Professional Supervision Framework

2019

Occupational Therapy AUSTRALIA

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1. Introduction

The Professional Supervision Framework:

- Outlines the professional and regulatory expectations of professional supervision of qualified occupational therapists.
- Identifies 'best practice' professional supervision models, processes, and practices within the contemporary Australian, international, and related disciplinary contexts.
- Establishes the basis for the development of advanced and extended scopes of occupational therapy professional supervision practices.
- Recommends strategies to evaluate professional supervision practices for the purpose of quality improvement and service development.

Research behind The Framework:

A thematic analysis of 'best practice' professional supervision was conducted following:

- A systematic search of data bases, including MEDLINE, CINAHL, EMBASE, AMED (Allied and Complementary Medicine Database), and CDSR (Cochrane Database of Systematic Reviews). Priority was given to international, peer-reviewed, allied health research publications on clinical or professional supervision with a publication date of 2012 onwards. National and international occupational therapy specific publications on professional supervision, was however, included from the year 2000 onwards given the scarcity of literature in this category.
- Manual search of relevant journals within the last year, i.e. The Clinical Supervisor, and Counsellor Education and Supervision.
- Pearling of the reference lists of eligible studies (secondary searching) to identify any additional studies.

Research publications with a focus on student supervision were excluded from the searches. Findings were then augmented with international and national allied health professional guidelines for supervision, and published government department documents, such as the National Clinical Supervision Competency Resource (Health Workforce Australia, 2014).

2. Significance of a Professional Supervision Framework for Occupational Therapy

Occupational Therapy Australia (OTA) is the professional association for occupational therapists in Australia. One of its aims is to develop and maintain excellence across the scope of professional occupational therapy practice. As part of its commitment in promoting quality services, OTA released a position paper in 2017, *'Occupational Therapy Scope of Practice Framework'* that outlined occupational therapists' responsibility "to ensure currency of practice, registration, and contemporary professional knowledge by seeking appropriate professional supervision, training and professional development to maintain practice within the scope of practice" (p.6).

The Scope of Practice Framework (OTA, 2017) espoused the need for a national professional supervision framework to underpin scope of practice. A national framework for professional supervision will provide:

- Agreement on the descriptors of what is, and what constitutes professional supervision, and its parameters for effective practice (such as content, frequency and duration).
- Guidelines on 'best practice' supervision that can inform practitioners, managers, employers, service users, regulatory agencies, funding bodies, policy makers and others.
- Recommendations for extended scope of professional supervision, where supervision practices may occur in a range of settings (i.e. regional and remote, National Disability Insurance Scheme, host settings), are performed by other health professionals (inter-professional supervision) and use alternative formats of supervision (i.e. peer or group supervision).
- Recommendations for development and practice pathways for the future.

By developing and implementing this resource, it is hoped that practitioners engaging in supervision processes will gain an understanding of the challenges associated with good supervision and have an accessible resource to relevant information and strategies about this practice. In addition, such a resource could also be utilised beyond staff supervision practices as a reference point for increasing knowledge on student supervision.

The Occupational Therapy Australia Professional Supervision Framework will be regularly revised to reflect current needs, knowledge and research to include new areas of activity for occupational therapists in Australia.

3. Professional Drivers for Supervision

For occupational therapists in Australia the mandate and expectations of supervision are reinforced by:

- **The Australian Occupational Therapy Professional Code of Conduct** (March 2014). The code stipulates that:
    - "Teaching, supervising and mentoring practitioners (and students) is important for the development of practitioners and for the care of patients or clients. It is part of good practice to contribute to these activities, and provide support, assessment, feedback and supervision for colleagues…"
      (p. 5).
    - "Maintaining and developing knowledge, skills and professional behaviour are core aspects of good practice. This requires self-reflection and participation in relevant professional development, practice improvement and performance-appraisal processes to continually develop professional capabilities" (p. 18).

(Occupational Therapy Board of Australia, Code of Conduct, 2014 http://www.occupationaltherapyboard.gov.au/Codes-Guidelines/Code-of-conduct.aspx)

- **The Australian Occupational Therapy Competency Standards** (2018) outline professional behaviours all occupational therapists should demonstrate to practise safely and ethically. According to the standards, an occupational therapist:
    - Identifies and uses relevant professional and operational support and supervision (p. 6).
    - Contributes to education and professional practice development of peers and students (p. 6).
    - Seeks and responds to feedback, modifying communication and/or practice accordingly (p. 9).

(Occupational Therapy Board of Australia, Australian occupational therapy competency standards 2018, http://www.occupationaltherapyboard.gov.au/Codes-Guidelines/Competencies.aspx)

- **The National Safety and Quality Health Service (NSQHS) Standards** (2017) require that
    - "The workforce has the right qualifications, skills and supervision to provide safe, high quality health care to patients" (p.4).
    - "The health service organisation provides supervision for clinicians to ensure that they can safely fulfil their designated roles, including access to after-hours advice, where appropriate" (p.11).

Australian Commission on Safety and Quality in Health Care https://www.safetyandquality.gov.au/wp-content/uploads/2017/12/National-Safety-and-Quality-Health-Service-Standards-second-edition.pdf

- **The Occupational Therapy Australia Code of Ethics** (2014) states that:
    - "Members have an individual responsibility to maintain their own level of professional competence and each must strive to improve and update knowledge and skills" (p.6).
    - Supervision is an important strategy in assisting occupational therapists to meet their professional obligations.

- **Occupational Therapy Board of Australia** (2014). 'Supervision Guidelines for Occupational Therapy'.
    - These guidelines were developed for occupational therapists holding limited registration or registration with conditions and do not intend to cover the supervision for professional development purposes. Professional development is an important formative function of professional supervision. Hence the Board's guidelines do not sufficiently support professional supervision for all occupational therapist.

In addition to national professional standards, certain Australian states have their own specific guidelines on the conduct of allied health professional supervision, notably (but not inclusively):

- **NSW:** The Superguide - A Handbook for supervising Allied Health Professionals. Health Education and Training Institute, NSW Government (2014). http://www.heti.nsw.gov.au/Resources-Library/The-Superguide-a-handbook-for-supervising-Allied-Health-professionals/
- **Queensland:** Department of Health: Guideline for Credentialing, Defining the Scope of Clinical Practice and Professional Support for Allied Health Professionals (2015). https://www.health.qld.gov.au/__data/assets/pdf_file/0021/155505/qh-hsdgdl-034-1.pdf;
- **South Australia:** Allied Health Clinical Support Framework (2014). http://www.sahealth.sa.gov.au/wps/wcm/connect/ad788900438bd2b689308dfd37f1549d/ASH+Clin+Super+Framework+2014.pdf?MOD=AJPERES&CACHEID=ad788900438bd2b689308dfd37f1549d
- **Victoria:** Clinical Supervision Guidelines - Enhanced Maternal and Child Health Program. State of Victoria, Department of Education and Training (2018). http://www.education.vic.gov.au/Documents/childhood/professionals/health/GuidelinesClinicalSupervisionEnhancedMCH2018.pdf
- **Western Australia:** Foundations to Supervision, WA Country Health Service Combined Universities Centre for Rural Health (2009). http://www.wacountry.health.wa.gov.au/fileadmin/sections/allied_health/WACHS_G_AH_FoundationsToSupervision.pdf

4. Professional Supervision: Definition, Purpose, and Core Concepts

4.1. Definition and purpose

Professional supervision is defined as a process “designed to support staff as they seek to promote the goals of the organisation and to advance their professional development" (http://www.staffingpractices.soe.vt.edu/supervision.htm).

In ‘*Supervision guidelines for occupational therapy’*, the Occupational Therapy Board of Australia defines professional supervision as “a formal process of professional support and learning which enables a practitioner (supervisee) to develop knowledge and competence, assume responsibility for their own practice, and enhance public protection and safety” (Occupational Therapy Board of Australia, 2014, p.2).

Thus, the primary aim of professional supervision is to promote optimal care, safety, and well-being for service users in accordance with organisations’ and professional standards (College of Occupational Therapists, 2015; Fitzpatrick et al., 2012).

The secondary purpose of the supervision process is to provide duty of care for staff by creating safe and supportive opportunities to engage in critical reflection in order to raise issues, explore problems, and discover new ways of handling both the situation and oneself (http://www.rico.com.au/training/life_skills/supervision.htm).

4.2. Core concepts of professional supervision

Although there are variations in the definitions offered by different professional organisations, common core concepts can be extrapolated in terms of:

- Foundations: A collaborative, professional relationship based on trust, safety, and rapport
- Aims: To ensure safe and ‘best practice’ service provision for service users; to improve, develop, and support the supervisee
- Focus: The supervisee’s practice, professional & personal development, and well-being
- Essential components: Reflections, critical feedback, problem solving, and discussions (of career goals and personal development plans)

(Allan et al., 2017; Australian Association of Social Workers Supervision Standards, 2014; College of Occupational Therapists, 2015; Egan et al., 2016; Fitzpatrick et al., 2012; Leggat et al., 2016).

5. Supervision Terminology

The terms most commonly used in the literature include *managerial supervision*, *clinical supervision*, and *professional supervision*. While some overlap may occur, activities subsumed under managerial supervision are commonly associated with performance reviews, conformance with organizational accountability, and delivery of specific organisational outcomes (Care Quality Commission, 2013; Egan et al., 2016; Lambley & Marrable, 2013; Leggat, 2016).

Perceived as distinct from managerial supervision, the terms clinical and professional supervision are used interchangeably and share similar characteristics. Both are associated with educational, supportive (personal and professional), and reflective functions (Association of Occupational Therapists of Ireland (AOTI), 2010; Australian Association of Social Workers (AASW), 2014; Care Quality Commission, 2013; College of Occupational Therapists, 2015; Dawson et al., 2013; Lambley & Marrable, 2013; Leggat, 2016). Henceforth, the term professional supervision or supervision will be used, encompassing both aspects of clinical and professional supervision as described in the literature.

