Allied Health Practice Profiles: Social Work

Purpose

The Allied Health Practice Profiles (AHPP) aim to provide a resource for each profession's use when reviewing the services they provide to SA Health clients.

Allied health service structures are in the majority a matrix model and cover many clinical areas within health services. Whilst this allows for agility, flexibility and responsiveness allied health services need to be able to clearly articulate why they provide services to clients or why they refer on to other services. This AHPP outlines the continuum of service provision based on the identification of key work practices and core business for each profession.

The AHPP articulates the scope of practice that are common amongst allied health professionals (Core Practice Profile) alongside the specific scope of practice for each profession (Specific Practice Profile). These profiles will assist allied health professions when reviewing their services to identify work that is no longer supported by the business unit that requires referral on and opportunities to provide full core business services. It will also allow allied health to clearly identify where they can assist other professions in their requirement to be working at the top of their scope through provision of extended scope of practice services.

The AHPP is intended as a guide for service provision and not a restrictive or conclusive list. The profiles will evolve with time as practices develop and change and thus will be updated periodically. The online version is the correct version and once printed may be out of date.

In this environment of change and models of care development it is important that professions are clear and consistent across the state in their communication about what they can or do provide to clients in South Australia.

Information in the resource

Information in the resource focuses on clinical rather than management roles in order to keep the statements specific to clinical care undertaken by allied health professionals and assistants. The scope of practice roles are mapped across a continuum from an assistant role through to advanced and extended roles. These statements are based on core services rather than competencies to circumvent the need to attach a classification level.

Context within the Transforming Health agenda

Through the implementation of the Transforming Health agenda, allied health services are being asked to provide wide ranging information including but not limited to; describing their roles, identifying innovative practice models, providing evidence for their service models, identifying efficiencies and opportunities to work to their full scope of practice and clearly articulating how they will contribute to the Transforming Health agenda. The AHPP are a starting point for Local Health Network allied health professions to be able to clearly describe their roles, what they do and don't do and the opportunities to work towards a full scope of practice in line with Transforming Health models of care directions.

Scope of Practice Definitions

This document maps the scope of practice for social work across a continuum from allied health assistants through to advanced and extended scope roles. The following definitions apply to this document:

Allied Health Assistant encompasses technical staff who are trained to support allied health professionals with their practice. They may work for one professional group or a range depending on their work roles and tasks. Allied health assistants will be supervised by allied health professionals with a combination of direct and indirect support and will be assigned tasks based on their level of competence, knowledge and experience.

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Transition Scope is relevant for clinicians who are new to their profession or new to their role and are developing their core skills. The time a clinician spends in transition will vary from person to person and amongst areas of practice. Clinicians in transition receive intensive support and supervision while they build their competence, skills, knowledge and clinical reasoning skills.

Consolidation Scope encompasses a degree of competence, experience and skill that allows the clinician to work relatively autonomously in their work role. They feel confident in their role, have the ability to support others in their skill development and demonstrate effective clinical reasoning and reflective practice relevant to that work role.

Advance Scope of Practice: is a level of practice characterised by an increase in clinical skills, reasoning, critical thinking, knowledge, experience and complexity of service provision so that the practitioner is an expert working **within** the scope of established contemporary practice[1]

Extended Scope of Practice: is a level of practice which incorporates practice beyond the established, contemporary scope of practice. Competencies and training pathways for extended scope roles, for registered and self-regulating allied health professional groups, continue to be refined in South Australia[1]

Patient refers to service users who utilise allied health services. For the purpose of these profiles, patient includes client, consumer, service user, customer and other similar terms

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[1] Scope of Practice Roles in SA Health Policy Directive.

