruction and Assessment process prior to the AHA independently performing any direct clinical tasks. This process involves:

1. Instruction:
   - Theoretical information provided in an instruction guide, followed by
   - Practical education with an AHP (or AHA with competency).

   Throughout the education phase, opportunity for the AHA to clarify their understanding with the AHP or experienced AHA should be provided.

2. Assessment of competency by an AHP:
   - Satisfactory completion of an oral and/or written assessment, followed by
   - Satisfactory completion of simulated demonstrations, +/- observed demonstration (observed demonstration not appropriate for 'When to stop').

Essential Competency Instruction and Assessment templates are provided in (Attachments 2, 3 and 4) for the three essential competencies (clinical documentation, clinical handover, and when to stop a task). LHNs may also define additional relevant mandatory training requirements (e.g. manual handling) that AHAs must meet prior to performing direct client tasks

AHA competencies in direct clinical tasks are to be developed and assessed via a competency development and assessment process. This requires the development and use of a Clinical Task Instruction (CTI) to describe the best practice process for AHA performance of the direct clinical task. A competency development and assessment process will then confirm the AHA can safely and independently perform the task

Services may create task specific CTIs using the template in Attachment 1, which provides a structure for communicating task objectives, safety and quality considerations, and specific task instruction considerations. This will require the input of senior allied health team members and subject matter experts. CTIs are to be regularly reviewed and updated by subject matter experts in line with evidence-based practice, and within the 'next review' date indicated in the CTI.

A competency development and assessment process can be used:

- when a new AHA needs to develop and demonstrate competency for a direct clinical task within their individual scope
- when an AHA's individual scope is being extended to encompass a new direct clinical task
- when AHA competency needs to be reviewed or refreshed (for example after a period of not performing a task) at an interval determined appropriate by the service
- for monitoring and clinical governance of an AHA's direct clinical tasks.

The process is not intended to be used:

- for indirect tasks
- when an AHA has recently demonstrated competency for the same direct clinical task in their current role, or another service.

The competency development and assessment process can be structured around a staged approach incorporating learning, observation, practice, competence assessment and competence review, as outlined in table 3. Coordination of the AHA's training, and ongoing monitoring and direction relating to the task may be provided by an AHP and/or a more experienced AHA, however the competency assessment component may only be completed by an AHP who is competent in performing the task.

Table 3: *Staged approach for competency development and assessment for direct clinical tasks (adapted from Smith & Duffy, 2011[18] and Queensland Health, 2022[19])*

Stage	Development approach
Learning	- AHA undertakes learning of underpinning knowledge relevant to the task. This will include reviewing the CTI, as well as other relevant background, information, and guidance from AHPs.
Observation	- AHA observes the AHP or experienced AHA performing the task to learn the practical aspects of the task and allow them to safely ask questions to consolidate their learning. - The number of task observations will vary, depending on the complexity and variability of the task, the variety of settings in which the task is undertaken, the clinical risk associated with the task, and the baseline knowledge, skills and abilities of the AHA.
Supervised practice	- AHA performs the task for a period of supervised practice under direct monitoring and support of the AHP (or AHA3/AHA4 where they have demonstrated competency to perform the task). Where practical, this may include simulation/practice on a model, followed by supervised practice with a consumer. - The period of supervised practice is to be negotiated between the AHA and the AHP considering the complexity of the task, the variability of settings and consumer groups, the clinical risk associated with the task and the baseline knowledge, skills and abilities of the AHA. The plan may be varied to reflect the pace of the AHA's development.
Competence assessment	- The AHA demonstrates competence in the task and is 'signed off' by an AHP, who is competent in the task, using the CTI. - The AHP assesses the AHA's task completion on at least one occasion, however the number of assessments is at the discretion of the service. This may vary depending on the complexity and variability of the task, the variability in consumer presentation, the variety of settings in which the task is undertaken, the clinical risk associated with the task, and the baseline knowledge, skills and abilities of the AHA. The AHA must demonstrate competency in each of the task criteria at least once. The task can then be safely delegated to the AHA to perform with appropriate task monitoring and feedback (as outlined in Section 4: delegation of direct clinical tasks). - It is recommended that a maximum number of times an AHA can be assessed for competence in each task is set. If this number is reached without competency being demonstrated, further training, supervision and support to address the specific gaps should be provided before the AHA undergoes re-assessment. The development area may also be reflected in the AHA's PRD.

Stage	Development approach
Competence review and refresh	AHA task competence must be periodically monitored to maintain clinical governance, safety and quality. Competency review and refresh may take place: > in the course of usual service delivery, with an AHP directly observing an AHA performing the task for the mutually acknowledged purpose of confirming competence > via a planned simulated assessment of competence. The frequency for competency review will be negotiated between the senior AHP(s) and AHA, and will vary depending on: > task complexity > clinical risk > frequency of task performance > experience level of the AHA > task monitoring frequency and mode (direct, remote or indirect). The process for reviewing competence will depend on the number of AHAs and AHPs working in a service, and the number of competencies to be maintained. It should include: > a review of education resources (e.g. CTIs, information guides etc) and alignment to latest evidence by the AHP > allocated time for competency review to occur (e.g. prioritised as part of workload allocation) > documentation of the outcome of the competency review > an audit to monitor staff compliance, satisfaction and feedback.

Maintaining and developing AHA capability and competency

AHA competencies are to be maintained and developed through ongoing formal and informal professional training and development to support service quality and safety. AHA professional development also supports AHA job satisfaction and retention.

Professional development activities for AHAs are to be identified and supported at a service level. Appropriate training and development opportunities can be identified by all parties, including:

- service-led training, specific to AHAs or delivered to the broader service/team
- professional supervision
- AHA communities of practice, networking, peer learning and collaboration
- work shadowing or side-by-side practice with AHPs or more experienced AHAs
- training, support and mentoring by an AHP or a more experienced AHA3 or AHA4
- professional development, training courses, and webinars.

AHPs are well placed to deliver profession specific development activities for AHAs. Providing opportunities for AHAs to work closely with AHPs also complements and reinforces competency-based training, creates shared knowledge of roles, and builds mutual respect and strong working relationships.

Funding for external professional development opportunities will need to be identified and supported at the discretion of the employer according to service delivery requirements, as AHAs are ineligible for funding via the Allied Health Professionals Professional Development Reimbursement Program (AHP+PDRP) and the Country Allied Health Clinical Enhancement Program plus (CAHCEP+). AHAs may choose to self-fund external professional development activities that are of interest and relevant their role.

The PRD process can be used to facilitate an AHA's development in priority areas consistent with the AHA's development goals and service requirements. The PRD is to be overseen by the AHA's direct line manager, with contribution by the AHA's primary supervisor or a senior AHP as required. Targeted

learning goals can be identified by the AHA, line manager, or professional supervisor ensuring they align with both the AHA's development goals and service requirements.