6. Benefits of Professional Supervision

The key terms used in this framework to describe supervision are; *supervisee*, *service users* and *organisation*.

6.1. Supervisee

There is an emerging body of evidence on the impact of supervision across a range of health professions. Quality supervision processes have been linked with better problem-solving skills, decreased burn-out, enhanced work performance, and increased job satisfaction (Allbutt et al., 2017; Dawson et al., 2013; Koivu et al., 2012; Kumar et al., 2015; Social Care Institute for Excellence, 2017). A comparison study on the association between supervision and work-related well-being revealed that nurses who received efficient supervision reported more job and personal resources (Koivu et al., 2012). A qualitative study of early-career social workers and occupational therapists linked a productive supervisor relationship with: identifying gaps in training; directing career development; providing checks on caseload, and monitoring work/life balance (Pack, 2015).

6.2. Service users

It is widely assumed that supervision can assist in producing better outcomes and safety for service users when it is used to enhance competency in service provision (Dawson et al., 2013). Supervision can identify issues and training needs, resulting in positive changes to practice. A paucity of robust evidence remains regarding the direct effect of supervision on service users' health outcomes. A recent systematic review did find significant improvements in the *processes* of care that are associated with enhanced health outcomes of service users as a result of supervision (Snowdon et al., 2017).

6.3. Organisation

An organisational commitment to quality supervision has been associated with staff being more motivated and committed to the organisation, because they work in a culture where learning and development are valued (Ducat et al., 2016; Koivu et al., 2012). A meta-analysis of 27 studies around the world, found that effective supervision was also positively associated with lower staff turnover (Mor Barak et al., 2009).

7. Current Professional Supervision Practices: An Overview

7.1 Perceptions

Professional supervision is generally valued and perceived as being beneficial and important, and impacting positively on professional practice. There is broad agreement over its purpose and objectives (Dawson et al., 2012; Leggat et al., 2016; Pollock et al., 2017; Roberts & Fitzgerald, 2017).

7.2 Observance & implementation

In keeping with professional guidelines, most established work settings endorse professional supervision practices. The majority of employers are committed to the process and have appropriate supervision policies. However, these were unevenly implemented: Where supervision was a performance management target, supervisors were given allocated time to deliver supervision, and compliance with delivery was more closely monitored. Conversely, where supervision was a cultural expectation only, it became less of a priority when workloads were high (Allbutt et al., 2017; Lambley & Marrable, 2013; Roberts & Fitzgerald, 2017; Turner-Daly & Jack, 2017).

7.3 Quality

Whilst requirements and the perception of its value ensured supervision took place, external economic shifts has moved to a culture focused on compliance above considering the actual quality. Recent studies report significant variations in quality and effectiveness of supervision. Particularly, participants were unclear about arrangements for monitoring the frequency and quality of supervision. Structures and processes vary greatly and there is little agreement on what constitutes *good* supervision. Within occupational therapy, the lack of a theoretical background was noted (Allbutt, 2017; Benton et al., 2017; Davys et al., 2017; Herck & Hocking, 2010; Lambley & Marrable, 2013; Sweeney et al., 2001; Turner-Daly & Jack, 2017).

7.4 Qualifications

For some health professions (e.g. Marriage and Family Therapy), supervisors require specific training to be recognised as an “approved supervisor” while other professions, such as occupational therapy promote more experienced practitioners, who may or may not have training, into the role of professional supervisor after some time and practice experience. It is assumed they have the requisite skills for supervision and frequently undertake supervisory roles with little preparation and instructions (Dawson et al., 2013; Falender et al., 2013; Bernard & Goodyear, 2014; Allan et al., 2017; Fitzpatrick et al., 2012).

7.5 Content

Recent systematic reviews identified a lack of current evidence for what constitutes best content for supervision sessions, and a common absence of a theoretical framework to guide content and process of supervision (Dawson et al., 2013; Pearce et al., 2013). Legatt et al. (2016) confirmed a lack of agreement on the appropriate content of supervision sessions for Australian allied health professionals. Supervision sessions typically focused on case management, with much less attention paid to the supervisee and opportunities for them to reflect on their practice (Turner-Daly & Jack, 2017); Where supervision practices were in function of solving problems, the day-to-day case management was not discussed or reviewed (Herck & Hocking, 2010). Supervision often depended more on the characteristics of the supervisor and the agency context than the needs of the practitioner (Turner-Daly & Jack, 2017).

7.6 Evaluation

There is no established culture within health services for evaluation of professional supervision. Davys et al. (2017) identified a lack of reliable measures to evaluate supervision; no evidence of a culture promoting evaluation, and no organisational requirement for evaluation of supervision. The most commonly-used methods of evaluation were informal and verbal report or feedback (Davys et al., 2017). There is evidence that evaluation of supervision is occurring, but on a largely ad-hoc basis, it is mainly instigated by the supervisors, and has a strong bias towards process evaluation (Davys et al., 2017).

7.7 ‘Best Practice’ Consensus

Within the discipline of occupational therapy, the paucity of literature on professional supervision militates against consensus on ‘best practice’ guidelines and implementation strategies. Evidence from systematic reviews exploring the effectiveness of allied health supervision is weak; methodological flaws and a lack of comparative studies were common (Dawson et al., 2013; Ducat & Kumar, 2015; Pearce et al., 2013; Pollock, 2017; Snowdon et al., 2017). This is confounded by a lack of uniform definitions, interchangeable terminology, and variations in what is delivered as supervision (Pollock et al., 2017).

The agglomeration of these variabilities limits capacity to associate professional supervision with quality of care for service users (Kettle, 2015). It does highlight the need for a common occupational therapy view of what factors constitute effective professional supervision.

8. Guiding Principles for Supervision in Occupational Therapy

The occupational therapy professional codes and competency standards offer a foundation upon which to conduct professional supervision in line with the principles espoused by empirical literature. That is, a professional relationship and confidentiality as the secure base that allows supervisees to feel safe to participate fully (O'Donoghue, 2018). In addition, and anecdotally, the prevalence of mental health issues in occupational therapy practitioners warrants consideration of duty of care.

8.1 Professional values and integrity supporting professional relationships

All parties involved in supervision processes should be familiar with, and uphold professional ethical standards as outlined in:

- The Code of Conduct: **4.2 'Respect for colleagues and other practitioners'**
- The Code of Ethics: **'Professional Relationships and Responsibility'**
- The Australian Occupational Therapy Competency Standards: **Standards 1, 'Professionalism'**

8.2 Confidentiality

The parameters of confidentiality need to be stipulated in a supervision agreement. Supervisors maintain the confidentiality of the supervisee, unless safety or welfare of supervisee and service users is compromised. Limits of confidentiality and reporting processes need to be in line with professional and organisational policies, and should be communicated and documented.

8.3 Duty of care and mental health

It is recommended that all parties involved in the supervision process acquaint themselves with the Mental Health First Aid Guidelines – 'Providing mental health first aid in the workplace' (Mental health First Aid Australia, 2016). These guidelines are about how employees should tailor their approach when providing mental health first aid to a co-worker or employee they manage: https://mhfa.com.au/mental-health-first-aid-guidelines#mhfaworkplace

9. Effective Professional Supervision: Enablers

Implementation of supervision will be affected by a number of variables such as characteristics of supervisor, agency context, resources available to support supervision, access to supervisors, and the profession (Allan et al., 2017; Turner-Daly & Jack, 2017). Despite these factors, and the variations in definitions and activities included in supervision, research shows similarities across health professions in relation to its benefits and enablers (Allbutt et al., 2017; Ducat & Kumar, 2015; Fitzpatrick et al., 2012).

9.1 Explicit policies and guidelines

Effective supervision is linked with external profession-specific coordination of supervision, regulatory drivers, and comprehensive guidelines. Likewise, internal robust organisational policies and guidelines are key factors in supporting effective supervision practices. These could be linked to other organisational policies such as sickness and absence, health and wellbeing, whistleblowing, and grievance (Allbutt et al., 2017; Ayres et al., 2014; Davys et al., 2017; Fitzpatrick, 2012; SCIE, 2017; Snowdon et al., 2017).

9.2 Organizational culture

The culture of an organisation, its general commitment to professional values, will permeate the behaviours of the participants in supervision. An organization that understands and promotes the values and benefits of supervision for all its stakeholders is critical to its implementation. Supervision has a part to play in delivering positive outcomes for service users, employees, and the organisation. Practitioners therefore need to be allowed planning, preparation and supervision time as part of their workload (Kettle, 2015; Lambley & Marrable, 2013; SCIE, 2017; Snowdon et al., 2016; Turner-Daly & Jack, 2017).

9.3 Training

Providing effective supervision is a skilled task. Mandatory, specific, and quality supervision training (internal and external) for all staff involved is vital. Absence of training can lead to a lack of knowledge on how to implement the essential components of supervision (reflections, critical feedback, problem solving) and conflicting use of power and authority in supervising employees (Albutt et al., 2017; Ayres et al., 2014; Benton et al., 2017; Fitzpatrick et al., 2012; Kettle, 2015; Lambley & Marrable, 2013).

9.4 Separating supervision from line management

Professional supervision is more effective when provided by someone other than the supervisee's manager. Recent studies overwhelmingly indicate a strong preference of supervisees to differentiate line management functions from those of supervision, and to be supervised by someone other than the supervisee's line manager. If not well managed, dual roles can hinder the development of an effective supervisory relationship and poses a risk of authority being used coercively. Supervisees may be less inclined to disclose information and discuss ethically sensitive practice issues if they fear this information may effect performance evaluation, job retention, or promotion.