Allied Health Common Core Practice Profile[2]

	Allied Health Assistant	Transition Scope	Consolidation Scope	Advanced Scope	Extended Scope
Assessment	Gathering of background information from case notes/patient to support clinical assessment Gathering routine information from clients, family and service providers Assists AHPs with clinical assessments as directed With appropriate competency based training, conducts basic screening assessments Prepares assessment resources/equipment for instrumental assessments and assists AHPs with equipment operation	Complex, comprehensive assessment of patient needs relevant to clinical need with supervision Critically analyse assessment findings in relation to clinical care needs and liaise with team to set priorities and plans with supervision Making valid interpretations of assessment findings based on sound clinical reasoning Use of appropriate evidence based tools Undertakes assessments in order to plan for therapy goals, ongoing care needs, potential to regain independence and suitability for rehabilitation or suitable early intervention approaches Is an active member of the Multi-disciplinary team in assessment, goal planning and discharge planning	Complex, comprehensive assessment of patient needs relevant to clinical need Critically analyse assessment findings in relation to clinical care needs and liaise with team to set priorities and plans Application of a wide range of assessment and therapeutic interventions to clients with complex needs Reviewing and incorporating relevant evidence and/or accepted best practice into the assessment and management of patients	Specialised assessment of patients	Highly complex and specialised clinical assessment, may take on roles of other professional groups relevant to area of specialty
Case management/ Care coordination	Assisting with the making of appointments and liaison with other community agencies. Arranging client appointments, making routine reminder calls and following up patient non-attendances as appropriate Monitor patients who are stable and awaiting service provision and provide updates and information as it becomes available Monitor patients in community settings and provide updated information to allied health professionals as available	Actively contribute to ward rounds and/or clinical meetings Contribute to multi-d problem solving Effective communication with patients, carers, and relevant other personnel involved in patient care to facilitate improved health and discharge outcomes Contributes to case management processes providing information based on outcome of comprehensive assessment in conjunction with input from patient, family, carers, multidisciplinary team and service providers.	Manages complex case coordination Liaising with other Health Professionals on matters relating to patient care by communicating with the relevant staff and relevant others, as necessary, to ensure patient assessment and treatment by clinician is coordinated and appropriate	Coordinates care of highly complex patient groups Coordinates case coordination over multiple services in highly complex and volatile client/clinical environments	
Intervention	Assisting with, and participating in group and individual intervention programs. Assisting with inpatient & outpatient services. Preparing and maintaining therapy rooms/materials and packing up/cleaning therapy rooms/resources as required Carrying out of predetermined programs with patients with direct/indirect supervision Preparing patients for therapy Monitoring patients response to intervention	Complex, multifaceted interventions across a range of clinical areas based on clinical need with supervision Run preprogramed therapy groups for patients in conjunction with other team members or with indirect supervision Goal setting with patients and carers to ascertain therapy priorities and methods Delegating appropriate tasks to assistants ensuring that dedicated tasks are performed	Treatment planning for intervention/support services based on comprehensive assessment Specialised, complex, multifaceted interventions using evidence based practice	Undertakes evidence based practice reviews and critical analysis to determine best practice for a given specialised area or generalist team. Provides direction in regards to intervention strategies, practices and evidence for an allied health department or specialised area Developing new intervention methods based on evidence based practice, technology,	

[2] All Allied Health Professionals will include these core services in their role

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	and modifying to a limited extend to meet patients level of function Liaising with clinicians regarding patient progress and their response to interventions Making of therapy resources Preparing therapy services, rooms, resources etc. Escorting and/or organising transport for patients to/from therapy areas	safely and effectively Sets therapy goals and implements appropriate management/therapy, counselling and education to patients and carers with non-complex needs. Provides programs for AHAs		patient needs and available resources	
Interdisciplinary care	Articulate role in interdisciplinary team and assist as required	Articulate role within interdisciplinary team Seek support from senior members of team as required Working collaboratively with members of other disciplines within the hospital or community setting Contribute effectively to interdisciplinary team planning regarding care and treatment of client Attending and actively participating in ward rounds and/or client meetings	Participate in interdisciplinary clinical and planning activities		
Service provision /Coordination	Disseminating information to patients Sending/receiving referrals completed by clinician Following up on support services on request Maintains patient appointment scheduling including associated booking system requirements, transport etc.	Managing complex needs of patients, carers and families as relevant to caseload with support Identifying required support services Making referrals to support services Contacting support services and other systems to coordinate and collaborate regarding service provision Ensuring appropriate clinical handover for patients being transferred to the care of other professionals using appropriate tools and guidelines relevant to organisation Advising and liaising with external organisations which may require exchange of information on patients to ensure appropriate care of patients by a variety of communication processes involving professionals, family and/or relevant others	Managing complex needs of patients, carers and families as relevant to caseload Manages discipline staff resourcing, goods and services to ensure service needs are met which ensure optimal outcomes for patients, carers and families, other consumers/stakeholders	Developing service delivery models/services/clinics based on unmet need Evaluating service delivery models/services	
Advocating		Provides an integrated approach to patient management through counselling, discussion, educating and training patients, families, carers and staff in specific techniques to be followed Liaises with families/carers, other health	Advocating for clients and their family within the hospital and when referring to community services and other agencies Encouraging the active participation of patients and their families/ carers in their assessment and treatment, enabling them to achieve the optimal level of independence		