Competency records

A register of essential competencies and clinical task competencies achieved by the AHA should be confidentially maintained by the service manager. The AHA is strongly encouraged to keep a copy of their competency records as evidence for recognition of skills attained for future roles and settings.

An example AHA Competency Record template is provided in Appendix 6.

Section 4: Delegation of direct clinical tasks

AHA delegation is the process by which an AHP allocates a direct clinical task to an AHA.

On accepting the delegated task from the AHP, the AHA then carries the responsibility for completing the task in accordance with their training and the direction they receive from the AHP, and for providing timely communication to the delegating AHP regarding the performance and outcome of the task.

The delegating AHP retains responsibility for all clinical decision making, and accountability for clinical outcomes and consumer care.

AHAs also undertake indirect tasks including administrative, operational and other non-consumer facing clinical tasks that support care (for examples refer to Section 2: AHA scope and tasks). These indirect tasks are assigned rather than delegated to an AHA, and are supported by training, workplace instructions, procedures or protocols.

For assigned tasks:

- The AHA has the responsibility for completing the task in accordance with instruction and their training
- The service manager or senior AHP (depending on the task type) has the accountability of ensuring the AHA has the appropriate training and support to safely perform the task.

AHA delegation requires a structured, consistent approach to minimise risk, and to ensure appropriate governance, supports, communication and oversight processes are in place. The following principles underpin safe and effective AHA delegation:

Motivation: The primary motivation for task delegation must be to support provision of timely, high quality consumer care.

Scope: The task must be within the AHA and AHP's scope of practice, and not be prevented by law or policy from delegation to an AHA.

Training: AHA delegation is a skill that requires development. Both AHPs and AHAs must have access to training to develop and maintain sound delegation practice. The 'Understanding the SA Health Allied Health Assistant Framework' online training course on iLearn is available to support this and may be supplemented by professional supervision and other local resources.

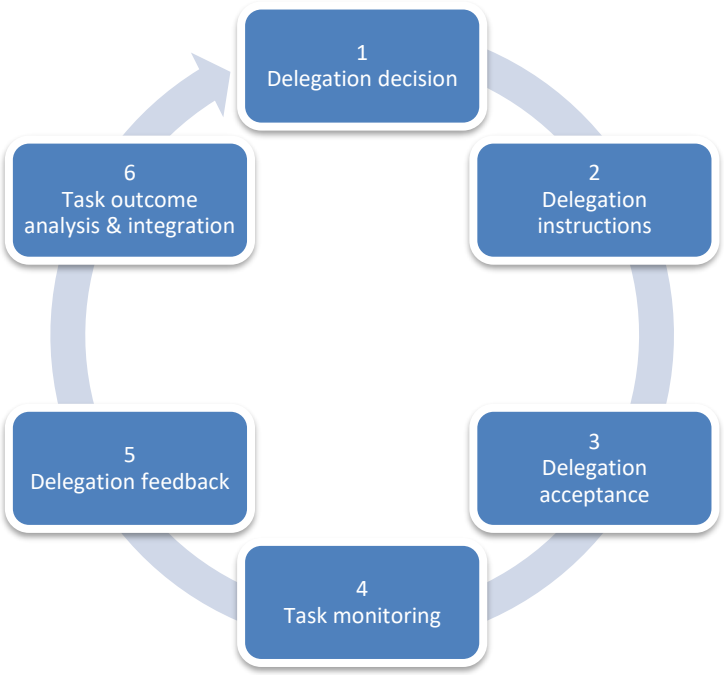
Competency: The AHA must have demonstrated competency to perform the task through a Clinical Task Instruction and Competency Development and Assessment Process (refer to Section 3: AHA competency: training and assessment). The AHP must be competent in performing the task themselves.

Consent: Consumer consent to receive care must be obtained by the AHA each time a delegated task is undertaken, consistent with SA Health consent guidelines.[20]

Communication: Effective mechanisms must exist to support two-way communication between AHA and AHP. The AHP must clearly communicate all task expectations and parameters, and have task monitoring strategies in place. The AHA must seek additional task clarification or direction as required, and provide feedback on task outcomes.

The AHA delegation process for direct clinical tasks consists of six steps (Figure 3).

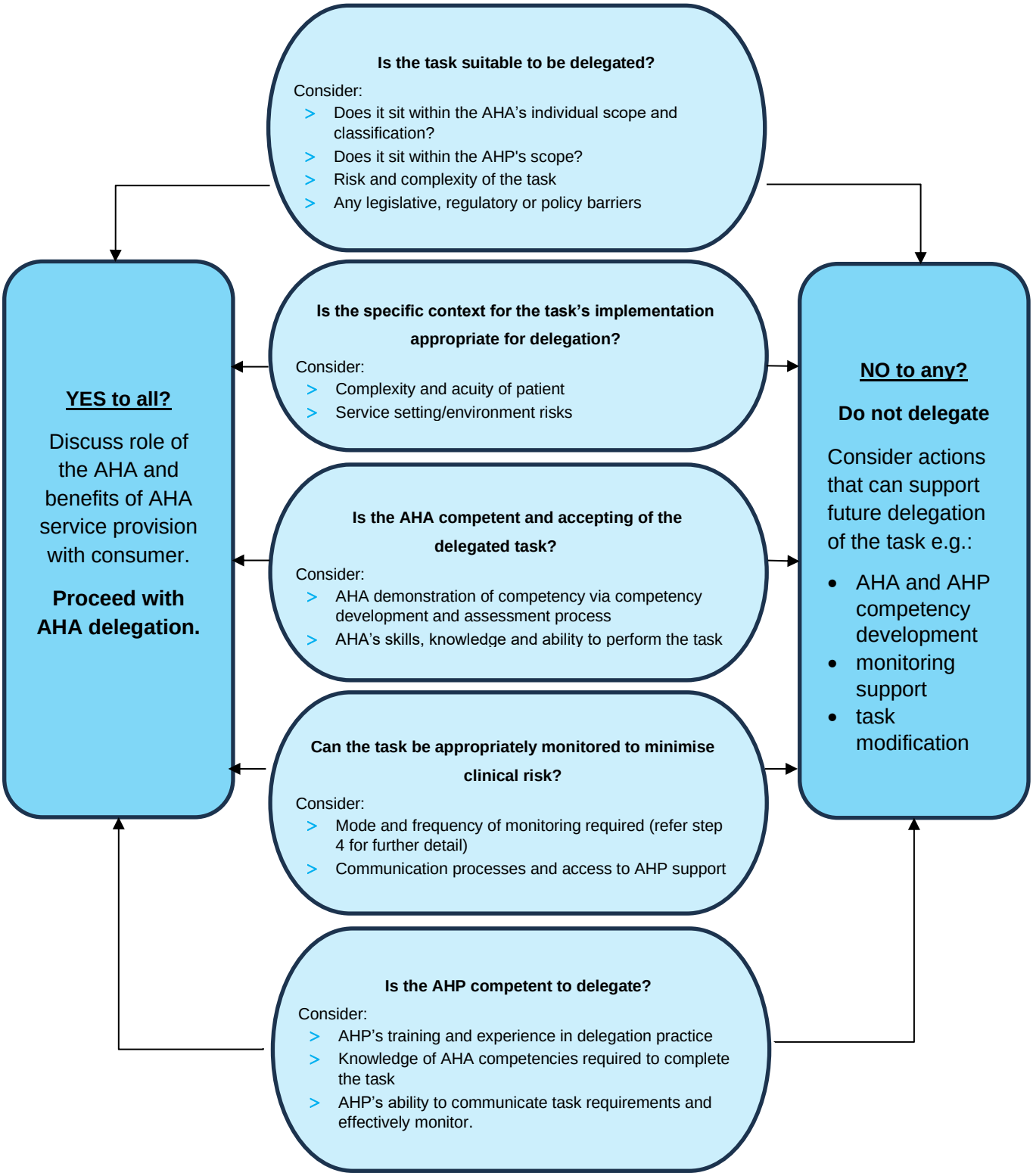
Figure 3: The six steps of AHA delegation