Where dual responsibilities cannot be avoided, it is important that:

- Supervision issues are clearly separated from line management issues, i.e. the supervision contract clearly structures and separates supervision and management agendas
- Regular reviews and feedback from the supervisees are undertaken
- All parties are aware of potential risk factors:
    - The use of covert agendas (i.e. for the benefit of the organisation, not the employee)
    - Hiding relevant information (which may impact safe and quality service delivery)
    - Attempts by supervisee at impression management
    - Potential consequences of future career prospects

(Davys, 2017; Egan et al., 2016; Hair, 2013; Legatt et al., 2016; Martin et al., 2014; Martin et al., 2015; Roberts & Fitzgerald, 2017; Sweeney et al., 2001).

9.5 Time

Work demands can often interfere with time allotted for supervision. Creating protected time and a quiet, safe space where there are no interruptions (lest there is an emergency) denotes the value of supervision. Conversely, and prominently reported in recent studies, rushed sessions, frequent interruptions, or compromising supervision time because of caseload demands can be detrimental to effective supervision and are likely to create the norm (Allbutt et al., 2017; Ayres et al., 2014; Benton et al., 2017; Dawson et al., 2012; Martin et al., 2016; Snowdon et al., 2016; Turner-Daly, 2017).

9.6 Challenging – Critical Feedback

Whilst supervision sessions need to be relaxed and supportive, they also need to be challenging and provide opportunities for reflection, analysis and constructive feedback. Supervisees value critical feedback more than supervisors appreciate, and most supervisors are apprehensive about giving critical feedback. A lack of challenging supervision engagements can lead to complacency in practice (Allbutt et al., 2017; Lambley & Marrable, 2013; Turner-Daly, 2017).

The following resources provide practical tips on how to give critical feedback:

- Cantillon, P. & Sargeant, J. (2008). Giving feedback in clinical settings. *British Medical Journal* 337(7681), 1292-1294. doi:10.1136/bmj.a1961
  https://www.researchgate.net/publication/23465494_Giving_feedback_in_clinical_settings

- Ramani, S. & Krackov, S.K. (2012). Twelve tips for giving feedback effectively in the clinical environment. *Medical Teacher* 34: 787–791.
  https://lo.unisa.edu.au/pluginfile.php/699009/mod_book/chapter/75798/12.tips_effective.feedback.pdf

9.7 Use of a supervision contract and supervision records

A contract or agreement at the outset of supervision sessions that establishes explicit lines of accountability is highly recommended. Good supervision is developmental and progressive. A written agreement and consequent written records of each session can support decision making, documenting these decisions, and a review of what has been achieved from session to session. These records can also provide evidence of continuing professional development for AHPRA (Davys, 2017; Falender & Shafranske, 2014; Gaitskell & Morley, 2008; Lambley &

Marrable, 2013; Saxby et al., 2015). (See ‘Supervision Documentation: Agreements & Records’).

9.8 A systematic approach

A task-oriented structure and focussed approach are essential to effective supervision. This can be instigated by:

- The use of a robust and unified supervision model
- The use of a clear contract
- The use of a supervision session pro-forma (with build in flexibility) to record decisions and feedback
- The use of a collaboratively developed agenda for each session
- Setting clear and explicit goals

(Allbutt et al., 2017; Benton et al., 2017; Davys et al., 2017; Fitzpatrick et al.. 2012; Ladany et al., 2013; Lambley & Marrable, 2013; Pack, 2015; Sweeney et al., 2001).

9.9 A reflective approach

This is fundamental to a supervisory process that increases learning and improves practice (Herkt & Hocking, 2010; Lambley & Marrable, 2013; Pack, 2015; Pearce et al., 2013). Reflective practice facilitates the integration of theory with "practical and self-regulatory understanding to solve problems in situations where procedural rules do not offer an explicit guide" (Allbutt et al., 2017, p. 122). Reflecting on practice also generates new ideas about how to improve the quality of service provision and the psychosocial work environment (Koivu et al., 2012). Giving supervisors the function of empowering supervisees through reflection and feedback provides a role that is different from but complements that of the line manager (Leggat et al., 2016).

Imperatives to a reflective approach include:

- A safe space - physically and psychologically - to reflect on practice
- Skills in reflection: Reflective skills are not inherent; beginning practitioners may need guidance in developing this skill
- A supervisory relationship that encourages a depth of critical reflection and feedback

The process can be enhanced by specific reflective processes that provide structure, the use of logs and diaries, and exchange of ideas, dialogue and discussion (Martin et al., 2014). (See 'Models of Supervision').

9.10 Supervisory relationship & choice of supervision

Effective supervision is strongly associated with supervisor-supervisee matching and fit. A good fit resulting in a positive, supportive supervision relationship has been identified as the single most important factor for effective supervision in many studies. The supervisory relationship and the manner in which supervision was conducted were considered as important, if not more important, than what was discussed in supervision (Davys et al., 2017). Allowing supervisee's some choice in the allocation of supervisors is highly recommend (Davys et al., 2017; Ducat et al., 2016; Ladany et al., 2013; Lambley & Marrable, 2013; Martin et al., 2016; Pack, 2015; Saxby et al., 2015).

9.11 Discipline-specific

In general, practitioners favour supervision from someone of their own discipline. The perceived benefits of this include a deeper understanding of the profession specific role and challenges (Allbutt et al., 2017; Lambley & Marrable, 2013). A lack of access to discipline-specific supervision may be less of an issue where other professional support forums are in place (Herkt & Hocking, 2010; Lambley & Marrable, 2013). It is recommended that at least one aspect of the supervision format is discipline-specific. Where this is not available on-site, the following two questions need to be considered:

- How can the practitioner keep practice knowledge up to date?

- How can a supervisor from a different profession ensure that the supervisee has access to another supervisor with the professional knowledge that will support them in their work? (Social Care Institute for Excellence, 2017)

(See 'When supervision is restricted or unavailable')

9.12 Ad-hoc supervision

The availability of informal supervision between scheduled, formal sessions is linked with supervisee's perceptions of enhanced quality of supervision. Informal supervision provides more immediate support in responding to the needs of service users, whereas formal sessions include a more holistic planning and reflective process (Lambley & Marrable, 2013; Martin et al., 2015; Turner-Daly & Jack, 2017). This also adds weight to Martin et al's (2015) findings that frequency of supervision is positively and significantly associated with quality supervision. (See 'Parameter of supervision').

10. Qualities and Skills of an Effective Supervisor

Research findings corroborated across allied health professionals suggest that effective supervisors:

- Build a positive relationship with supervisees, and create and sustain an atmosphere of trust and safety. This can be done by:
    - A hands-on approach
    - Openness to learning and shared learning
    - Self-disclosure
- Use basic counselling skills such as listening, reflection of feelings, empathy, encouragement
- Adapt the style and content of sessions to the needs and learning style of the supervisee
- Facilitate supervisees in reaching their own decisions and be self-directed, but offer clear guidance when needed
- Encourage professional development
- Ask open questions and give feedback
- Support innovative practice; encourage practitioners to bring new ideas into their practice and service development
- Provide a space for reflections and support reflexion as a means to transform practice
- Demonstrate practice skills and expertise; relate practice to theory; disclose professional knowledge that is relevant to the supervisees presenting concerns

(Benton et al., 2017; Davys, 2017; Kettle , 2015; Ladany et al., 2013; Lambley & Marrable, 2013; Snowdon et al., 2016; Sweeney et al., 2001; Turner-Daly & Jack, 2017)

11. The Role of the Line Manager, Supervisor, and Supervisee in Supervision

11.1 Line Manager:

- Regular review of supervision practices to ensure these reflect current professional standards and expectations, and are linked to organisational outcomes and values
- Instigate evaluation processes involving supervisors, supervisees and people who use services
- Promote a culture of valuing supervision, by:
    - Clarifying its role in delivering quality services and outcomes for service users
    - Making supervision mandatory as part of routine work
    - Quarantine preparation and supervision time
- Where possible, provide supervisee with a choice in supervisor
- Contribute to organisational procedures and guidelines for staff supervision, including:
    - Definition
    - Service expectations of supervision
    - Relationship between, and role and responsibilities of supervisor, supervisee, and manager
    - Principles for effective supervision
    - Contract setting
    - Recording
    - Duration and frequency
    - Confidentiality; limits of confidentiality
    - Use of supervision model to guide content and process

- Mandate training and other support and development opportunities to all staff involved in supervision processes, ideally within the first year of supervision. Recommended areas to address include:
    - Theoretical models of supervision, as a foundation for process, content, and evaluation
    - Communication – including questioning techniques, active listening, giving positive and constructive feedback rather than accolades or criticism, having difficult conversations and being assertive.
    - Conflict management
    - Skills in reflection
    - Professional reasoning, and integration of professional theories and evidence into the normative and formative components of supervision (See ‘Models of Supervision’)
    - Multicultural competent supervision
    - Telesupervision (use of technology; ethical and legal issues) (See ‘When supervision is restricted or unavailable’)
    - Evaluation of supervision

(Dawson et al., 2013; Lambley & Marrable, 2013; Robert & Fitzgerald, 2017; Scottish Social Services Council, 2016; Sweeney et al., 2001)

11.2 Supervisor:

- Review and uphold professional values supporting professional relationships, as stated in Code of Conduct and Code of Ethics (See 'Guiding principles of Professional Supervision')
- Consult relevant organisational supervision policy documents
- Protect the time and space of supervision sessions; ensure privacy and no interruptions
- In collaboration with supervisee:
    - Complete a supervision agreement (see 'Supervision Agreement')
    - Prepare agenda for each session
- Use a supervision model to ensure approach and content of supervision is holistic.
- Assist supervisee with critical reflection through the use of guided questioning (See ' Models of Supervision')
- Record discussions and decisions in a supervision record
- Review and reflect on supervision session (see 'Review & Evaluation of Supervision')
- In line with organisational policies, participate in procedures to evaluate supervision

(Leggat, 2016; SCIE, 2017)

11.3 Supervisee:

- Review and uphold professional values supporting professional relationships, as stated in Code of Conduct and Code of Ethics (See 'Guiding principles of Professional Supervision')
- Consult relevant organisational supervision policy documents
- Self-monitor performance; be proactive in developing reflective capability to determine competency areas of strength and those that require further development (Falender & Shafranske, 2014)
- Engage fully in the process of reflection and action; be open to change in practice; follow up on action
- Use a supervision model to identify practice, professional development, and support needs (See 'Models of Supervision')
- Take responsibility for enhancing personal knowledge and professional development; independently access knowledge and resources to bring to the supervision process (Herkt & Hocking, 2010; SCIE, 2017).
- Come prepared and bring relevant evidence:
    - Case notes they have concerns about and would like to discuss
    - Diary
    - Agenda
    - Specific literature and other evidence of best practice

12. Delivery Formats of Supervision

Supervision formats need to be determined by the experience and professional background of supervisors and supervisees, workload issues, resources available, and what is a practical fit for specific situations (i.e. geographical or professional isolation).

