Dynamic role boundaries in intermediate care services

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Summary This paper examines the impact of intermediate care service delivery on the role boundaries of service providers. Two intermediate care teams were selected as case studies to explore the roles of workers in the context of an admission avoidance and assisted discharge service. Data were collected through semi-structured interviews with 26 intermediate care staff, including physiotherapists, occupational therapists, nurses, a social worker and support workers. The study found that therapists’ roles were most closely aligned with each other, whilst nurses perceived their roles as being distinct from therapists, with a more medical emphasis. Therapists and nurses delegate a range of tasks to support workers, although the nature of task delegation differed across the two teams. A number of factors were associated with the role flexibility of staff including the setting, duration and nature of care, access to alternative care providers and the ability of staff to undertake joint visits. Contrary to previous research, the practitioners were not threatened by overlapping roles, and recognised that confidence in their own roles and an understanding of the roles of other workers was necessary to avoid feeling threatened. The study concludes that intermediate care can promote role overlap across a range of workers. Role overlap can enhance clinician confidence in their own area of expertise whilst optimising patient care. Role overlap has the potential to optimise limited staff resources in an interprofessional working environment. Interprofessional working can be enhanced in the workplace through joint visits and shared working practices.

Key words: Role boundaries; intermediate care; physiotherapy; occupational therapy; nursing.

Introduction

Intermediate care services have grown rapidly in the UK in response to recent policies that emphasise new approaches to care for older people (Department of Health, 2001a,b,c). Most intermediate care services have evolved in the context of the NHS ‘Modernisation’ philosophies of care which include joined up, flexible, seamless, patient centred care, and interdisciplinary working (Department of Health, 2000a,b, 2002b,c,d). Thus, they present an ideal setting to examine the impact of new ways of working on clinician roles and boundaries. To date, research has emphasised the importance of intermediate care on service and user outcomes (Forster et al., 2002; Griffiths et al., 2001; Peet et al., 2002; Shepperd & Iliffe, 2001;
Steiner et al., 2001), but the impact of intermediate care services on staff roles and needs has received little attention.

There is no clear understanding of who makes up the intermediate care workforce or the roles that staff are required to perform (Nancarrow & Mountain, 2002). This makes it difficult to know how many workers in each field should be trained and what their training needs are.

This research examined the impact of intermediate care on the roles and role boundaries of workers involved in two teams; an admission avoidance and assisted discharge team in South Yorkshire.

Background

The dynamic nature of health and social care service provider roles is receiving increasing attention. Current policies support increased workforce flexibility through initiatives such as the skills escalator and interprofessional working (Department of Health, 2000a,b, 2002a). Workload studies have shown that most professionally trained staff, including nurses, doctors and allied health professionals, spend a high proportion of their time performing tasks that do not require their expertise or experience (Richardson et al., 1998). Increasingly, tasks are being delegated from highly skilled, high cost workers, to less qualified, lower cost workers. Additionally, many roles can be undertaken by more than one provider, creating opportunities for role overlap in some settings.

The nursing and medical workforce has received the greatest attention regarding flexible workforce roles (Jenkins-Clarke & Carr-Hill, 2001). The changing boundaries between other types of workers have undergone less scrutiny.

There has been no empirical evaluation of the nature or extent of task allocation or substitution in intermediate care services, although examples from other models of care are relevant. The existing literature is largely qualitative and descriptive in nature.

Brown et al. (2000) undertook a comparative study of three interdisciplinary community mental health teams to identify their perceptions of role boundaries. The teams included psychiatrists, psychologists, occupational therapists, social workers, community mental health nurses and mental health support workers. Participants identified two broad types of boundaries. The first were the management boundaries, where non-hierarchical management structures meant that team members were occasionally required to undertake management tasks, such as chairing meetings. Some team members felt that they did not have adequate skills to perform these tasks. The second was ‘role’ boundaries, which reflected a blurring of professional values and, in some cases, an overlap in roles. For instance, social workers perceived that the move to the interdisciplinary team meant that their health colleagues had accepted their greater emphasis on social needs in the delivery of care, reflecting a shift in the values of the team. Other providers also reported a tendency for roles to overlap, for instance, occupational therapists adopting nursing roles and vice versa.

An exploratory study by Booth and Hewiston (2002), of physiotherapists and occupational therapists in an in-patient stroke rehabilitation unit found that there was role overlap between the two disciplines in this setting, particularly in the management of physical functioning and transfers. Joint training of health professionals was raised as one factor that contributed to role overlap. However participants felt that different philosophical backgrounds meant that their approaches to care were not the same. Practitioners reported less anxiety about role overlap when a collaborative treatment approach was used (Booth & Hewiston, 2002).