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		service staff and relevant community service agencies with regards to assessment findings and recommended management plans. Advocates for clients and their family in order to access appropriate ongoing management e.g. referral to community services and agencies	Implements new initiatives which improve outcomes for patients, families and / or community, involving consumers in consultation and development of relevant policies and procedures		
Discharge planning	Delivering resources or information to patients Giving routine information about services in the community	Makes referrals to external service providers and coordinates care for discharge Referrals are accepted and responded to by community agencies Ensures relevant and appropriate clinical handover and completion of appropriate discharge documentation Contacts support services to coordinate service provision Contributes to complex discharge planning	Leads complex discharge planning	Applies expert clinical knowledge in regards patient care to ensure safe and sustainable discharge across a range of highly complex patient needs	
Documentation	Assisting the inpatient staff by helping to prepare documentation and supportive resource information. Documentation in medical records, and written and verbal reporting on intervention Document service provision/ education/ resources/ equipment provided to patients Documents clinical handover to other care providers using established systems Adheres to minimum standards for documentation	Documented evidence of intervention in case notes Document assessment findings, intervention outcomes, discharge plans, family/carer needs/concerns, ongoing needs and potential barriers for discharge/recovery	Provision of high quality written reports/assessment to be included in case notes Completes appropriate documentation as per allied health, discipline and service guidelines	Writes proformas, guidelines and standards for documentation Support staff with complex documentation needs Document data, patient outcomes, discharge planning outcomes, barriers to discharge etc for management or hospital wide committees	
Supervision	Participates in direct and indirect supervision activities	Participate in supervision, performance appraisal, professional development, clinical reflection Supervise students as appropriate Seeking guidance and supervision from experienced staff when more complex problem solving , professional decision making and practice skills are required	Participate in supervision, performance appraisal, professional development, clinical reflection Supervise students and clinical staff as required Provide professional supervision and management to clinicians within team	Participate in supervision, performance appraisal, professional development, clinical reflection Supervise supervisors Coordinate and supervise student supervision program Conduct performance appraisals	
Quality assurance /Risk	Collection and analysis of data to provide information on patient progress or services Participation in team quality activities, research and evaluation Maintaining required statistics, recording accurate and timely workload data Develops resources e.g. handouts	Participating in quality improvement activities, research and performance enhancement programs Contributing to the development of departmental and organisational procedures and policies Actively promote contribution of allied health	Participate in quality management, quality assurance and risk management activities Contribute to service development Encourage and foster positive culture and safe work environment Work in collaboration with other health	Develop and implement quality, risk management projects and monitor quality of service provision Develop and maintain an appropriate system of referral and work allocation ensuring equitable distribution of workload within the team	