The most common formats of supervision include individual (traditional face-to-face), peer (in pairs or in group), and group supervision. Supervision can be provided by a supervisor who is internal or external to the organisation, or/and whose experience is in a different professional area.

Supervision can also include facilitated team-based consultations, presentations via case discussion, video review or live presentation and demonstrations, guided observation of peer's practice; co-treatments; undergoing observation of practice with feedback, or listening to tape recorded treatment sessions (Allan et al., 2017; Pearce et al., 2013).

12.1 Individual face-to-face supervision

This can include observation, modelling, co-treatment, discussion, teaching and instruction (Sweeney et al., 2001a), however, occupational therapy traditionally prefers the one-to-one method (Martin et al., 2014). The ability to provide individual discipline-specific supervision has been influenced by factors such as the development of collaborative approaches to work practice, budgetary constraints, and a lack of available professional staff (Sweifack, 2017). Individual supervision is a predictor variable with a positive influence on the quality of supervision in occupational therapy (Martin et al., 2016). It is argued that any supervision format should include at least some one-to-one supervision (Lambley & Marrable, 2013).

12.2 Peer or co-supervision

This denotes a collaborative learning and supervision forum whereby two or more practitioners (discipline-specific or multidisciplinary) of equal standing discuss work with each other (AASW, 2014; Care Quality Commission, 2013). Peer supervision can provide more immediate feedback or support, and can be useful for debriefing stressful, external issues and for furthering reflective practice (Benton et al., 2017).

12.3 Group supervision

Group supervision usually involves one supervisor facilitating a supervisory forum with a discipline-specific or multi-disciplinary group. Group supervision is NOT individual supervision in a group context (Knight, 2017). The purpose of group supervision can be collective problem solving and team development, and practice and service delivery. The supervisor's role in group supervision is to facilitate a process whereby supervisees can learn from and support one another (Knight, 2017). Group supervision is most often used to complement or enhance individual supervision. It may reduce how often one-to-one supervision is needed, however, it is rarely sufficient on its own to meet the individual supervision needs of practitioners (Benton et al., 2017; Lambley & Marrable, 2013).

12.4 Advantages and challenges of individual, peer, and group models

MODEL	POSSIBLE CHALLENGES	POSSIBLE BENEFITS	REQUIRED
Individual	• Resource & time intensive	• Enables supervisee to explore practice weaknesses without feeling defensive or exposed • Ad hoc sessions useful for providing more immediate support & learning from difficult situations that arise. • Supervisory relationship can develop more quickly • May allow for more in-depth reflection	• Supervisor & supervisee need to be appropriately matched • Need enough experienced & trained supervisors in an organisation to be able to provide reliable ad hoc & scheduled sessions
Peer-based	• Less appropriate for the less experienced practitioner (as a sole method) • Sessions may become too informal, lacking the process & challenge to enable growth	• Less threatening – more comfortable in using skills and resources of trusted colleagues to support reflection on practice • Peers will usually be familiar with the situation being discussed	• In the absence of a group leader there is greater need for a clear structure, and specific outcome objectives • Requires greater commitment from the group (OT Irl, 2010)
Group	• Fear of being judged • Interactions between members that detract from learning, i.e. disagreement & competition • Poor time management • A cohesive group may make it difficult for individual members to express different views or challenge the group norms. This can limit new ideas, constructive debate & sound decision making • Difficult to meet specific individual needs; discussions remain generalised and do not meet anyone's needs in a satisfactory way	• Encourages support & validation of supervisees' experiences & reactions • Opportunities to learn from others & appreciate alternate points of view • More distribution of power in a group: Different views & ideas may challenge those of the supervisor - this may be more difficult to achieve in one-to-one supervision • May be an efficient use of time & resources: Issues which are relevant to most staff (e.g. policies & procedures) can be discussed in group rather than one-to-one • May help develop skills which are transferable to other practice situations (i.e. working in teams & groups)	• Setting clear expectations; establishment of ground rules • Monitor time • Knowledge of core supervisory skills and the ability to adapt them to a group context • Experience and understanding of group dynamics

(Adapted from Knight, 2017; Helen & Douglas House Clinical Supervision Toolkit, 2014; Lambley & Marrable, 2013; AOTI, 2010; SCIE, 2017; State of Victoria, Department of Education & Training, Clinical Supervision Guidelines, 2018)

The following websites provide further information on supervision formats:

- www.knowledge.scot.nhs.uk/nmahpsupervision/participation/models-of-supervision/structural-models.asp
- www.stepintoleadership.info/supervision.html

13. Supervision Models

Similar to other occupational therapy practices, it is important for supervision to be grounded in a theoretical framework that can guide the supervision process and forms the basis for evaluation. There are many theories and models of supervision, but there remains insufficient empirical evidence to impose one single framework from existing models (Pollock, 2017).

Sweeney et al. (2001) suggest that occupational therapy can learn from other professions that have a long history of professional supervision, such as social work and clinical psychology. Two holistic supervision models that are described widely in social work literature and warrant consideration in occupational therapy are ***Proctor's functional interactive model*** (1987), and the ***4 x 4 x 4 model*** first developed by Tony Morrison (Morrison, 2005; Wonnacott, 2012). There are other models, tools and techniques available and these should be looked at if required (See 'Recommended Resources').

13.1 Proctor's functional interactive model

Proctor's model is the most commonly reported theoretical framework in recent systematic reviews (Dawson et al., 2013; Snowdon et al., 2016). In the model, supervisor and supervisee are jointly responsible for effecting three domains of supervision; normative, restorative, and formative:

- **Normative (Managerial)** focuses on:
    - Accountability and quality assurance: Ensuring professional standards in service provision, and professional and organisational roles are met
    - Managing workload and organisation
- **Restorative (Supportive)** focuses on:
    - Facilitating collegial and supportive relationships
    - The emotional needs of supervisee: How he/she has been affected by the interactions with service users, and how to deal with these constructively; How he/she is responding to the stresses and demands of the practice environment
    - Directing to appropriate help
- **Formative function (Educative)** focuses on:
    - Continued development of professional knowledge and skills, through regular reflection on the supervisee's practice
    - Developing awareness and understanding of skills and ability
    - Developing awareness of reaction and reflection on intervention

(Adapted from: Proctor, 1987; Calvary Health Care Sydney, 'Clinical Supervision', 2013)

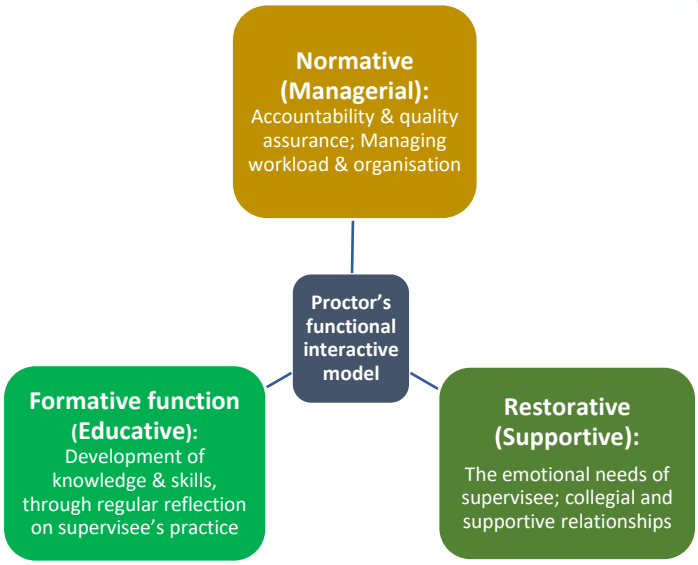

Figure 1: *Proctor's Functional Interactive Model*.

Proctor's model addresses the profession's specific aims of accountability and professional development. Like most models, it does not provide details of practical applications of its functions, nor does it intend to dictate practice. Rather, it can be a useful starting point to guide content of supervision, conceptualise central functions of supervision and as a basis for organising and structuring supervision. Importantly, it underpins one of the most widely used and validated tool to measure perceived effectiveness of supervision from the supervisee's perspective; the Manchester Clinical Supervision Scale (MCSS-26) (Dawson et al., 2013). (See 'Evaluation of Supervision').

13.2 The 4 x 4 x 4 Model

This model extends Proctor's interactive model. It integrates the ***four functions*** of supervision (adding 'Mediation' to Proctor's management, support, and development), with the ***four elements*** of the reflective supervision cycle and considers the needs and priorities of the ***four stakeholders***: Service Users, Staff, Organisation and Partners.

4 x Functions	4 x Stakeholders	4 x Elements
Management	Service users	Experience
Personal support	Staff	Reflection
Professional development	Organisation	Analysis
Mediation	Partner organisation	Action planning

The 4 x 4 x 4 Model aligns well with occupational therapy's client-centre approach; it regards supervision as an essential part of the interventions with service users. Further, the model promotes critical analysis and reflection within an organisational context. Reflective practice is an important professional competency in occupational therapy, and vital to our continuing professional development (Australian Occupational Therapy Competency Standards, 2018).