The studies by Brown et al. (2000) and Booth and Hewiston (2002) both reported mixed perspectives from staff on the impact of role overlap on the benefits to the patient whilst
threatening professional role identity. A common feature of both studies was the difficulties defining the roles of particular professional groups. Role ambiguity has also been reported in nursing and speech and language therapists involved in rehabilitation (Needham, 1997; Webb et al., 2002).

Input from more than one therapist is seen as a normal part of the rehabilitation process by many intermediate care practitioners and a certain amount of overlap of roles between team members is seen as acceptable (Nancarrow, 2004; Plant et al., 2001). However, some perceive that newly qualified staff may be at risk of loss of professional identity and role ambiguity if they entered a setting with high levels of role overlap (Nancarrow, 2004).

The purpose of this paper is to describe the impact of intermediate care on role boundaries across two types of intermediate care teams. In particular the study examines the types of role boundaries that exist and the factors that impact on changing role boundaries.

**Method**

This study utilised an exploratory approach to examine the perceptions and experiences of staff regarding their roles in intermediate care service delivery.

To enable the exploration of staff roles in the context of the whole team, two case study services were chosen. The sites were chosen on the basis of the length of time the services have been in operation and the types of intermediate care service delivered. Previous literature indicates that a minimum of 18 months is required for team formation (Sanderson & Wright, 1999). Thus, services were chosen that had been in operation for longer than 18 months. An admission avoidance (‘Rapid Response’) and supported discharge (‘Hospital at Home’) service were selected to provide a basis for comparison between teams with different types of remit. To reduce the likelihood of confounding from extraneous contextual factors, the services were chosen from the same Primary Care Trust, so that they came under the same management remit.

A number of approaches to team selection could have been used. However the limited literature on intermediate care workforce development that is available indicates that there is unlikely to be a ‘typical’ intermediate care team (Nancarrow & Mountain, 2002; Vaughan & Lathlean, 1999). The two teams have been explored to examine factors that may be of relevance to other intermediate care teams, but as is the case with case study research, the findings need to be interpreted in terms of their relevance to the context in which they are to be applied (Stake, 2000).

The primary methods of data collection were interviews with staff and access to documentary evidence about the teams, including job and service descriptions. Interviews were used to establish the core roles and skills of the worker, perceptions of shared roles and skills and the delegation of tasks to other workers.

Ethics and research governance approval was obtained through the appropriate committees.

**Analysis**

All interviews were tape-recorded and the data transcribed for analysis. The Spencer and Ritchie qualitative ‘framework’ was used. ‘Framework’ involves a systematic process of familiarisation of the data; identifying a thematic framework; indexing the themes; charting those themes into a hierarchical framework; then mapping and then interpretation of those themes (Ritchie & Spencer, 1995).

Verbal and written reports were provided to the team members for verification to ensure the accuracy of the interpretation of the data and to ensure that no staff member felt compromised in any way as a result of the outputs of the research.
Services and participants

Despite having the common label of ‘intermediate care’, the Rapid Response and Hospital at Home teams present quite different organisational structures and needs (Table 1). These, in turn reflect different management requirements in terms of workforce planning, communication strategies, referral processes and handovers. The implications of the team differences are summarised in Table 4.

All staff employed by the two intermediate care teams were eligible to participate in the interviews. The normal staffing of both teams is summarised in Table 2.

The large numbers of support workers meant that not all were interviewed instead, a sample were interviewed, based on their availability, until no new themes were raised by staff in either team (Table 2). Similarly, not all staff nurses in the Rapid Response team were interviewed. All of the therapists and senior nurses in each team were interviewed (not all therapy positions were filled at the time of the interviews). In total, twenty-six staff were interviewed (Table 3).

Findings

All interviewees were asked whether their roles overlap with other members of the intermediate care team, and if so, to describe how their roles overlapped. The data were interpreted to identify how role overlap occurs in intermediate care; staff perceptions of role overlap; and to examine the barriers and facilitators of role overlap in this setting. The key differences between the two teams are summarised in Table 4, and described below. A number of factors that influence role boundaries in the delivery of intermediate care emerged from the two case studies which are summarised in Table 5.

