Metro South Health | Queensland Government

Better together

Developing a Comprehensive Learning Framework for Speech Pathologists in Chronic Cough Care: Utilising Entrustable Professional Activities to Enhance Clinical Capabilities

Dr Chloe Walton[1], Kelly Beak[2], Dr Tim Ryder [3], Marnie Seabrook[1] & Kristy Perkins[4]

1Speech Pathology Department, Logan and Beaudesert Health Service, Metro South Health, Queensland Health, Australia , 2 Clinical Education and Training, Queensland Children's Hospital, Queensland Health, 3 Respiratory Medicine, Division of Internal Medicine, Logan and Beaudesert Health Service, Metro South Health, Queensland Health, Australia, 4 Allied Health Services, Logan and Beaudesert Health Service, Metro South Health, Queensland Health, Australia.

Background

Chronic Cough (CC) affects up to 18% of adults and referrals place a significant burden on Respiratory Outpatient waiting lists. Given current Specialist Outpatient Department (SOPD) waiting list pressures, patients referred for a CC may be waiting longer than the recommended wait times for a specialist medical review. After seeing a Physician, up to 80% of CC patients are referred to a Speech Pathologist (SP) for further education and management of their CC

SPs are key members of the multidisciplinary team to help support CC care. SPs are allied health practitioners (AHPs) who possess the required skills and knowledge to support CC care. Queensland Health (QH) has numerous sites that have developed and refined models of care to support patients with CC. These sites have demonstrated how SPs can help reduce symptom burden and improve quality of life, while increasing activity and supporting the timely discharge of patients from hospital waiting lists.

SPs working with this clinical population have identified that further training and upskilling beyond that provided in undergraduate/ graduate entry masters programs is beneficial in providing quality care to CC patients. Therefore, a Learning Framework (LF) has been designed to support the knowledge & clinical skills for SPs providing CC care, supporting skill optimisation, improving access & consistency of clinical care provision to SP-led CC services across QH sites.

The concept of Entrustable Professional Activities (EPAs) was first reported in the medical training of doctors and are used to scaffold learning in health care. EPAs are defined as discrete, observable tasks that clinicians can be entrusted to perform independently once sufficient capability is demonstrated. The EPA uses a 6-level entrustment scale which helps guide clinicians and trainers to determine how much supervision/ support a learner requires when performing an EPA. The entrustment scale supports both learners and trainers to identify when a learner can perform an EPA independently by supporting scaffolding and building trainer trust in the learner's capability. EPAs have been used in the training of Allied Health clinicians e.g., Pharmacists to determine their readiness for independent practice and guide decisions on progression on entrusting tasks work-place setting during intern training.

Table 1. EPA level 6 entrustment scale

6 level EPA entrustment scale	
1	**Observe the EPA only** *The learner is allowed to observe but not perform the EPA, even with direct supervision.*
2	**Perform the EPA jointly with the supervisor** *The learner performs the EPA with the supervisor present and actively guiding*
3	**Perform the EPA with a discussion prior to and afterwards with the supervisor** *The learner performs the EPA with the supervisor immediately available, intervening only when necessary.*
4	**Perform EPA and seek support and feedback on occasion** *The learner performs the EPA independently, but the supervisor reviews all aspects afterward.*
5	**Perform the EPA independently** *The learner performs the EPA independently with occasional oversight or consultation.*
6	**Supervision of more junior colleagues conducting EPA** *The learner is trusted to supervise junior trainees performing the EPA.*

QH SPs have commenced using EPAs to support new skill development for beyond entry level skills e.g. Flexible Endoscopic Evaluation of Swallowing and Videofluoroscopic Swallow Study via LFs. This has allowed for uniform training of clinicians across the state, clear learning objectives and tasks for clinicians working in these instrumental clinics. It has therefore been identified that there is a need for a SP CC LF with EPAs to standardise the knowledge and skills of SPs, to ensure consistency of care and access to SP-led services across QH sites.

Acknowledgements:
Office of the Chief Allied Health Officer (OCAHO) Model of Care Grant 2024/2025
Logan Beaudesert Health Service, Metro South Health
CC Project Steering Committee

Contact: Chloe Walton (chloe.walton@health.qld.gov.au) & Kelly Beak (SPCEP@health.qld.gov.au)

Aim: To create a comprehensive LF for SPs in CC care, utilising EPAs to enhance clinical capabilities through various learning methods, including online resources and integrated training pathways.