Similar to occupational therapy practice models, the model integrates the environment as an essential component. The **'Mediation'** function emphasises the engagement of the supervisee with the organisation and highlights the significance of the organisational culture. This function may include:

- Mediation or advocacy on behalf of the supervisee to gain access to organisation systems or resources
- Liaising of supervisees with external organisations (SCIE, 2017)

In a supervisory relationship, both parties aim for a balance between functions. Where an imbalance occurs, the supervisor can reintroduce those elements that have gone missing, for example by asking a reflective question that introduces a team or organisations perspective. (http://www.stepintoleadership.info/assets/pdf/SSSC-Supervision-learning-resource-section-3.pdf)

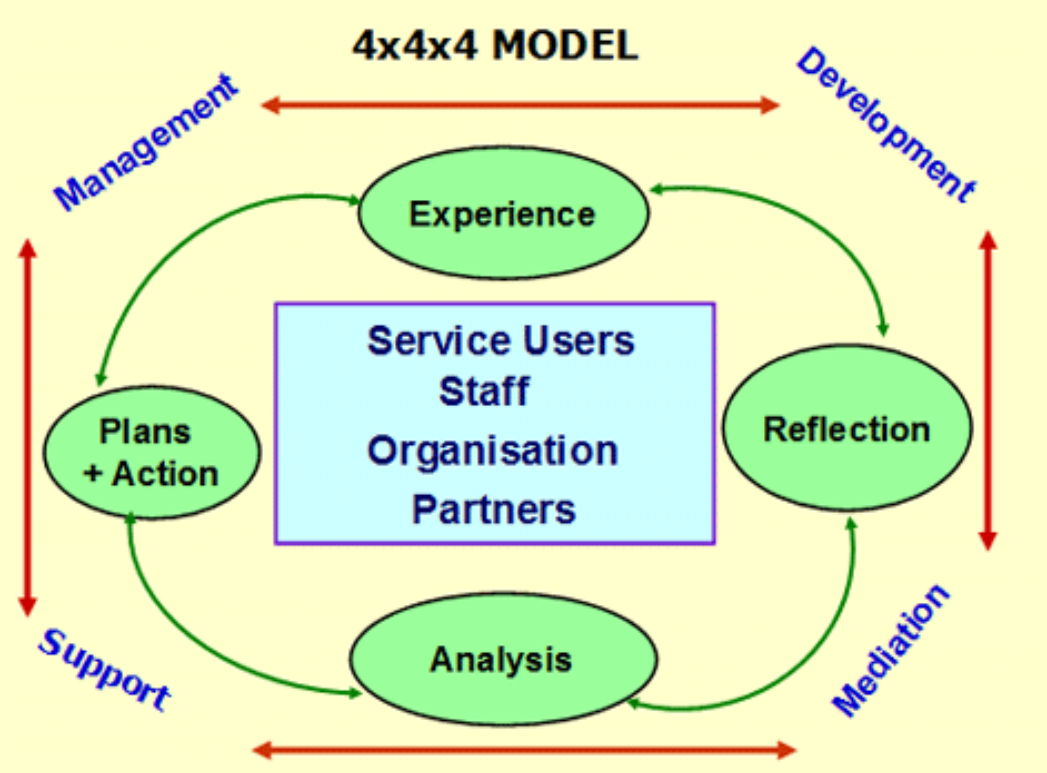

Figure 2: From:

Morrison, T. & Wonnacott, J. (2010). Now or Never: Reclaiming Reflective Supervision in Social Work. February 2010. http://www.in-trac.co.uk/supervision-now-or-never/

13.3 The reflective supervision cycle of the 4x4x4 Model

The four elements of the supervisory cycle are based on Kolb's learning cycle (1984). The cycle promotes the notion that supervisees can learn from their experiences, ***if*** reflection is an integral part of such learning. The process of learning follows a pattern of four stages:

Experience - Engaging and observing (What happened?): Experiences could be prompted by the outcomes of objectives prioritised in previous supervision sessions, and/ or may be related to interactions with any of the four stakeholders or functions of supervision. The supervisee should come prepared with points they wish to discuss. Where experiences relate directly to interactions with service users it is an opportunity to introduce their perspective into the discussion where possible (SCIE, 2017).

- *Can you describe an experience that made you feel proud to be an occupational therapist?*
- *Where did you meet success; describe an experience that brought you satisfaction*
- *Describe an experience where you encountered some difficulties, and what did you do to deal with it?*
- *What happened before the event? What did you expect? What happened during the event? What happened afterwards?*

Reflection - Investigating the experience (What was it like?): The supervisor engages with the supervisee to explore their feelings, reactions and intuitive responses, and those of other stakeholders involved in the experience. This is an opportunity to discuss any anxieties and acknowledge situations where stress may be impacting on their work (restorative domain). Where the discussion relates to interactions with service users it is an opportunity to explore any assumptions and biases that might be driving practice (SCIE, 2017).

- *What did you feel before/ during the event? Did you have any preconceptions?*
- *Where and when did you feel most/ least comfortable?*
- *How did you think the service user (or other) felt? Why?*
- *Now you've had a chance to think about it a little, how do you feel about the event now?*
- *Were there any factors that influenced your reactions? (I.e. gender, culture, personal boundaries)*

Analysis - Seeking to understand (Asking why; what does this mean?): To avoid drawing subjective conclusions following reflection, the supervisor helps the supervisee explore the situations from different angles. Both parties consider relevant resources that enrich perspectives and strengthen knowledge (for example: organisational policies, professional codes and position papers, clinical guidelines, professional models and theories, colleagues with relevant experiences, research evidence, internal and external training).

- *What lessons were learned from this experience?*
- *Who might benefit most from what you've learned along the way?*
- *What do you need to revisit or feel is not known?*

Action planning - Preparing for informed action; trying things out (What next?): – The supervisor works with the supervisee to identify the goals they wish to achieve, to explore other ways of working, and to develop strategies on how to go about this. The supervisor may need to use his/ her experience to help generate different options and identify a contingency plan.

- *What is the situation now?*
- *What information do you have? What information is missing?*
- *What is your plan?*
- *What are your next steps? Which of those steps will come easiest? Where will the terrain become rocky? What can you do now to navigate the road ahead with the most success?*

Questions adapted from:

http://www.brilliant-insane.com/2015/03/ten-reflective-questions-ask-end-class.html

https://carers.ripfa.org.uk/wp-content/uploads/Critical_reflection_tool.pdf

http://fieldworkeducatortips.blogspot.com.au

13.4. Using the supervision cycle in practice

The Social Care Institute for Excellence (2017) offers the following recommendation for implementing the cycle:

- One may begin at any stage, but the sequence must be followed
- Do not feel that each stage of the cycle must rigidly follow the last – there will be many times when the conversation moves back and forth between the stages
- Use mainly open questions in order to facilitate discussion and explore the supervisee's perspective
- Resist the 'short circuit' which moves directly from experience to action and does not engage with reflection and analysis
- Practise using the cycle in both formal situations and in ad hoc supervisory conversations.

https://www.scie.org.uk/publications/guides/guide50/foundationsofeffectivesupervision/reflectionandcriticalthinking.asp

The following resources provide a comprehensive overview of reflective models practical tools and self-assessments:

- http://cw.routledge.com/textbooks/9780415537902/data/learning/8_Reflection%20in%20Practice.pdf
- www.businessballs.com/reflective-practice.htm

14. Supervision Parameters (Duration, Frequency)

National and international Occupational Therapy Professional guidelines refrain from stipulating standards for length and frequency of supervision. Requirements will vary according to:

- The experience of the supervisee
- The length of time in the job
- The complexity and demand of the caseload
- The individual's support needs
- The organisational context (COT, 2015).

Practitioners new to their practice or those who handle more complex cases may require more frequent supervision (Martin et al., 2016). There is evidence of a positive correlation between effective supervision and duration and frequency of supervision (Martin et al., 2016; Saxby et al., 2015; Snowdon et al., 2016,); more frequent supervision predicts higher quality supervision (Martin et al., 2016; Snowdon et al., 2016).

A duration of ninety minutes is specified for social workers after their first 6 months in employment following qualification in England (Turner-Daly & Jack, 2017) and this was perceived by supervisees as the right amount for supervision (Lambley & Marrable, 2013). This corresponds with the minimum recommended standards for Australian social workers, i.e. sessions should be a minimum of 60 minutes duration, fortnightly for graduates with 2 years or less experiences, and monthly for more experiences social workers (AASW, 2014).

The Queensland Department of Health recommends that newly graduated allied health professionals with less than two years' experience are expected to undertake one hour of formal supervision per week; those with two to five years' experience, a minimum of one hour per fortnight; and those with over five years' experience, a minimum of one hour per month (Queensland Health Service Directive Guideline, 2014).

The nature of supervision may need to change over time depending on the experience of the supervisee: Inexperienced supervisees would be expected to initially require the supervisor to assume more of a teaching role, helping them improve their practice and meet agency mandates (Knight, 2017). As practitioners become more experienced, less emphasis on case management and more time for in-depth reflection and professional development may be needed (Turner-Daly & Jack, 2017).