<table>
<thead>
<tr>
<th>Table 1. Service descriptions</th>
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<tbody>
<tr>
<td>The services</td>
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<tr>
<td>Purpose</td>
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<tr>
<td>Established</td>
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<tr>
<td>Manager</td>
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<tr>
<td>Service capacity</td>
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<tr>
<td>Referral sources</td>
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<tr>
<td>Duration of care</td>
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<td>Location of care</td>
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<td>Other</td>
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<table>
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<th>Table 2. Intermediate care staff members</th>
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<tr>
<td>Type of worker</td>
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<tr>
<td>Physiotherapist</td>
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<tr>
<td>Occupational therapist</td>
</tr>
<tr>
<td>Support worker</td>
</tr>
<tr>
<td>Social worker</td>
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<tr>
<td>Nurses (RGN)</td>
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<tr>
<td>Secretary to intermediate care services</td>
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</tbody>
</table>
Role overlap

Two types of role overlap were observed. ‘Qualified staff’ (nurses, physiotherapists and occupational therapists) identified areas of overlap across the roles of the other disciplines. This is described as horizontal substitution, where a discipline moves outside of its traditional boundaries to adopt tasks that are normally performed by other health service providers, or inter-disciplinary change.

Vertical substitution was seen through the delegation of traditional nursing and therapy tasks to support workers. Additionally, most qualified staff had adopted some management roles, which could be seen as a form of vertical substitution from managers to non-managers.
Horizontal substitution occurred between therapists and nurses across both teams, however the two models of care presented different opportunities for role overlap. In general, therapists had the greatest areas of overlap whereas nursing roles were seen as being more discrete. Nurses described their role overlap more in terms of overlap with other nurses and nurses in both teams described their roles as being separate from therapy roles. Nurses perceived that they were responsible for the management of the medical needs of the patient, and that the therapy needs were clearly the remit of the therapists.

I wouldn’t be led down the path of making physio decisions or OT decisions. I think that’s where your experience and your confidence in yourself and acceptance of your own limitations and not compromising safety (nurse 2:187).

<table>
<thead>
<tr>
<th>Item</th>
<th>Influence</th>
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<tr>
<td>The setting of care</td>
<td>All practitioners had to extend their roles in the client’s home as they are often the ‘solo practitioner’ in that environment. The goals of patients at home tend to reflect their environment, and cannot always be clearly separated into nursing, physiotherapy or occupational therapy goals. The lack of dedicated equipment in the home reduces the clear delineation of rehabilitation roles. For instance, the home, not the gymnasium, becomes the setting for rehabilitation.</td>
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<tr>
<td>The duration of care</td>
<td>The longer duration of care in the Hospital at Home service (4 – 6 weeks) provided a greater opportunity for more delegation of tasks to support workers as well as more joint visits between therapists. In Rapid Response, client needs changed more rapidly, requiring more regular input from qualified staff, leaving the support workers with more caring than rehabilitative roles.</td>
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<tr>
<td>Staff training approaches</td>
<td>Support worker training was led by the physiotherapists and occupational therapists, and this was reflected in the roles of the support workers.</td>
</tr>
<tr>
<td>Availability of staff</td>
<td>Role overlap and delegation enables workers to compensate for other staff shortages. The roles of the more scarce staff groups tend to be adopted by the more abundant staff.</td>
</tr>
<tr>
<td>The nature of the tasks</td>
<td>Areas requiring high levels of clinical expertise or knowledge tended to be owned by the therapists or nurses, such as specialist patient assessments, the management of medical needs such as medication and intravenous drips, and any ‘hands on treatment’. These were the areas that were not delegated to support workers, and not subject to horizontal substitution. Tasks that were easily delegated to support workers tended to be more manual and could be undertaken with a small amount of training or through clear documentation in the patient’s file. Some of the nursing tasks delegated to support workers required a small amount of expertise and experience, as well as interpretive ability, for instance, blood pressure monitoring and blood glucose testing. Safety was a consideration of practitioners in their delegation of tasks to support workers.</td>
</tr>
<tr>
<td>Joint visits</td>
<td>Joint visits facilitated shared treatment approaches across physiotherapy and occupational therapy. The support workers said that they learnt a variety of skills from watching other clinicians, including the therapists and ambulance service.</td>
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*Horizontal substitution*

Horizontal substitution occurred between therapists and nurses across both teams, however the two models of care presented different opportunities for role overlap. In general, therapists had the greatest areas of overlap whereas nursing roles were seen as being more discrete. Nurses described their role overlap more in terms of overlap with other nurses and nurses in both teams described their roles as being separate from therapy roles. Nurses perceived that they were responsible for the management of the medical needs of the patient, and that the therapy needs were clearly the remit of the therapists.