Step 1: Delegation decision

Determining whether a task is appropriate for AHA delegation is a complex professional process that requires the AHP to consider risk and governance factors. Figure 4 outlines the key factors that should be considered to support AHPs in determining whether a task is appropriate for delegation to an AHA.

Figure 4: Flowchart to support AHP decision making on whether a task is suitable for delegation to an AHA (adapted from Queensland Health, 2022[21])



Step 2: Delegation instruction

The delegation instruction from the AHP to the AHA must include all relevant information required by the AHA to safely perform the task. This requires a conversation between the AHP and AHA, or a locally determined written process. The delegation instruction will be informed by the standard CTI created for the task, which defines general task preparation, consent, positioning, procedure, documentation and handover processes.

During delegation instruction the AHP must highlight any task-specific (e.g. weight bearing status, number of repetitions, duration, assistive technology, dietary status, off-site safety) and/or consumer-specific (e.g. past medical history, risk behaviours, personal equipment, cognitive status, communication requirements, diversity considerations) parameters, along with any required variation to the standard task instructions documented in the CTI.

If more than one task is required to be completed within a session, where practical, the AHP should provide instructions on the intended order for the tasks to be carried out, along with any additional monitoring and feedback requirements that must be met before proceeding with the next task.

It is the responsibility of the delegating AHP to document in the consumer's medical record via a locally agreed process:

- the plan for the task to be delivered by an AHA
- key task-specific and/or consumer-specific parameters
- any variation to the standard task instruction documented in the CTI.

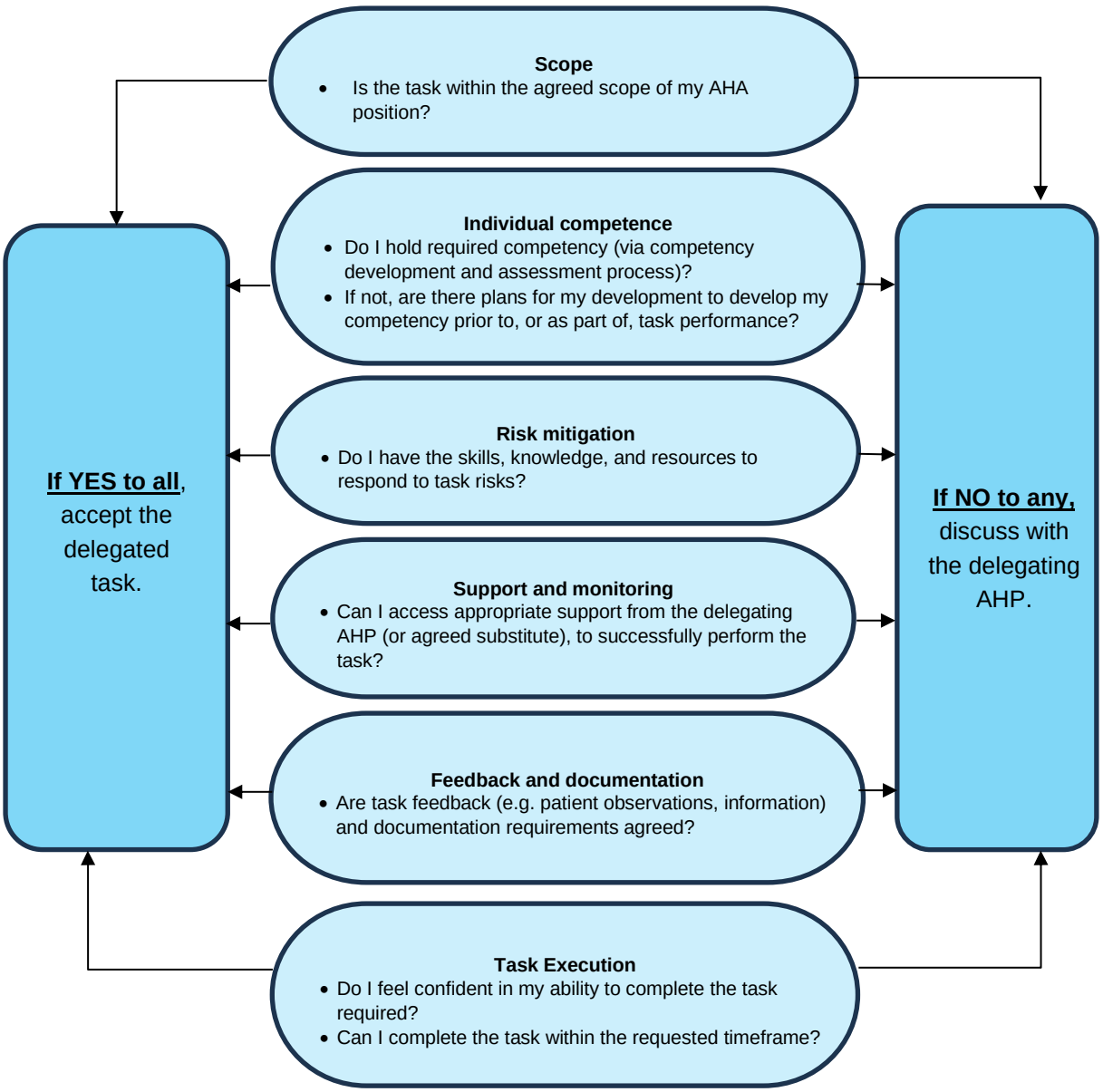
Step 3: Delegation acceptance

The AHA accepts the task and seeks clarification of any unclear instruction or information.