Agglomerate findings suggest that:

- Supervision sessions of less than 60 minutes duration may be of questionable value for allied health practitioners
- Less experienced practitioners (2 years or less) require more frequent supervision (i.e. minimum fortnightly); practitioners with more experiences require a minimum of monthly supervision
- Supervision should be ongoing, disregarding experience, in recognition of professional life-long learning and professional development requirements

15. Supervision Documentation: Agreement and Records

15.1 Supervision Agreement

A supervision agreement, also referred to as a supervision contract, can be used to:

- Orient both parties to the process and expectations of supervision (Dawson et al., 2013)
- Support the structure and content of supervision (COT, 2015)
- Clarify the potential role conflicts the supervisor and supervisee may encounter as the supervisor performs these multiple roles (Falender & Shafranske, 2014)

The supervision processes outlined in the agreement should be linked with organisational supervision policies and other relevant policies and procedures (e.g. grievance procedures; confidentiality procedures) (AOTI, 2010)

Supervision agreements may include:

- The agreed purpose and goals of supervision
- Content of supervision (for example standard agenda items; the arrangements for agenda setting; reference to supervision model that will guide content)
- The roles and responsibilities of both parties
- Where a supervisor has a dual role (i.e. supervisor and line manager), specification of the different functions of the roles; specification on how conflict of interest will be avoided
- Where face-to-face, one-on-one supervision is not the norm; specification on the formats and modalities that will be used, including how the discipline-specific component will be safeguarded.
- Anticipated duration of each session; minimum frequency
- Arrangements for any ad-hoc or unplanned supervision
- Arrangements for cancelling or rescheduling supervision
- Documentation processes: who is responsible for recording; what needs to be recorded; what template will be used; where will the records be kept
- Confidentiality and limits to confidentiality. This process might include that the supervisor will advise the supervisee in advance, including what will be shared, with whom and for what purpose.
- Specification of evaluation measures and timing of those
- Duration, monitoring and evaluation of the agreement
- The process for managing and resolving conflict in the supervisory relationship

(Adapted from: COT, 2015; Falender & Shafranske, 2014; SCIE, 2017)

See Appendix 1: Template Supervision Agreement

15.2 Records of supervision meetings

It is recommended that all supervision sessions are recorded. One of the enablers to effective supervision is a systematic approach (See 'Effective Supervision Enables'): The use of a supervision session pro-forma (with built in flexibility) to record decisions and feedback can facilitate structure and focus. Records can also be useful to monitor achievement and progress, and to follow-up on actions. Records should include main topics discussed, outcomes and actions, and who is responsible for carrying them out. They should be signed by both parties and kept in a safe place. Organisational policies may dictate that they remain property of the organisation, and may be used for auditing purposes (COT, 2015; AOTI, 2010). See Appendix 2: Template Supervision Record

The following websites provide examples of supervision agreements and records:

- https://www.health.qld.gov.au/__data/assets/pdf_file/0029/371288/c_super_agreement.pdf
- http://www.sahealth.sa.gov.au/wps/wcm/connect/ad788900438bd2b689308dfd37f1549d/ASH+Clin+Super+Framework+2014.pdf?MOD=AJPERES&CACHEID=ROOTWORKSPACE-ad788900438bd2b689308dfd37f1549d-lmkgFAc (p.13)

16. When Supervision is Restricted or Unavailable

Professional guidelines stipulate that occupational therapists should have some level of professional supervision. The literature supports the inclusion of discipline-specific individual supervision as part of supervision arrangements. However, this may not be easily attained for occupational therapists working in:

- Regional, rural, and remote practice settings
- Organisations where occupational therapists practice in a host setting, i.e. a workplace in which occupational therapy is practiced, but other disciplines dominate the labour force (Sweifach, 2017)
- Practices such as the National Disability Insurance Scheme where occupational therapists work in a generic or managerial role
- Small organisations where in-house supervision is not always practical
- Emerging areas of practice where practitioners are establishing occupational therapy services

There is consistent evidence that for practitioners in these settings, supervision is a key method of support to ensure the safety and welfare of both service users and practitioners. The availability of professional support and supervision are key factors that reduce professional isolation, enhance professional enthusiasm, and influence retention (Ducat & Kumar, 2015; Ducat et al., 2016).

16.1 Barriers to supervision

Recent studies, including a systematic review of professional supervision experiences of allied health practitioners working in non-metropolitan settings (Ducat & Kumar, 2015) reaffirmed a number of barriers:

- Recruitment and retention difficulties stemming from professional and geographical isolation
- The complexity of the specialist generalist scope of practice
- High workload demands, particularly for sole practitioners
- Limited access to relief to allow professional or service development
- Limited or no dedicated work time allocated for professional reading or study
- New graduates and sole practitioners possessing limited skills in service development (Ducat & Kumar, 2015; Kumar et al., 2015; Martin et al., 2017; Moran et al., 2014)

16.2 Issues to consider in implementation:

- ***Communication:*** Enablers of effective supervision previously stated equally apply to any of the settings described above. However, the aspect of communication bears greater significance. A recent systematic review identified the lack of agreed definition and functions of supervision amongst diverse allied health practitioners in non-metropolitan health care settings (Ducat & Kumar, 2015). In some settings, different functions of supervision may need to be delivered by different people of non-discipline specific backgrounds. This necessitates the need for an implementation framework that clearly articulates lines of accountability, and role delineation to ensure there is a common understanding across all stakeholders. (See ‘Enablers of Effective Supervision’)

- ***Dual relationships:*** A limited number of staff available for supervision can result in a lack of choice of supervisor and occurrence of dual relationships, i.e. a colleague performing either supervision and line management functions, or a colleague supervising a practitioner who is a friend. The former poses the risk of departmental issues taking priority over the supervisee’s learning needs (Martin et al., 2015).The latter may curtail critical feedback and challenge, leading to ineffective supervision (Dawson 2013). (See ‘Enablers of Effective Supervision’)

- ***Non-metropolitan supervisors:*** A systematic review of supervision experiences of allied health professional in non-metropolitan health care settings identified that regional practitioners preferred

supervision from other non-metropolitan practitioners over access to more experienced supervisors from metropolitan areas (Ducat & Kumar, 2015).

- ***Face-to-face:*** Developing a supervisory relationship face-to-face first or have some prior interaction before commencing online or telephone communication was found to improve perceptions of the quality of supervision received via telephone. The inability to read non-verbal cues appears to be more detrimental when the supervisee did not have prior face-to-face interactions with the supervisor. It is recommended that initial sessions where goals and expectations are discussed and a supervision contract developed, be undertaken face-to-face before transitioning into telesupervision. If this is not feasible, telesupervision using videoconference is preferable (Deane et al., 2015; Martin et al., 2015, Martin et al., 2017).

- ***Resources:*** Most importantly, in rural and remote contexts the evidence suggests that supporting practitioners to access support interventions by means of financial reimbursement, travel subsidies, backfilling and organisational commitment can directly or indirectly influence retention of staff and the quality and safety of services (Moran et al., 2014).

16.3. Strategies for Supervision

16.3.1 Development of a proposal

In circumstances where professional supervision is overlooked, The College of Occupational Therapists (2015) suggest that the best way to gain support for supervision is to put forward a proposal. This could include:

- Reference to National standards (in Australia, the NSQHS Standards), and key documents that dictate profession-specific requirements for supervision (see 'Professional Drivers for Supervision')
- Benefits to the organisation, the service users, and the practitioner (See 'Benefits of Supervision')
- Specific requirements for minimum supervision arrangements (format, frequency, duration, etc.) (See 'Parameters for Supervision')
- Proposition of a flexible supervision structure (See 'A flexible model of supervision')
- Potential cost involved (i.e. if supervision needs to be purchased)

(Adapted from: The College of Occupational Therapists, 2015)

16.3.2 Adopting a flexible model of supervision

Where there are specific challenges to traditional face-to-face, discipline specific supervision, a 'one size fits all' approach is unlikely to work. Instead, it is recommended to construct a supervision structure of multimodal methods, consisting of internal and external arrangements; face to face and online forums; a combination of individual, peer, and group supervision (professional and inter-professional), and a range of professional forums (COT, 2015; Kumar, 2015).

In developing this structure, it is helpful to consider:

- The supervision models, i.e. Proctor's Model and the 4x4x4 Model (management, support, development, and mediation). All functions are important to support growth and development. In the practitioners work context, can these be delivered by different people or modalities? Which function is most neglected?
- The resources, feedback, and experiences each of the 4 stakeholders (service users, staff, organisation, and partner organisations) can bring to the process
- The goals of the supervisee, in relation to the four supervision functions. A proactive approach by the supervisee using the reflective supervision cycle of the 4 x 4 x 4 Model may help establish clear needs and goals for supervision
- The most suitable supervision format and modalities in response to established goals

16.3.3 Examples of supervision modalities

Strategies to enhance quality of service provision (the management function) can include:

- Allocated time in interdisciplinary team meetings to discuss individual cases
- Peer supervision with clear focus, i.e. structured discussion around clinical guidelines and how these can address gaps in the practitioner's clinical repertoire
- Group supervision themed around feedback from service users and identification of targets and strategies for responsive service provision
- Short term access to a more experienced occupational therapist via teleconference or web-based program for a specific area of practice.

A personal support or professional development structure may include:

- Formal in-house group supervision to explore the emotional demands of the role, augmented with:
- Regular, informal, supervision with a colleague with a context-relevant background for the purpose of debriefing and reflecting on specific situations
- A range of professional forums to build knowledge and network, such as Occupational Therapy Special Interest Groups (using telecommunication and availability of minutes), Journal Clubs, podcasts or video recordings of professional scenarios with interactive questions
- Individual professional mentoring for profession-specific issues or conflict. Occupational therapy professional membership allows access to mentor link, a program aimed to provide practitioners with peer support tailored to their professional development, via telesupervision (https://www.otaus.com.au/singular-pages/content-pages/mentorlink)

16.3.4 Use of telesupervision

Telesupervision (also known as E-supervision) is an umbrella term used for supervision that employs mediums such as email, teleconference, and videoconference (Martin et al., 2017). Web-based programs such as Skype, Adobe Connect, Cisco WebEx, Microsoft Lync, etc., have made videoconferencing more accessible, reliable, and affordable (Deane et al., 2015).