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		staff to the delivery of high quality health care Contribute to service development and planning Evaluate own practice	professionals to achieve optimal client outcomes Develop and foster a culturally appropriate, respectful and safe work place	Developing and maintaining team priority setting Monitoring workloads and practice standards through regular supervision Represent team/service at working parties/committees as required Conducting relevant research and promulgating the results Leading and supporting team members in conducting research and evaluation activities	
Professional Development	Maintaining and developing knowledge and skills in relation to position requirements Undertakes Credentialing / competency training for advanced AHA roles e.g. swallow screening.	Maintaining and developing clinical and professional knowledge and skills Participating in departmental and organisational professional development programs Complete annual professional plan and training as required to maintain registration/professional association membership as required	Professional development undertaken and where relevant, current approaches are integrated into clinical practice Understand and identify professional strengths, limitations and challenges Complete annual professional plan and training as required to maintain registration/professional association membership as required		
Education / Research	Support group work planning and interventions Prepare for education sessions as directed by clinician Provide research support to implement research projects such as collection of data	Contribute under direct supervision to development of research proposal Conduct literature reviews to support research proposal Collection and collation of data Run pre-prepared education sessions for patients and their families/community members/staff	Develop a research proposal and implement with direct support Conduct research into current practice standards Run education sessions/clinics/presentations on a range of topics relevant to clinical expertise for staff, consumers, community groups, students	Provide education to other health professionals in relation to advanced roles and tasks Developing an education strategy for a local health network or department Lead research projects requiring ethics approval, organisational support or specialised research skills	Provide education to other health professionals in relation to extended scope roles and tasks
Equipment Provision	Maintains equipment required for services Assists therapists in the issue and adjustment of equipment/aids for patients Assists clinicians in operation of equipment for instrumental assessment. Cleans and maintains clinical equipment. Key equipment reprocessing including cleaning and high level disinfection of clinical equipment with appropriate training. Assists with ordering and supply of patient equipment and general clinic supplies				

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Social Work Specific Practice Profile[3]

The social work profession facilitates social change and development, social cohesion, and the empowerment and liberation of people. Principles of social justice, human rights, collective responsibility and respect for diversities are central to social work. Underpinned by theories of social work, social sciences, humanities and indigenous knowledges, social work engages people and structures to address life challenges and enhance wellbeing[4].

Social workers in health care provide a unique and multidimensional service to patients. They are concerned with the social, cultural, economic, psychological, emotional, political, legal and environmental factors affecting the health and wellbeing of individuals. They work with people who are vulnerable because of physical, emotional, psychological or environmental difficulties as work to maximize their recovery with the broader healthcare team[5].

Social Work	Allied Health Assistant	Transition Scope	Consolidation Scope	Advanced Scope	Extended Scope
Engagement	Positive engagement of clients	Tunes into client issues Actively engages clients in variety of settings with understanding of verbal and non-verbal cues Uses empathy, genuineness and respect Builds rapport with client in assessment phase	Tunes into client issues from prior information before seeing client Exhibits range skills and qualities that allow clients to build trust quickly Engage and draw out client on taboo topics	Ability to successfully engage non-voluntary clients Minimises power differential in relationships through working in client centred partnership	
Assessment	Assess eligibility of patients for financial assistance from the hospital and external agencies Triage of "walk ins"	Effective and efficient psychosocial assessment with indirect supervision Use of appropriate evidence based tools Assessment of psycho-social/emotional/mental health issues under indirect supervision Awareness of cultural or family of origin factors on functioning	Conduct comprehensive biopsychosocial assessments of complex psychosocial/emotional/ mental health issues including understanding and engagement of cultural and/or family of origin factors in functioning of client system Treatment planning for intervention/support services based on comprehensive assessment Apply a wide range of assessment and therapeutic interventions to clients with complex needs Critically analyse/evaluate clinical care issues Uses & articulates coherent assessment framework	Assessment of highly complex and multiple psycho-social/emotional/mental health issues, including risk assessments in collaboration with psychiatric services	
Case management /Care coordination	Monitor patients who are stable and awaiting service provision or residential care placement and provide updates and information as it becomes available Routine reviews using structured questioning for country patients awaiting transplants etc.	Case management role is undertaken within the multidisciplinary treatment team in relation to complex discharge planning needs Coordinate/initiate case meetings where necessary	Case management role is undertaken within the multidisciplinary treatment team in relation to complex discharge planning needs	Case management of 'high stakes' patients, potentially in collaboration with less experienced workers. e.g. DSA patients requiring housing Specialised skills in psycho-geriatric issues	
Intervention					
Service provision/ Coordination	Maintaining good networks with external welfare agencies	Identifying and arranging required social support services Apply ethical decision-making skills to issues specific to clinical social work	Formulation of effective intervention plans in partnership with the client Managing complex social support needs for patients, carers and families Uses judicious self-disclosure to aid intervention	Coordinating and advocating for support services for entire groups of patients, i.e. the stranded patient, young disabled etc. Provide consultation and education on psycho-social issues to other team members	