It is the AHA's responsibility to raise concerns regarding their experience level, confidence and competence relevant to the task, and to request additional information or support as part of the delegation acceptance process. This process should be allowed for by the AHP, and may result in the modification of the task, provision of additional support or monitoring, or if necessary, the withdrawal of the delegation instruction.

Figure 5 outlines key factors to be considered to support AHA decision making relevant to delegation acceptance. Where the answer to any question is no, the AHA should discuss their concerns with the delegating AHP. Following discussion with the AHP, if the AHA still feels the task is not appropriate for them to undertake, they should speak with their line manager or a senior AHP.

Figure 5: Flowchart to support AHA decision making on whether to accept a delegated task (adapted from Queensland Health, 2022[21])



Acceptance of task delegation must only occur once there is a clear understanding and agreement between the AHA and AHP on how, when, where and with what support the task will be undertaken.

The delegated task can now be performed by the AHA.

Step 4: Task monitoring

The AHP must support safe and high-quality performance of the delegated task by providing appropriate task monitoring. Monitoring allows the delegating AHP to:

- ensure the task is being completed by the AHA consistent with instructions and timeframes indicated

- modify the task and/or instruction as required
- ensure the outcomes of the task are appropriate
- determine if the AHA may need further instruction, support or development to competently complete the task.

The intensity of task monitoring should be appropriate in both mode and frequency:
Mode:

- **Direct, in person monitoring,** where the AHP works alongside the AHA and can observe the task and provide immediate feedback, guidance and intervention as required.
- **Remote monitoring**, where the AHP is off-site and monitoring in real-time via telehealth. This allows the AHP to make real-time clinical decisions and if necessary, modify the delegation instruction based on the response of the consumer, but does not allow for direct physical intervention by the AHP.
- **Indirect monitoring** where the delegating AHP is not physically present. This requires clear processes to ensure AHPs are easily accessible to provide direction, guidance and support to AHAs if required. Task performance is tracked, and consumer progress monitored through AHA feedback and reporting, and review of clinical notes.

Frequency: refers to how often the AHP is engaged in monitoring the task. This may range from intermittent or occasional frequency, through to every time the task is undertaken.

To determine appropriate task monitoring intensity, the AHP must consider:

1. Task-specific factors, including the:
   - complexity
   - associated clinical risk
   - possible variance of outcomes of the task
   - frequency the task occurs in the service
2. Consumer-specific factors, including the:
   - severity, complexity and stability of the consumer's health status
   - risk of deterioration in the consumer's health status
   - potential impact of the task on the consumer's health status
   - level of consumer engagement from a behaviour, cognitive and communication perspective
   - the frequency in which the task will be undertaken
3. Setting/environmental factors, including:
   - availability of the delegating AHP
   - proximity to other health professionals and other support infrastructure (duress alarm, mobile phone, vehicle)
4. Capability factors, including:
   - AHA current knowledge, skills and competencies
   - AHA experience and confidence in undertaking the task (or similar tasks)
   - AHP experience and familiarity with the task, setting/environment and consumer group

Figure 6 provides further guidance to AHPs to determine an appropriate intensity of task monitoring. Where task, consumer, setting or capability factors indicate the need for higher intensive monitoring, a direct mode and/or higher frequency of monitoring should be provided by the AHP.

Figure 6: Factors that influence intensity of AHP task monitoring (adapted from Queensland Health, 2022[21])

Less intensive	Continuum for monitoring	More intensive
Routinely delegated in the team and care setting Team has well established governance and processes for delegation	**Team delegation model**	Novel task not usually delegated in this team or setting Team are new, or under-developed governance and process
AHP has experience in delegation practice	**AHP delegation practice**	AHP is new to, or inexperienced in, delegation practice
Stable Limited or slow progression/regression Low anticipated change	**Consumer's presenting health condition**	High variability within and/or between sessions Unanticipated changes likely
Lower complexity and limited variation between and within sessions	**Health and other consumer characteristics**	Complex and high potential for rapid changes between and within session
Competent and confident Experience in delivering the task Frequently performs the task	**AHA characteristics**	Not confident in the task Inexperienced delivering the task Infrequently performs the task
Low procedural complexity Task done with limited variations between consumers or sessions	**Procedural complexity of the task**	High procedural complexity (i.e. numerous steps, high variation in sequence of steps, intermediate decision-points) Regular decision making required during/between session to adjust task
Not likely	**Poor performance of the tasks results in adverse outcome (e.g. harm, distress)**	Likely
Significant time can elapse before error has impact and error is reversible	**Timeliness of identification of task performance error**	Immediate, irreversible impact evident.

Step 5: Delegation feedback

On completion (or cessation) of the task or therapy session, the AHA is responsible for providing comprehensive, timely feedback to the delegating AHP via the process agreed during delegation instruction and acceptance. In cases where a block of therapy is being delivered by the AHA, there may be agreement on the level of feedback to be provided after each session, versus at completion of the therapy block.

The AHA must complete the required documentation based on the Essential Competency Instruction for clinical documentation (Attachment 2), any required task-specific documentation (outlined in the standard CTI for the task), and any applicable LHN-specific documentation requirements. The AHP clarifies any information provided as part of the feedback process.

Step 6: Task outcome analysis and integration

Using clinical reasoning, the delegating AHP analyses and interprets the clinical and task outcome information provided by the AHA during delegation feedback and integrates this into the consumer's care plan. This includes an evaluation of the decision to delegate the task to the AHA, based on the task outcomes.

The AHP makes a decision for ongoing clinical care for the consumer, including:

- whether the task needs to be repeated, and if so whether it is suitable for ongoing AHA task delegation, and if the delegation instructions need to change
- whether a new task needs to be undertaken (either by the AHP, or delegated to the AHA where appropriate)

The process of delegation can continue as a repeated cycle over time. Throughout this cycle, the clinical decision-making remains the responsibility of the delegating AHP. Likewise, every time AHA delegation re-occurs, the AHP must evaluate task, consumer, setting/environment, and capability specific factors to understand the cumulative clinical risk of delegating the task, and account for this using appropriate levels of task instruction, monitoring and feedback. If the risk cannot be satisfactorily managed, then the task should not be delegated to an AHA.

Section 5: AHA professional supervision

Professional supervision is "*…a uniquely designed development activity, emphasising personalised learning, skill and practice development and personal support…. It is co-designed with the supervisee to ensure it is fit for purpose, in line with the supervisee's learning needs, styles and learning stages*".[22]

Professional supervision provides wide-ranging benefits to consumers, individual staff members and organisations. This includes supporting supervisees' wellbeing, establishing workplace identity, providing clarity around work roles and responsibilities, developing clinical skills, and supporting professional skills such as problem solving, conflict resolution and teamwork. It also provides a safe environment in which AHAs can discuss any issues or concerns. Combined, this positively impacts consumer safety, service quality and staff retention.