Tools such as blog, micro-blog, wiki, video chat, virtual world, podcast and social networks can also play a role in telesupervision (Deane et al., 2015; Martin et al., 2017). Deane et al. (2015) identified the following 3 minimum requirements for effective telesupervision:

- Support for Microsoft Windows and Mac OS X platforms
- Simultaneous audio and video support
- Encrypted communication

16.3.5 Telesupervision: Terms of Engagement

A systematic review of supervision experiences of allied health practitioners in non-metropolitan settings identified that optimal and effective use of telesupervision was inherent to a positive supervision culture and led to positive supervision outcomes (Ducat & Kumar, 2015). Conversely, technology can be a potential barrier to effective supervision, if access is poor, and participants are not adequately trained in its use (Ducat et al., 2016; Ducat & Kumar, 2015).

One of the more common pitfalls of using telehealth is the temptation of users to multitask by engaging in other computer programs such as email during supervision meetings. Proficient telesupervision requires clear communication protocols, privacy and confidentiality policies, appropriate security mechanisms, and educating users in their implementation (Deane et al., 2015).

Based on a review of the literature, Martin et al. (2017) outlined ten evidence-based practical tips for using telesupervision efficiently, key points of which they presented in the model below:

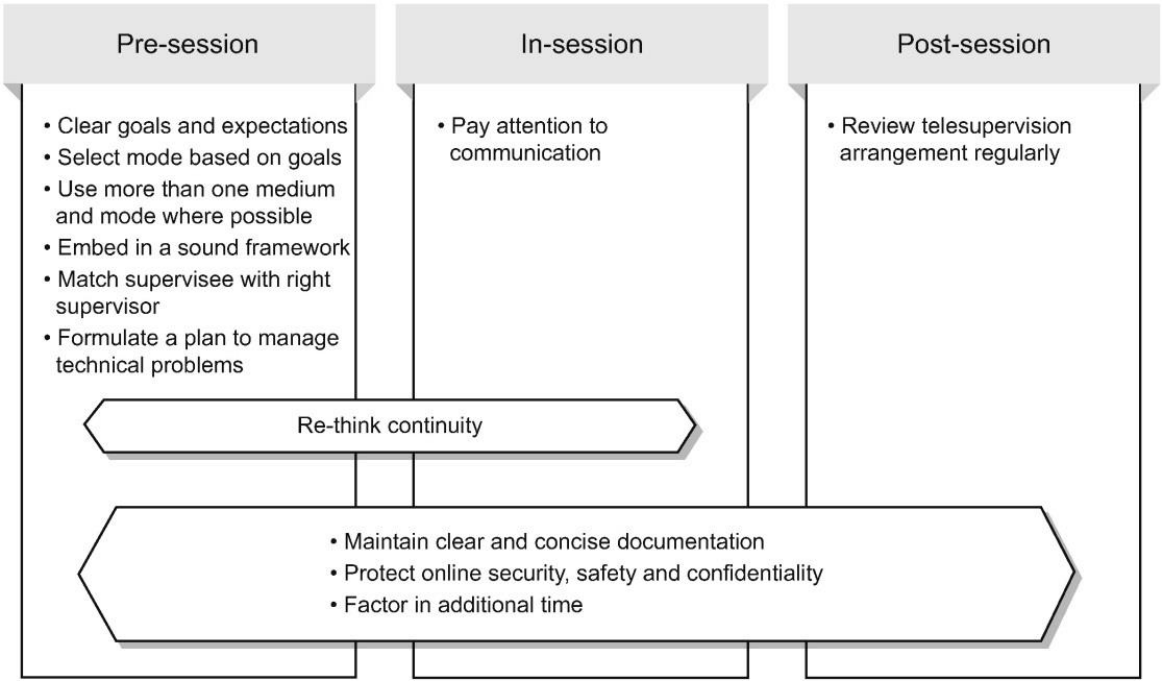

Figure 3: From: Martin, P., Kumar, S., Lizarando, L. (2017) Effective use of technology in clinical supervision. Elsevier Internet Interventions, Volume 8, June 2017, 35-39

Recommended reading:

- Tips for using telesupervision: Martin, P., Kumar, S., Lizarando, L. (2017) Effective use of technology in clinical supervision. Elsevier Internet Interventions, Volume 8, June 2017, 35-39 https://www.sciencedirect.com/science/article/pii/S2214782917300131#bbb0085
- Tips for using social media for health professions educators: Kind, T., Patel, P. D., Lie, D., Chretien, K. C. (2014) Twelve tips for using social media as a medical educator, Medical Teacher, 36:4, 284-290, DOI: 10.3109/0142159X.2013.852167

17. Evaluation of Supervision

It is important to evaluate supervision in order to maintain an effective supervision relationship that encourages discussion of difficulties early on, ensure the supervisee's ongoing development, and to attend to the safety of service users (COT, 2015; Davys et al., 2017).

Evaluation procedures should be embedded in the supervision processes and endorsed at an organisational level. Specific training and the availability of tools such as evaluation checklists and more formal methods should be available to support employees in this process (Davys et al., 2017). Evaluations should attend to the process, the content, and the outcome of supervision. Evaluation should be followed by changes to the supervision process if required (Martin et al., 2014).

17.1 Aspects to evaluate:

- The supervision arrangements (as outlined in the supervision contract): Are these still achievable for all stakeholders? Are they meeting the needs of the supervisee?
- The effect of supervision on the supervisees in relation to the 4 functions of supervision (management, support, development, and mediation)
- The content of supervision: Does it reflect all four functions? Is it responsive to the needs of the supervisee? Is there an imbalance in favour of one function, i.e. management?
- The impact of supervision on the 4 stakeholders: service users, staff, organisation, partner organisations
- The supervision processes itself, particularly:
    - The supervisee's engagement with that process. For example, is reflection occurring?
    - Supervisor's style, strategies, and interventions
    - Effectiveness of feedback provided – is it sufficiently challenging?
- The nature of the supervisory relationship (boundaries, overlapping or conflicting roles and relationships)
- With regards to telesupervision, are the supervisee's learning goals met using this medium
- What is not being addressed in supervision

(Adapted from: COT, 2015; Davys et al., 2017; Martin et al., 2014; Martin et al., 2017)

17.2 Methods for Evaluating Supervision

A multipronged approach that includes the following three elements is recommended:

- Review of the supervision contract
- Informal, regular review or reflective discussions throughout the supervisory relationship
- More formal, structure evaluation, i.e. a form or other formal evaluation process

17.2.1 Review of supervision contract

The supervision contract can be used as a structure against which standards and expectations can be reviewed on a regular basis to ensure these are clear and can be reasonably complied with. It is recommended to review all or some parameters on a regular basis (i.e. every six months), or when changes occur (i.e. a change of supervisors).

17.2.2 Reflective discussions throughout the supervisory relationship

Supervisor should regularly check with their supervisees that the process is meeting their needs. This can be done by asking questions such as: *What helped you today? What change can I make to help you more?*

It is recommended to spent time at the end of each supervision session to reflect on what added value supervision has brought to the supervisee, the supervisor, and the service users. Hawkins and Shohet (2012) offer the following questions as a basis for reflective dialogue:

- *What have we learned that neither of us knew before supervision?*
- *What have we learned that neither of us could have arrived at alone?*
- *What do we think this will mean for the person we are working alongside?*

17.2.3 Using an evaluation form or other formal process

A systematic review of supervision for allied health professionals identified the Manchester Clinical Supervision Scale as the most commonly used evaluation approach (Dawson & Leggat, 2013). The Manchester Clinical Supervision Scale (MCSS-26) includes 26 items (reduced from 36 in the original version), each rated on a five-point response scale ranging from 0 ('strongly disagree') to 4 ('strongly agree'). The items are grouped within six subscales, which in turn correspond with the three components of Proctor's model (See 'Models of Supervision'):

- Normative: Importance/Value of Supervision; Finding Time
- Restorative: Trust/Rapport; Supervisor Advice/Support
- Formative: Improved Care/Skills; Reflection

The Manchester Clinical Supervision Scale and the 26-item version MCSS-26, are protected by copyright, with all rights reserved to Osman Consulting Pty Ltd, Sydney, Australia (www.osman consulting.com). A detailed outline of the items in the scale can be found in: Winstantley, J. &White, E.(2011). The MCSS-26©: Revision of the Manchester Clinical Supervision Scale© using the Rasch Measurement Model. *Journal of Nursing Measurement*, 19(3), 160-178.

The following resources provide examples of supervision evaluation forms:

- http://www.wacountry.health.wa.gov.au/fileadmin/sections/allied_health/WACHS_G_AH_FoundationsToSupervision.pdf (p.45)
- http://www.sahealth.sa.gov.au/wps/wcm/connect/ad788900438bd2b689308dfd37f1549d/ASH+Clin+Super+Framework+2014.pdf?MOD=AJPERES&CACHEID=ROOTWORKSPACE-ad788900438bd2b689308dfd37f1549d-lmkgFAc (p.21 – 23)

18. Recommended Resources

- Social Care Institute for Excellence (2017). Effective supervision in a variety of settings https://www.scie.org.uk/publications/guides/guide50/index.asp
- Helen & Douglas House Clinical Supervision Toolkit (2014). https://www.helenanddouglas.org.uk/our-care/healthcare-professionals/
- Health Education and Training Institute, NSW Government (2014). The Superguide - A Handbook for supervising Allied Health Professionals http://www.heti.nsw.gov.au/Resources-Library/The-Superguide-a-handbook-for-supervising-Allied-Health-professionals/
- http://www.stepintoleadership.info/supervision.html

19. Future Directions & Recommendations

- ***Research within the Australian occupational therapy context:*** Within the time and resources dedicated to developing this framework, a thematic analysis of contemporary literature and allied health guidelines on 'best practice' professional supervision was able to be conducted. Leading up to future reviews of this framework; it is recommended that Occupational Therapy Australia invests resources to research the supervision practices of its members. Identifying current trends can inform the need for specific training needs and resources, and would strengthen the accuracy and relevance of subsequent guidelines.