I wouldn’t be led down the path of making physio decisions or OT decisions. I think that’s where your experience and your confidence in yourself and acceptance of your own limitations and not compromising safety (nurse 2:187).
This distinction was greater in the Rapid Response team, where nurses saw their roles as distinctly medical. Where they did undertake therapy roles it was for practical reasons, such as the lack of after hours therapy staff.

One exception to this was an E-grade nurse in Rapid Response who had learned how to assess basic equipment needs of patients through previous work with occupational therapists in the Hospital at Home team. This was important in the prevention of unnecessary placements of patients. The same nurse felt that a lack of physiotherapy assessing skills at the initial assessment could lead to unnecessary placements.

Because if I know a patient can mobilise, I’m going to potentially keep them at home. The difference—not having a physio assessment until the next day, I might have placed the patient somewhere... but if it’s a Friday, you know it’s going to be two days until they’re assessed by the physio... If I’d not had my Hospital at Home experience, I would be placing a lot more patients (nurse 12:230).

The sole social worker did not report role overlap to the same extent as the nurses or therapists. Her role was dominated by assessments and coordination of client care. However, one of the nurses in the Hospital at Home team reported that his assessment and care coordination role required social work skills.

Areas of occupational therapy and physiotherapy overlap included mobility, manual handling and components of kitchen assessments.

Physios are wiping down the benches, washing the pots, looking at the activities and things (occupational therapist 1:240).

Similarly, physiotherapists reported taking on roles that are traditionally the domain of occupational therapy such as washing and dressing, and in some cases, dealing with aspects of memory and cognition.

The ability to discuss issues with clinicians from other disciplines provided staff with a range of perspectives on care. For instance physiotherapists and occupational therapists said that they examine complementary aspects of the same component of care, such as mobility and developing independence in personal care, as illustrated by the following description by a physiotherapist of walking a client.

We’re looking to see if it’s functional, if there is heel strike, there is ground clearance, how well they’re walking. They’re interested in how they attempted to get from a to b and were successful in doing so (physiotherapist 10:208).

However, occasionally nurses and therapists reported that they had conflicting priorities in determining the goals of the patient. The following example illustrates the need for a shared understanding of the perspectives of other disciplines.

The physio might say this woman can walk fine, we can get her home with carers. Then again, we say her BGL is 20 odd, we can’t get her home until we get that stable. Yes but she can walk fine. So, for the therapy type patients, like the patient with TIA, then it’s good to get the therapist along. But for someone who’s unstable with blood glucose or nauseous and things like that, tends to be more nursing (nurse 13:328).
Reports of conflict were rare, however, and team members felt that they were able to negotiate differences without difficulty, and acknowledged the value of listening to the perspective of their team members.

Whilst therapy staff identified some areas of overlap with their nursing colleagues, they were clear about their own boundaries in the delivery of nursing care, as the following quote illustrates.

I would never take someone’s blood pressure or talk to them about, well I’d talk to them about medication but I wouldn’t give them advice on their medication (physiotherapist 3:191).

Therapists in both teams acknowledged that their knowledge of medication had increased by working closely with the nurses, which they felt was useful from a safety perspective. They said they would use this information to report back to the nurses or to the patient’s GP, but would not provide advice to patients.

Vertical substitution

Therapists and nurses delegate a variety of tasks to support workers. Support workers would only undertake therapy tasks after the patient had been assessed by the relevant therapist and the work had been formally delegated to them via written instructions in the patient’s notes. Table 6 summarises the roles of support workers in the two teams.

The boundaries of what could be delegated to support workers could not be clearly defined. Support workers said that they would undertake any task that was set them by qualified staff, but felt confident to contact the staff if they had concerns. In order for the qualified staff to determine what they could delegate, they had to know their own boundaries, and they assumed that the support workers would be able to do slightly less than they could do themselves. Having an awareness of their own limitations was acknowledged by support workers as an important boundary to their care:

You’ve got to be confident to say, I’m sorry, I know that Joe Bloggs could do such and such, but I can’t (support worker 7:120).