AHA professional supervision provides a formal, regular, and structured opportunity to support and facilitate each AHA's personal and professional development within and beyond a clinical context. It has a strong self-reflective focus on clinical, personal, and professional experiences, attitudes, and beliefs.

In the context of the AHA workforce, professional supervision is distinct from:

- service, operational and line management
- delegated task monitoring
- workload supervision
- cultural mentoring.

AHA professional supervision requirements and guiding principles

As non-AHP classified staff, AHAs are not within the scope of the *SA Health Allied Health Professional Supervision Framework*[23], however the overarching principles of the Framework are relevant to support the personal and professional development of AHAs.

To ensure quality professional supervision for AHAs, the following requirements adapted from the *SA Health Allied Health Professional Supervision Framework*[23] apply:

- Each AHA will:
  - participate in reflective practice supervision with a primary supervisor in-person or via videocall platform
  - have a co-designed AHA Professional Supervision Agreement that outlines the parameters of the supervisory relationship (including purpose, roles, responsibilities, and confidentiality), and identifies the AHA's current supervision goals (Appendix 7).

- The minimum recommended time and frequency for professional supervision of AHAs is 1 hour every 6 weeks (for all AHA classifications). Services may choose to provide more frequent supervision based on factors such as competence, experience, scope and learning style.

- Reflective practice supervision may occur:
  - 1:1 with an AHP or AHA4 who has the appropriate skills and experience to support the AHA's learning and development
  - in a group setting with an experienced AHP supervisor.

  Supervisors with an understanding of the AHA's scope and work environment, and the service's needs, are well placed to provide the most effective supervision.

- Reflective practice supervision may be supplemented by other professional supervision elements outlined in the *SA Health Allied Health Professional Supervision Framework*[23] where this meets the AHA's supervision goals. This may be particularly relevant for AHAs in multi-disciplinary positions. Other professional supervision elements include:
  - point of care supervision

- group supervision
- peer supervision
- extending professional self
- facilitated learning.

Mentoring by a more experienced AHA3 or AHA4 may further supplement reflective practice supervision.

Supporting quality supervision

AHAs and supervisors should be supported to understand reflective practice and their roles in professional supervision. Relevant sections of the SA Health Allied Health Professional Supervision Online Learning Modules (*Professional Supervision Essentials*, and *Professional Supervision for Supervisors*) can be accessed by AHAs and their supervisors on iLearn to support this. Supervisor skills and knowledge to support Aboriginal AHAs, and AHAs from culturally and linguistically diverse backgrounds should also be developed.

The application of a cultural lens within professional supervision is a crucial strategy for supporting a culturally safe and responsive AHA workforce. This can include reflecting on workplace experiences, exploring how to integrate cultural training into clinical practice, and identifying resources to support growth and capability. A cultural lens can be applied to all forms of professional supervision to facilitate cultural learning, advice, and support, and should be tailored to the AHA's scope and service setting.

- Applying an Aboriginal cultural lens is a focused approach within the broader concept of a cultural lens, encouraging consideration and development of cultural capability and responsiveness when working with Aboriginal people. While a cultural lens promotes awareness across diverse backgrounds, an Aboriginal cultural lens ensures the unique sovereignty, histories, and cultural realities of Aboriginal peoples are specifically centred.
- A broader cultural lens can be applied to support other diverse groups including culturally and linguistically diverse people, people with disabilities, and those who identify as LGBTQIA+.

There may be some overlap between an AHA's professional supervision goals, and work or organisational priorities identified in PRD discussions. AHAs are encouraged to highlight professional supervision goals they have achieved at their PRD and consider how professional supervision could support work priorities and development areas identified in their PRD discussions.

Supervision documentation and confidentiality

The AHA Professional Supervision Agreement should be reviewed as needs or circumstances change (minimum annually). This should include:

- discussion on the supervision relationship
- review of supervision goals
- identifying changes to ensure professional supervision is suiting both supervisee and supervisor needs.

AHAs should maintain a professional supervision log detailing the date, duration, and method of professional supervision (Appendix 8). More detailed supervision notes may be maintained for reflective practice supervision sessions by both parties to promote accountability of actions and decisions, and enable consistency from one session to the next. The proposed content of notes and level of detail should be established within the AHA Professional Supervision Agreement (Appendix 7).

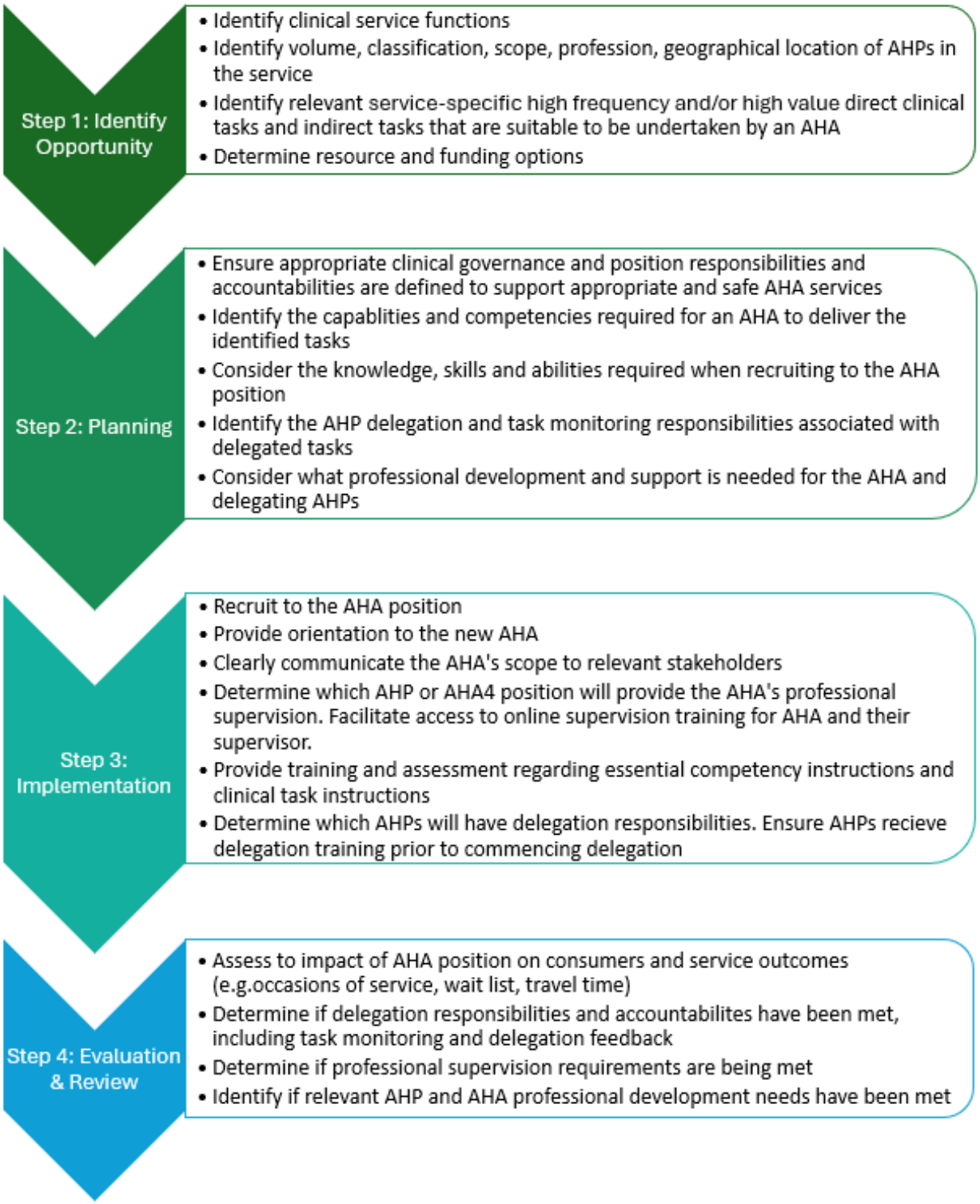
Notes and documentation relating to professional supervision are corporate records and must be stored, retained and disposed of in accordance with the State Records Act 1997, SA Health's Corporate Records Management Policy and any relevant local records management procedures. In line with the South Australian Information Classification System, supervision records should be classified as 'OFFICIAL:Sensitive' and accessible only to the supervisor and supervisee unless legally required by another party.