- ***Extended guidelines – Telesupervision:*** These guidelines have touched on, and acknowledged the diverse occupational therapy practices and the challenges these may present in terms of accessing reliable professional supervision. The establishment of the National Disability Insurance Scheme is likely to lead to an increasing number of practitioners working in host organisations and / or in generic roles. In such circumstances, traditional face-to-face supervision may need to be augmented or replaced by telesupervision modalities. This warrants a more detailed practice document that includes professional guidelines and recommendations for: Using technology and social media; 'online' professional conduct; privacy and confidentiality, and security mechanisms and policies (Deane et al., 2015; Martin et al., 2017).

- ***Accredited professional supervision training:*** Most occupational therapists in Australia assume the role of supervisor with little or no formal training. This is despite professional supervision being a mandated requirement, and consistent findings in the literature that quality training is a prerequisite to fulfilling the complex role of professional supervision skilfully. Davys et al. (2017) argue for an endorsement role for the professional or regulatory bodies, and Sweeney et al. (2001) suggest that 'an occupational therapy supervision course validated by the national professional body and culminating in an official certificate would help to reiterate the importance and value of training in supervision' (p.428). It is recommend that OTA explore the feasibility of an accredited professional supervision course and the contributions this could make in helping the transition from practitioner to supervisor; the quality of supervision; and ultimately, improved outcomes for service users.

- ***Involvement of Service Users:*** Available evidence suggests that the involvement of service users' perspectives in the supervision process rarely takes place. Emerging literature proposes that service users can be involved in the supervision feedback loop, and that this should be promoted as part of the process of monitoring and improving quality of care (the 'management' function of supervision). The Social Care Institute for Excellence (2017) offers a number of strategies on how to implement this (some of which have been integrated in this framework) (https://www.scie.org.uk/publications/guides/guide50/peoplewhouseservices/index.asp). As further research becomes available, it is recommended that future additions to this framework feature more prominently guidelines on safe and sensitive strategies to include service users in the supervision process.

20. Summary

- Professional supervision is mandated by the profession. This is articulated in the Occupational Therapy Code of Conduct (2014) and Competency Standards (2018).
- The foundation for professional supervision is a collaborative and professional relationship based on trust, safety, and rapport. All parties involved should be aware of the inherent professional values, as stipulated in the Code of Conduct (2014) and Code of Ethics (2014), which underpin such relationship.
- Supervision has a formative, normative, and restorative function. It aims to:
    - Ensure safe and 'best practice' service provision for service users
    - Improve, develop, and support the supervisee
- A number of components are critical to the implementation of effective supervision, most notably:
    - Supportive organisational guidelines and culture
    - Critical reflection and feedback
    - The use of a theoretical model to guide content, process, and evaluation
    - Documentation (i.e. agreement, records, agenda) and structure
- Further improvements are needed in the quality control of supervision, in particular:
    - Preparation and training of supervisors
    - Monitoring frequency and content of supervision
    - Evaluation of supervision
- Occupational therapists that work in geographical or professional isolated areas face additional challenges that may impact frequency and quality of supervision. To address these, the application of varied telesupervision modalities may be needed, as well as a combination of different formats (i.e. group or peer supervision), and the input of non-discipline specific professionals. Supervision should always include a discipline-specific component.
- Further research is recommended to identify current Australian occupational therapy supervision practices in as broad a range of setting as possible, to identify:
    - Current practices and processes
    - The needs of supervisee and supervisors in terms of training and support
    - The outcomes of supervision for the 4 stakeholders (service users, staff, organisation, partners)
- Occupational Therapy Australia has a role to play in mandating training for occupational therapy supervisors and, following further research, developing extended scope of practice to address the needs of an increasing population of practitioners working in emerging settings.

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APPENDIX 1
Template Supervision Agreement: Example

This template is a suggestion only. It is recommended that you modify the examples (in italic) to suit your supervision context and organisational policies.

Goals of supervision

The goals of supervision are:

- To ensure safe and 'best practice' service provision for service users
- To improve, develop, and support the supervisee:
    - *Assist in the identification of professional and personal needs and strengths*
    - *Promote professional development and identify future goals and resources for learning*
    - *Promote self-reflection as a means to transform practice*

Prerequisite

Supervisee and supervisor review professional values that underpin confidentiality and professional relationships as documented in Occupational Therapy Australia Code of Ethics (2014) and Occupational Therapy Code of Conduct (2014)

Content of supervision

- *The content will be set collaboratively between supervisor and supervisee.*
- *The content will be focussed on Proctor's and the 4 x 4 x 4 Model of Supervision functions, with consideration of the 4 stakeholders*
- *Both supervisee and supervisor will complete agenda 2 days prior to meeting*

4 x Functions	4 x Stakeholders	4 x Elements
Management (Normative)	Service users	Experience
Personal support (Restorative)	Staff	Reflection
Professional development (Formative)	Organisation	Analysis
Mediation	Partner organisation	Action planning

Responsibilities of supervisor and supervisee

As a supervisor I agree to:

- *Uphold professional values supporting professional relationships*
- *Consult relevant organisational supervision policy documents*
- *Protect the time and space of supervision sessions; ensure privacy and no interruptions*
- *In collaboration with supervisee:*
    - *Complete a supervision agreement*
    - *Prepare agenda for each session*

- *Use a supervision model to ensure approach and content of supervision is holistic*
- *Assist supervisee with the four elements of critical reflection through the use of guided questioning*
- *Record discussions and decisions in a supervision record*
- *Review and reflect on supervision session*
- *In line with organisational policies, participate in procedures to evaluate supervision*
- *In line with professional and organisational codes of conduct, maintain confidentiality*

As a supervisee I agree to:

- *Uphold professional values supporting professional relationships*
- *Consult relevant organisational supervision policy documents, including grievance procedure*
- *Self-monitor performance; be proactive in developing reflective capability to determine competency areas of strength and those that require further development*
- *Engage fully in the process of reflection, analysis, and action; be open to change in practice; follow up on action*
- *Use a supervision model to identify practice, professional development, and support needs*
- *Take responsibility for enhancing my personal knowledge and professional development; independently access knowledge and resources to bring to the supervision process*
- *Come prepared and bring relevant evidence:*
    - *Case notes I have concerns about and would like to discuss*
    - *Diary*
    - *Agenda*
    - *Specific literature and other evidence of best practice*

Additional items:

- Where a supervisor has a dual role (i.e. supervisor and line manager), add specification of the different functions of the roles; specification on how conflict of interest will be avoided

Duration - frequency - delivery format

- *Formal face to face supervision sessions will occur at least once a month, for a minimum duration of 60 minutes.*
- *If a supervision session is missed, the supervisor takes responsibility to rearrange an alternative date as soon as possible.*

Additional items:

- Arrangements for any ad-hoc or unplanned supervision
- Where face-to-face, one-on-one supervision is not the norm; add specification on the delivery formats and modalities that will be used, including how the discipline-specific component will be safeguarded

Documentation processes

- *The supervisor will record each session using the Supervision Record Template*
- *Both supervisor and supervisee sign and date each record as evidence of the content discussed*
- *The supervisee will receive a copy of the records*

- *The notes (records; agendas) will remain accessible to both the supervisor and supervisee*
- *All notes will be* securely stored in……

Confidentiality

- *Matters discussed in supervision will remain confidential and will not be discussed with any other party.*
- *Confidentiality will not be uphold if either party becomes aware of information related to issues of safety which could adversely affect themselves or others.*
- *If information needs to be shared, the supervisor will advise the supervisee in advance, including what will be shared, with whom and for what purpose.*

Evaluation of supervision

- *Evaluation of the supervision will occur as an ongoing part of the supervision process*
- *A formal evaluation will take place once a year involving all parties. Evaluation data will inform changes to the supervision agreement*
- *The supervision agreements will be reviewed every 6 months (or sooner if changes occur, i.e. change of supervisor or to organisational policies)*

Managing conflict in the supervisory relationship

- *Every effort should be made to resolve any issues at the earliest opportunity, within supervision*
- *Both parties review the organisation's remediation and grievance policies and the terms of engagement in the supervision agreement. The following resource may be of assistance: https://www.researchgate.net/publication/232609296_Managing_Difficulties_in_Supervision_Supervisors'_Perspectives*
- *Both parties identify and discuss points of differences (i.e. practice decisions, learning styles, personality, etc. in a constructive way*
- *In situations where agreeing to a resolution is challenging, and with agreement of both parties, a third party will be involved. The third party will be……..*
- *In exceptional circumstances, where issues cannot be resolved, the supervisee has recourse to the line manager and the supervisory relationship may be ceased*

Signature of Manager:_____Date

Signature of supervisor:_____Date

Signature of supervisee:_____Date

APPENDIX 2
Template Supervision Record: Example

This template is a suggestion only. It is recommended that you modify the subtitles to suit your supervision context

Review of action points from previous session

Achievements since last supervision meeting

Difficulties or problems since last meeting

Key points for reflective discussion and brief discussion outcomes	
Management (what has worked well in service provision; any issues related to safety or quality of practice; managing professional & organisational expectations; impact of new policies or procedures)	
Support (current stressors or issues relating to staff wellbeing, the demands of the practice environment; interactions with service users; directing to appropriate help)	
Development (progression and awareness of personal & professional skill development; feedback from training; professional development needs and opportunities)	

Mediation (access to organisation systems or resources; liaising with external organisations)	

Agreed actions
Supervisor:
Supervisee:

Any other matters discussed

Record below any significant issues requiring onward reporting, to whom and when it will be reported

Issues of disagreement
Session Evaluation
What have we learned that neither of us knew before supervision? What have we learned that neither of us could have arrived at alone? What do we think this will mean for the person we are working alongside? What can we change to make the session more effective?

Date and time for next session

Date:

Individuals present:

Supervisor (Name & Signature):

Supervisee (Name & Signature):

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