<table>
<thead>
<tr>
<th>Hospital at Home</th>
<th>Rapid Response</th>
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<tr>
<td>Support with dressing practice, stairs, kitchen tasks, speech therapy exercises</td>
<td>Install equipment, aids and adaptations</td>
</tr>
<tr>
<td>Promoting patient independence</td>
<td>Some physiotherapy/mobility support</td>
</tr>
<tr>
<td>Indoor and outdoor mobility practice</td>
<td>Support patients washing, dressing, personal hygiene, taking medication, blood</td>
</tr>
<tr>
<td>Feedback on patient progress</td>
<td>pressure and temperature</td>
</tr>
<tr>
<td>The identification of unmet patient need</td>
<td>Showering</td>
</tr>
<tr>
<td>Assistance with walking and dressing</td>
<td>Toileting</td>
</tr>
<tr>
<td>Moving and handling</td>
<td>Meal preparation</td>
</tr>
<tr>
<td>Supervision of medication—timing and doses</td>
<td>Blood glucose testing</td>
</tr>
<tr>
<td>Exercise programmes from the physio</td>
<td>Acumed</td>
</tr>
<tr>
<td>Follow the care plan</td>
<td>Sit with patients</td>
</tr>
<tr>
<td>Fitting equipment—toilet seats, bed levers, bath boards, zimmer frames, tap</td>
<td>Observe drips</td>
</tr>
<tr>
<td>extensions</td>
<td></td>
</tr>
<tr>
<td>Remove equipment</td>
<td></td>
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<tr>
<td>Do not do BPs</td>
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The physical requirements of the patient also dictated the delegation of tasks. For instance, a heavier patient may require two support workers.

There were some tasks that support workers would ‘never’ undertake. For instance, they were not involved in formal client assessments. However, they played a vital role in the informal assessment of patients, such as reporting changes in the status of the patient.

We go back to the office and say she’s having problems can we get anything for it. Such as a kettle. If it’s a great big kettle—can we get a travel kettle? (support worker 6:42)

**Clarity of role boundaries**

Interprofessional team working increased each discipline’s awareness of others’ roles. For instance, nurses were able to identify physiotherapy and occupational therapy needs, and the therapists were more likely to identify medical needs.

...(the nurse) was saying this lady needs a bed and other things—very OT focussed. He can spot problems and ask me to look at that—the same with physio (occupational therapist 5:281).

The increased understanding the roles of other workers enhanced clinicians awareness and confidence in their own role boundaries and areas of clinical expertise. Despite the overlap in roles, staff reported that they did not feel professionally threatened in any way.

I don’t think I could define it but there’s definitely certain parts of your job that no-one would touch, that’s why you’re a physio or a nurse. I don’t know how we know, but... I think it’s because you’re a team. Everyone communicates and talks without realising that there probably are definitions. It’s just that we don’t write them down (physiotherapist 3:209).

Therapists and nurses all specified the importance of having confidence in their own roles and core skills.

We’re all very aware of our core skills and things. As far as equipment and things go, physio’s go aargggh. We are much more adept and knowledgeable of the equipment side of things, how to go about getting equipment, perception and cognitive areas with individuals (occupational therapist 1:162).

Similarly, nurses were confident in their areas of care, and did not feel that therapists would attempt to impinge on their roles.

**Discussion**

This paper has identified some barriers and facilitators to role overlap in the intermediate care setting including the setting, duration and nature of care, access to alternative care providers and the ability of staff to undertake joint visits. This is by no means an exhaustive list, and presents findings from two case studies only. Other factors that are likely to influence the roles of staff members within teams include the attitudes and support by management, structures of team meetings and access to interprofessional education. Further research is required to investigate the importance of team structures and management on role boundaries.
Some role overlap is likely to be inevitable in most interdisciplinary team structures. As this study has shown, role overlap has the potential to benefit a range of stakeholders. It can optimise service provision and patient care by ensuring the appropriate placements of patients and the necessary support once they reach their destination of care. Role overlap has the potential to limit the number of different types of clinicians seen by a service user. Successful role overlap appears to both depend on, and enhance clinician confidence in their areas of professional expertise.

Contrary to findings in other studies, practitioners in this study were not threatened by role overlap. Confidence in their own core roles, and an understanding of the roles of other workers was necessary to avoid feeling threatened. The seniority of the therapy staff, and most nursing staff in this study means that clinicians are more likely to have confidence in their roles derived from previous experience. Settings employing more junior staff may need to provide support mechanisms to enhance professional confidence. Role overlap requires that staff have some degree of flexibility, an attribute which may need to be considered in the recruitment of intermediate care staff.

The case studies have illustrated that interprofessional awareness can be promoted in the workplace through joint working across disciplines. The interprofessional learning opportunities offered by intermediate care may benefit staff from other settings through short term rotations and clinical placements for undergraduate students.

The dynamic nature of the intermediate care workforce has implications for skill mix. Where tasks can be delegated to lower cost or less trained workers, it makes sense to do so, freeing more highly trained providers to undertake more specialised tasks. To achieve successful task delegation, workers require appropriate training to deliver the roles expected of them and confidence to know when they have reached the limits of their capability. Further research is required to determine optimal ratios of support worker staff to qualified staff in different intermediate care settings.

Acknowledgements

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References