Documentation of consumer-related information must be non-identified to maintain confidentiality.

Confidentiality within the supervisory relationship is vital to building trust and safety. The content of professional supervision must remain confidential except where information is required to be disclosed under law; or in response to an identified risk (e.g. risk to consumers, other staff, or the supervisee). If disclosure is considered necessary by the supervisor due to an identified risk, they must inform the supervisee of the reasons for disclosure and the process that will be followed.

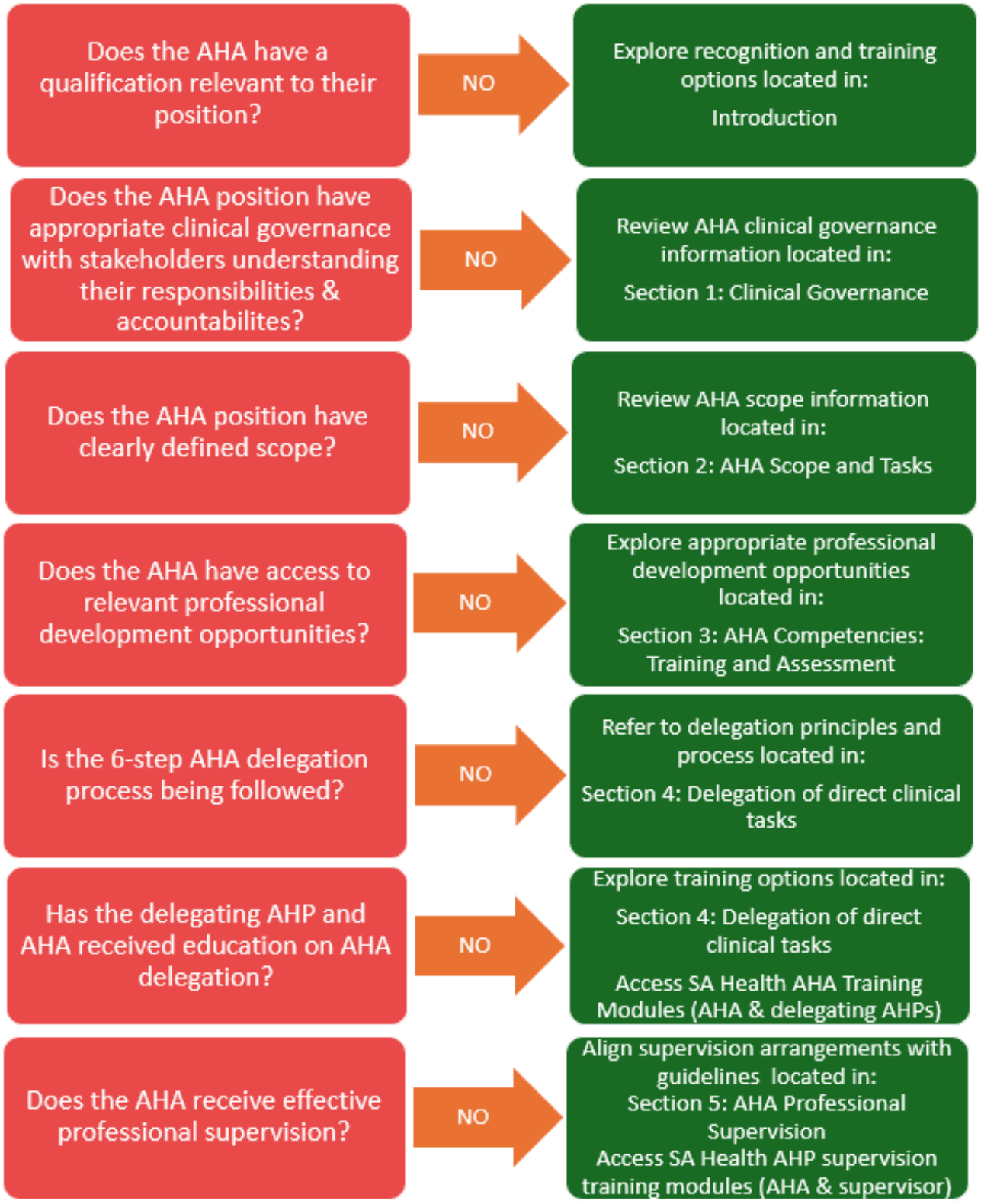
Appendix 1: Considerations when establishing/expanding AHA positions

(Adapted from NT Health, 2024 [24])



Appendix 2: Considerations when reviewing existing AHA positions

(Adapted from NT Health, 2024 [24])



Appendix 3: Tasks within possible AHA scope

This list is intended as a guide to possible AHA scope tasks. It includes direct clinical tasks (requiring a Clinical Task Instruction and Competency Assessment process), indirect tasks and other responsibilities an AHA may undertake.

These tasks are sourced from the units of competency within the Certificate IV in Allied Health Assistance and a review of contemporary best practice for the AHA workforce in Australia. There will be tasks in addition to those listed that are relevant to specific services and professions.