[3] Specific Social Work roles will provide a range of these core services
[4] Australian Association of Social Workers (AASW) 2013, What is social work? Accessed online 27/8/2015 https://www.aasw.asn.au/information-for-the-community/what-is-social-work
[5] Australian Association of Social Workers Queensland (AASW QLD) 2014, Queensland branch position paper on the role of social work in health care, accessed online 31/8/2015 www.aasw.asn.au Canberra, Australia

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				Developing new support services in conjunction with service providers based on clinical needs of patient groups	
Accommodation	Coordinating residential care placements Communicating with housing services for waitlisted patients awaiting accommodation	Referring to SACAT, Housing SA and other accommodation organisations as required	Managing patients, carers and families with complex accommodation needs	Managing the accommodation needs of an entire patient group with highly complex needs	
Grief, loss, adjustment assessment and support	Provides practical support in response to social work request Disseminating pre-packaged information Communicating grief and loss issues to social worker	Assessment of grief and loss issues with support of supervisor Provision of basic counselling and support	Provision of simple/complex grief, loss or adjustment assessment and support	Management of complicated/unmanaged grief, loss, adjustment matters Addressing issues of chronic sorrow associated with grief and loss	Management of maladjusted/ multiple/ cognitive-behavioural grief, loss or adjustment assessment and management
End of life (EOL) planning	Dissemination of information packs Assisting patients/carers/families lodge necessary paperwork	Educating patients, carers and families about advanced care planning/directives Assisting families to understand and prepare for bereavement, where to locate community resources, how to ask for assistance, and navigate the government and non-government organisation (NGO) systems following death Assisting patients and families to develop Advanced care directives and resuscitation plans as required with supervision	Supporting families/carers where there is no advanced care directives and the patient does not have capacity to make their own decisions Supporting/advocating families/carers to enact advanced care directives Supporting staff to undertake crucial conversations regarding EOL and preparation for death and withdrawal of care, case conferencing participation Assisting patients and families to develop Advanced care directives and resuscitation plans as required Provision of education regarding EOL	Training and educating all staff within scope of practice in how to undertake sensitive conversations around EOL needs, preparation for death, withdrawal of life support, bereavement issues, risk factors for and indicators of complex grief in the caregiver/family member Working across services and community to promote the need for EOL preparation in all age groups Working in partnership and developing initiatives to promote EOL issues across services and communities	
Patients who have attempted or plan to attempt suicide		Mental state examination with support as required Identifying services/ care in place	Assessment, intervention, support and referral for patients who have attempted suicide or who plan to attempt suicide Comprehensive Mental State Examination and monitoring		
Child safety and wellbeing	Mandatory notifier	Staff are aware of their legal obligations to report a high risk pregnancy/birth of infant and suspicion of child abuse/ neglect Recognise signs and symptoms of abuse or neglect Accurate reporting of suspected child abuse/ neglect to Families SA as required	Providing assessment and support for children and families with child protections issues Communicating with Families SA and child protection services re patient/family needs, concerns and plans Organising and coordinating Case Conferences regarding child protection issues Coordinating communication and liaison between acute sector and Families SA and/or child protection agencies services Engagement of parents/carers of high risk infants/children (including unborn) to develop safety plans for infant/child Knowledge of child protection system and processes including Youth Court Orders, Investigation and assessment orders, Removals of infants/children and Guardianship of the Minister processes	Specialised skills in relation to child, youth and adult mental health Engagement of disengaged non-voluntary parents/carers of infants/children to ensure develop safety plans for infant/child Therapeutic interventions to improve parenting capacity and reflective function in care of high risk infants/children Identifying and developing solutions to system level gaps around child protection Providing training to other staff about child protection issues	Able to support/advise other professionals on child protection issues