Methods

To develop a comprehensive CC LF for SPs, a structured approach using EPAs was employed. The methodology involved a multi-step process:

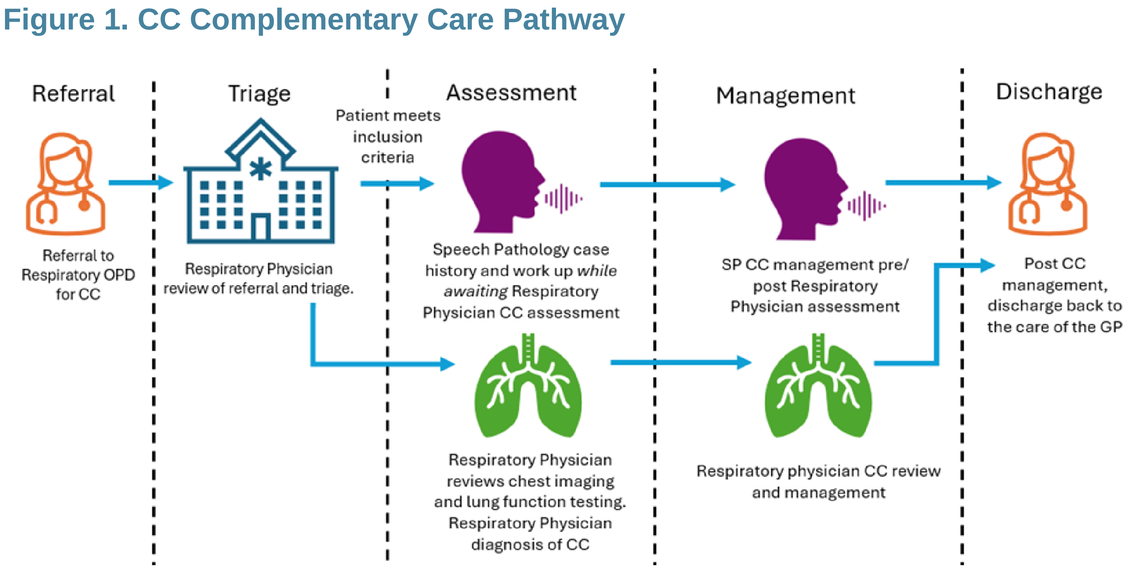
1. Identification of CC Clinical Pathways: Three distinct CC care pathways relevant to SP-led CC management were identified through consultation with clinical experts and review of current service models across QH sites.

2. Task analysis & mapping: Core clinical tasks were mapped for each pathways, focusing on assessment, diagnosis, and treatment components specific to CC. This included both foundational and advanced practices, reflecting the varied scope of SP roles. Each task/ clinical element was reviewed to determine the underlying knowledge, skills, and experience required.

3. EPA Development: EPAs were formulated for each pathway, incorporating the identified knowledge and skills. Each EPA was designed to be measurable via set observable skills and suitable for entrustment decisions.

4. Integration into a LF: The EPAs were embedded into a comprehensive LF that includes supervised clinical practice, and reflective learning activities. This LF supports progressive skill development and readiness for independent practice.

Figure 1. CC Complementary Care Pathway



Results

Three distinct CC care pathways for SPs were identified: 1. Standard Care, 2. Complementary Care, and 3. Primary Contact Care. For each CC pathway, a tailored set of EPAs was developed to support capability development and guide clinical practice.

Standard Care Pathway: 5 EPAs were developed, focusing on foundational tasks such as supporting medical teams in assessment and therapy, implementing treatment plans, and monitoring patient progress.

Complementary Care Pathway: 9 EPAs were created to reflect a more active SP role in CC care, including collaborative assessment, contributing to diagnosis, and delivering targeted interventions alongside other healthcare professionals.

Primary Contact Care Pathway: 13 EPAs were established to support SPs functioning as the primary point of contact for CC patients. These EPAs encompass comprehensive assessment, independent clinical decision-making, definitive care coordination, and patient education.

Conclusion

A structured, **EPA-based LF** was successfully developed to support SPs delivering high-quality CC care across varying scopes of practice. By identifying **three distinct CC care pathways**, the LF provides a **scalable and flexible approach** to capability development. A total of **27 EPAs** were created each aligned with **observable clinical tasks and professional requirements**. This LF not only supports **consistent training and assessment** across QH services but also enables **SPs to safely expand their scope of practice** (where appropriate). Ultimately, it lays the foundation for more **accessible, efficient, and patient-centered SP-led models of care in the management of CC**.