The following tasks can only be completed by an AHA:

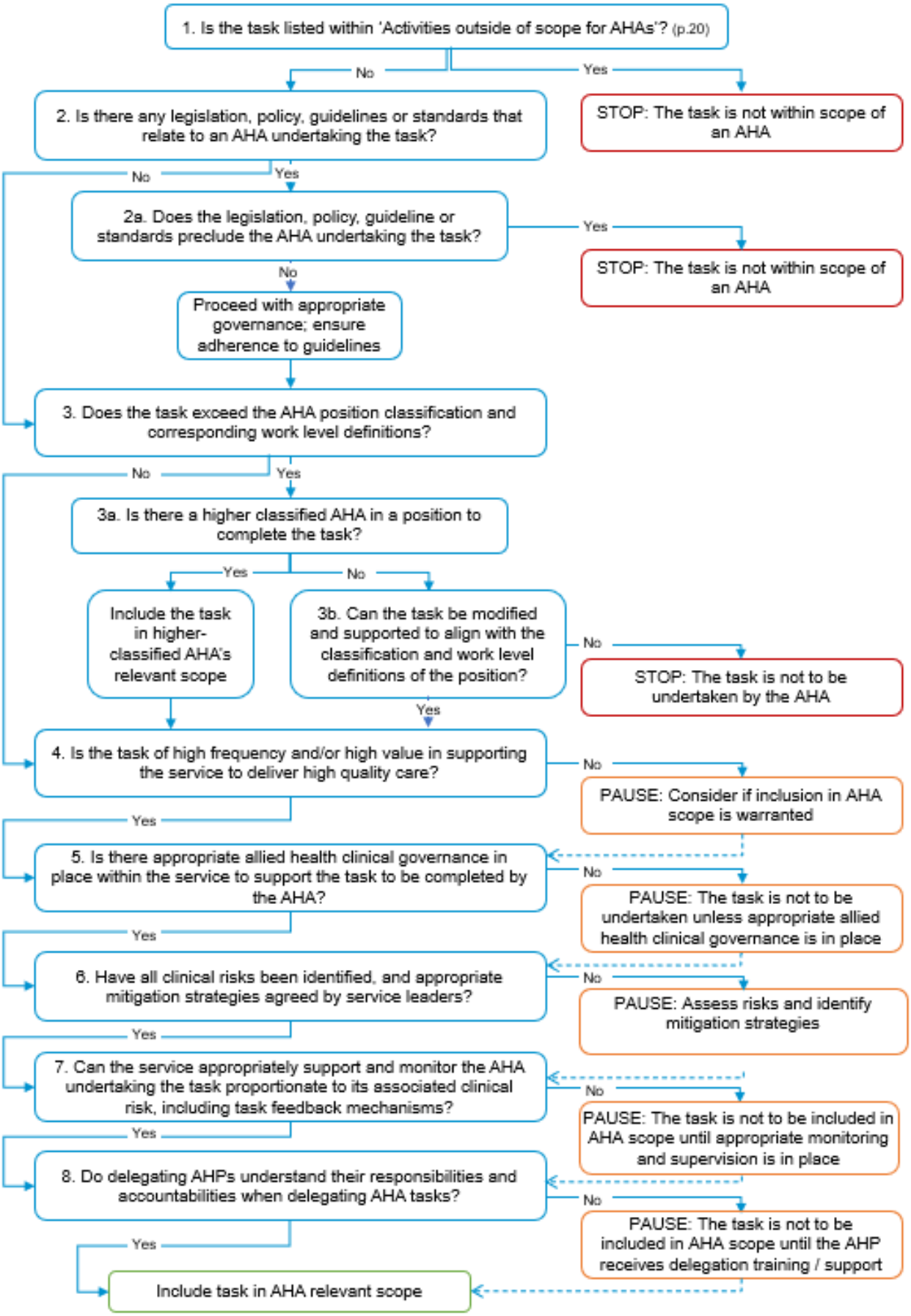
- as instructed, and with the appropriate task monitoring by an AHP,
- where the AHA has received appropriate training, and
- where the AHA has been confirmed by an AHP as having the required capabilities and competency to safely complete the task.

Area	Possible AHA tasks
Assessment support	> Gather background or routine information from case notes, consumers, family and service providers to support the AHP's clinical assessment > Prepare assessment resources > Prepare equipment for assessments and assist with equipment operation > Assist AHPs with clinical assessments > Conduct standardised screening
Care Coordination	> Collect information to assist with intake or triage > Coordinate referrals initiated by AHPs > Assist with arranging appointments > Liaise with other service providers and support agencies > Make routine reminder calls and follow up non-attendance > Monitor consumer journey and provide updated information to AHPs > Identify consumer eligibility for additional supports (e.g. financial assistance) > Provide practical support to consumers preparing for hospital discharge > Coordinate and plan community visits > Deliver resources and disseminate information to consumers
Intervention	> Prepare and maintain therapy rooms and resources, including packing up and cleaning therapy rooms and resources > Assist with set up and troubleshooting for telehealth appointments > Create therapy resources > Prepare consumers for therapy > Escort and/or organise transport for consumers to and from therapy > Assist with and participate in group and individual therapy programs > Provide assistance in therapy where two or more people are required for safety (e.g. to assist with positioning or manual handling) > Carry out predetermined therapy programs with consumers under direct or indirect supervision > Provide practical support to consumers to access government benefits and other external supports and agencies > Support consumers to access and navigate the community > Monitor consumer response to therapy and modify to meet their level of function, in line with CTI > Liaise with AHPs regarding consumer progress and their response to therapy > Travel with AHPs to support safe regional or consumer home visits
Education	> Prepare venues and resources for education sessions > Deliver predetermined education to consumers/carers/family

Area	Possible AHA tasks
Equipment	> Maintain consumer equipment and general clinical supplies required for services including ordering, receipt of, storage and maintenance of stock > Assemble aids or equipment > Asset tag new equipment > Assist AHPs to issue and adjust aids or equipment for consumers > Assist in equipment loan programs including supply and retrieval of equipment > Maintain equipment databases > Undertake equipment reprocessing including general checks, maintenance and cleaning > Undertake equipment audits
Advocacy	> Promote the Australian Charter of Healthcare Rights > Engage in service and team promotional activities > Promote awareness, and use, of available allied health services > Support communication with key stakeholders about allied health services, including scheduled visits > Assist consumers, carers, families and communities to access and participate in health interventions > Assist consumers to understand and access services and benefits for which they are eligible > Support consumers and families to communicate their needs and concerns and understand information that has been provided.
Clinical Documentation	> Assist with preparation of documentation and supportive resources > Document in patient information systems with adherence to documentation standards
Quality Assurance/ Research	> Participate in service and team quality activities, research and evaluation > Collect and process data to provide information on consumer progress or services > Maintain required statistics, record accurate and timely workload data > Prepare resources and participate in health promotion activities
Supervision	> Participate in professional supervision > Supervise less experienced AHAs (AHA4 only) > Support and mentor less experienced AHAs and AHA students as appropriate
Professional Development	> Maintain and develop knowledge and skills aligned to the position requirements > Participate in relevant professional development opportunities
Vehicles	> Coordinate and prepare vehicles for trips

Adapted from NT Health, 2024 [24]

Appendix 4: AHA relevant scope task decision making tool



Appendix 5: Documenting individual AHA scope example template

Individual AHA Scope Summary

Role title:	
LHN:	
Department/Work area:	
Individual AHA scope created/ last reviewed date:	

The AHA position described will function according to the key result areas defined in the relevant position description.