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			Collaboration with Families SA to ensure effective safety plans for high risk infants/children upon discharge from health services		
Trauma / Crisis	Disseminating pre-packaged information Sourcing and stocking of trauma information packs	General support to victims/ families/ carers	Counselling/debriefing/supporting patients, carers and families following trauma	Supporting multidisciplinary team members who have been exposed to trauma directly or indirectly Supporting patients, families, carers, members of the public following major/multiple trauma Specialised expertise in working with trauma across the age spectrum which contributes to better outcomes for individuals and communities Providing high level SW services entailing crisis intervention, social assessment, therapy and counselling techniques, negotiation and mobilisation of community resources Participate in counter disaster activities and training as required	
Severe loss of capacity/decision making abilities		Identification of potential capacity issues Referring to South Australian Civil and Administrative Tribunal (SACAT) and coordinating SACAT process where necessary	Coordinating multidisciplinary assessment of capacity and making recommendations for care needs/legal advocacy Coordinating/negotiating guardianship/power of attorney responsibilities		
Homelessness	Disseminating pre-packaged information	Referring to homelessness services	Providing comprehensive assessment of patient needs and issues relating to homelessness Linking patients with support services		
Victims of crime		Identifying potential victims of crime and reporting to supervisor	Supporting in the reporting of crimes Advocating for victims of crime as required Providing counselling services		
Lack of family support/complex family issues		Identifying complex family/carer needs Supporting patients/ carers/ families with indirect supervision	Coordinating/ supporting family mediation/discussion		
Domestic/ family violence / Abuse of vulnerable patients/ carers		Identifying domestic/family violence/abuse and reporting to relevant senior social worker for support in management and assessment Undertake risk assessment and referral with support of senior social worker	Providing counselling and support to victims of abuse Advocating for victims of abuse in relation to service provision, accommodation, criminal charges etc. Undertake Domestic violence risk assessment and referral Undertake Family Safety Framework Assessments	Specialised skills in relation to child abuse, neglect, elder abuse, domestic and family violence	
High level stress of vulnerable patients/ carers			Assessment of psycho/social/emotional needs and stressors Identification of stress management strategies Coordinating family/carer/patient needs in regard to stressors		

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Alcohol and Other Drugs (AOD)	Disseminating pre-packaged information	Screening for AOD issues Referring to AOD services	Providing comprehensive AOD assessment, counselling, case management, treatment planning and discharge planning		
Advocating	Ensuring patients receive financial services and benefits to which they are entitled to with reducing the impact of hospitalisation and ongoing care	Provide clients and family members with information on rights, benefits and available services including contact with appropriate community resources and support groups to assist in social integration Optimising client and carers use and access to health, government and community resources Counselling and implementation of intervention plans Advocating for clients and their family within the hospital and when referring to community services and agencies and ensuring the relevant information about client and carer needs is exchanged	Advocating for clients and their family within the hospital and when referring to community services and agencies	Provide psychosocially complex case support and education across all disciplines	
Discharge planning	Coordinate residential care placements, community packages and service for patients who are awaiting discharge from hospital and have been referred by a social worker	Conduct complex discharge planning with a strong focus on advocating for the patient, their family, carers and other stakeholders Facilitate and support patients and significant others in the move to residential care Organise referrals to community agencies and resources for financial, legal, home care, counselling, rehabilitation and other services as required Liaising with welfare officers and providing information to clients and their families to make decisions about supported accommodation options	Conduct highly complex discharge planning with a strong patient/family/carer focus Support assistant and social work staff with their complex discharge planning cases Provide a flexible, innovative approach to discharge planning and responds to various hospital/health service demands as required	Support groups of patients who are ‘stranded’ or who have highly complex needs with a hospital wide or regional approach to coordination and resource allocation	Criteria led discharge in emergency or mental health units
Documentation	Document progress with residential care placement, service provision or information/education given to patient/family	Document social work assessment findings, intervention outcomes, discharge plans, family/carer needs/concerns, ongoing needs and potential barriers for discharge/recovery Document family meeting minutes/notes/plans/outcomes Document reports high level committees and groups including guardianship, child protection, mental health orders etc.	Document high level reports regarding patients with complex needs and issues advocating for resource intensive services or funding	Formulate report proformas and templates. Support staff with complex documentation needs Document data, patient outcomes, discharge planning outcomes, barriers to discharge etc. for management or hospital wide committees	

Version Control and Change History

Version	Date From	Date to	Amendment
V1	September 2017	September 2020	

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