This 'Individual AHA Scope Summary' provides further detail on the direct clinical tasks, indirect tasks and other responsibilities the individual AHA will undertake, in line with the service or work area requirements and the AHA's knowledge, skills and abilities. It is to be shared with relevant team members to provide a clear understanding of AHA roles.

Practice Area	Individual AHA Scope	Comments
Assessment	•	
Care coordination	•	
Intervention	•	
Education	•	
Equipment	•	
Advocacy	•	
Clinical documentation	•	
Quality assurance/ research	•	
Supervision	•	
Professional development	•	
Vehicles	•	
Other	•	

Appendix 6: AHA compentency record (example template)

AHA competency record

Name:	
LHN:	

Competency (Essential competencies; direct clinical task competencies)	**Date assessed as competent**	**Assessor name**	**Assessor position title**

Appendix 7: AHA professional supervision agreement template

AHA Professional Supervision Agreement

Allied Health Assistant	
Delegating profession(s)	
Primary supervisor	
Profession of primary supervisor	
Line manager	
Review date	

Supervision Agreement Sign Off

Allied Health Assistant	**Name**	
	Signature	
	Date	
Primary Supervisor	**Name**	
	Signature	
	Date	

The Supervision Agreement should be reviewed annually at a minimum.
Changes to the agreement may be made at any time with the agreement of both parties.

Supervision Agreement

1. **Practicalities**

Frequency of supervision: (refer to SA Health AHA Framework for minimum recommended intervals)	
Responsibility for scheduling:	
Location of supervision:	
Acceptable reasons for cancellation or rescheduling:	
Notice of cancellation (e.g. phone, SMS, email, page):	

2. Responsibilities

The supervisee will prepare for supervision by:	
The supervisor will prepare for supervision by:	

3. Learning Preference

Consideration of supervisee's preferred feedback style, learning style, previous supervision experiences and other factors that may contribute to the success of supervision:

4. Confidentiality

The content of professional supervision is confidential and is only to be shared outside of the supervisory relationship under the following circumstances:

- As required by policy or legislation (e.g. as required under law, or where disclosure of information is required in response to identified risk to consumers, other staff or the supervisee). If disclosure is considered necessary by the supervisor due to an identified risk, they must inform the supervisee of the reasons for disclosure and the process that will be followed.
- With the consent of both parties (e.g. to support a supervisor's reflection in their own supervision sessions; to seek further opinion relating to an ethical dilemma).

Other considerations e.g. how will consent to share be obtained?

5. Record Keeping

A Supervision Log should be maintained for clinical governance record keeping purposes and stored securely according to LHN requirements.

Records created during supervision sessions must be stored, retained and disposed of in accordance with the State Records Act 1997, SA Health's Corporate Records Management Policy and any relevant local records management procedures.

In line with the South Australian Information Classification System, supervision records should be classified as 'OFFICIAL:Sensitive' and accessible only to the supervisor and supervisee unless legally required by another party.

In the event of the supervisor leaving their position, a discussion should occur to determine the supervisee's preference for the previous supervision notes to be transferred to a new supervisor or archived with the department's approved temporary storage provider until their scheduled destruction.

How will personal supervision records be stored?	
What will happen to records when a supervisor or supervisee leaves their position?	

6. Conflict Resolution

Should conflict arise between supervisee and supervisor, all efforts should be taken to resolve or negotiate the conflict in the first instance. Where this has been unsuccessful, it is appropriate to engage an agreed mediator (usually a senior AHP) to assist in facilitating a path to resolution.

Any further considerations on how conflict will be addressed, or the process to be used when managing conflict?

7. Feedback and Evaluation

Consideration of opportunities for informal feedback, reflection and evaluation of supervision should be incorporated into supervision sessions.

How and when will informal feedback on the style, content and effectiveness of supervision be provided by the supervisee and supervisor?

8. Supervision Goals

- Identify goals that can be met through professional supervision.
- Consider which supervision elements can help achieve these goals (reflective practice, point of care, group, peer, extending professional self, facilitated learning).
- Reflect on learnings and impact on practice once each goal has been achieved
- New goals may be added as supervision goals are achieved, and new goals are identified

Goal 1

Date	**Goal**	**Supervision element(s) and activities to achieve goal**	**Indicators this goal has been met**
Once achieved: Reflections on learnings and impact on practice			

Goal 2

Date	**Goal**	**Supervision element(s) and activities to achieve goal**	**Indicators this goal has been met**
Once achieved: Reflections on learnings and impact on practice			

Goal 3

Date	Goal	Supervision element(s) and activities to achieve goal	Indicators this goal has been met
Once achieved: Reflections on learnings and impact on practice			

Goal 4

Date	Goal	Supervision element(s) and activities to achieve goal	Indicators this goal has been met
Once achieved: Reflections on learnings and impact on practice			

Goal 5

Date	Goal	Supervision element(s) and activities to achieve goal	Indicators this goal has been met
Once achieved: Reflections on learnings and impact on practice			

Goal 6

Date	Goal	Supervision element(s) and activities to achieve goal	Indicators this goal has been met
Once achieved: Reflections on learnings and impact on practice			

Appendix 8: AHA professional supervision log template

AHA Professional Supervision Log

Allied Health Assistant	
Primary Supervisor	

Date of session	Supervision element*	Duration	Outcomes & actions

* Supervision elements include reflective practice, point of care, group supervision, peer supervision, extending professional self, facilitated learning

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Document Approvals

Version	Status:	Date	Author/Editor	Details of changes
0.1	Draft	14/04/2025	Nicolette Varvounis, Jodie May & Nathan Fox	
0.2	Draft	14/07/2025	Nicolette Varvounis, Jodie May & Nathan Fox	Various changes made following broad consultation (for detail, see consultation executive summary)
1.0	Finalised	24/09/25	Nicolette Varvounis	Minor changes to reflect new EA and titles of online training course and Framework attachments. Endorsed by Allied Health Executive Council in September 2025.