Royal Hobart Hospital

Clinical Support Services

Department of Health and Human Services

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Supervision – A Journey towards Best Practice

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Why supervise?

- Organisation – clinical governance
  - Quality service
  - Reduce risk to patients and staff

- Profession – OT responsible for professional practice of selves and support staff
  - Safe and effective delivery of OT service
  - Fosters professional competence and development (OT Australia[1] & American Assoc. OT, 2004[2])

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The Journey begins

- 2000 Seniors meeting established
  - Support to develop skills in supervision
- Established group to look specifically at supervision
  - Support and sharing ideas
  - Development of structure for consistency
  - Baseline of problems encountered
  - Search for resources and articles

Outcomes from step one

- Include supervision as focus in orientation;
- Determination of core skills required in orientation – new grads / experienced OTs;
- Allow time for staff to have supportive ‘settle in’ prior to taking on full caseload;
- Resource folders for rotations, specific skills.

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Supervision Guidelines (Take One)

Guidelines for Supervision document:

- Allocation of supervisor;
- Inform new staff of obtaining alternate supervision;
- Ongoing process;
- Establishment appropriate of learning / teaching styles;
- Flexibility in relationship;
- Outline of expectations for each level of staff.

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Evaluation of Step One

- Exit interviews showed positive results
- Returning staff praised seniors for quality and quantity of supervision

- Senior staff not satisfied that best practice reached – inconsistency and gaps for both supervisors and supervisees

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Issues – relating to Supervisees

- Responsibility fell on supervisor
- Boundaries of supervision blurred
- Confidentiality
- Style differences between supervisors
- Inconsistency in use of documentation
- Shopping around

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Issues – relating to Supervisors

- Burden fell to few seniors
- No training for new supervisors
- No formal supervision for level 2 / 3 staff
- Not sure where responsiblility and autonomy ends

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Step Two

- Made a plan
  - Models and frameworks of supervision
  - Learning styles relating to supervision
  - Skills and training needs of supervisors
  - Documentation
  - Rules of supervision
  - Reasons for supervision
  - Relationship to caseload allocation

Updated Guidelines (Take 2)

- From literature, OT Australia guidelines for Supervision[3], and training
  - Definition of supervision (or not)
  - Supervisor allocation
  - Procedures
  - “Fleshing out” of old document

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Training

- Education and Training Grant
  - Workshops March 2006
    - Supervisees (1/2 day)
    - Supervisors (full day)

    “Making supervision work for you”

    - Definition and practice of clinical supervision
    - Stages of supervision
    - Contract setting, use of log books
    - Essential skills for supervisees
    - Feedback

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Evaluation of training

- Expectations of workshops
- Training – meeting expectations - Av. 7.5
- Satisfaction of supervision prior to workshop - Av. 5.1
- Attitude of supervision prior to, and after workshop - Av. 8.4

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Integration of workshop

- Guidelines Updated (Take 3)
  - Peer supervision model
  - Group supervision
  - Pre-supervision meeting held
  - Prompts sheet developed to help promote a supervisee centred session
    - Strengths, needs, goals identifier
    - Supervision agreement
    - Supervisor feedback on Supervisee
    - Supervision attendance record

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A sidetrack on a gravel road - Change to supervisor allocation

- Recommendation to have consistent professional supervisor for year (from 4 months)
- Staff rotation needed change for clinical work
- Unwieldy
  - One for clinical day to day clinical
  - One for professional development supervision
  - Unable to differentiate
  - One supervisor – too many supervisees

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Why was it so?

- ?OTs are based in practical sphere
- Level one staff unsure which supervisor to go to
- Issue of confidentiality between supervisors
- Staff not able to freely chose supervisor
- Role of supervisor vs mentor for seniors

Mentoring

- **OT Australia Victoria (1999) defines a mentor as:**
  - "a colleague who is selected to assist, guide, advise and counsel, but who is not a formal supervisor or assessor of the mentee in the workplace" (cited by Fone 2006)4
- Junior staff not ready for "mentoring"

Mentoring vs supervision (Adapted Rose and Best, 2005)

	Supervision	Mentoring
Relationship type	Clinical enabling relationship	Intimate, personal enabling relationship
Socialisation	Clinical socialisation, focus on practice	Career socialisation, providing social and political networks
Learning support	Semi-structured learning support	Unstructured learning support
Duration	Medium-term, determined by clinical partnership and working alliance	Long term, determined by those involved
Assessment	Clinically and professionally related tasks, and self-assessment	Multi-faceted assisting roles but no formal assessment
Selection	Chosen by individual (or assigned 'in-house' situations)	Chosen by individual

Where are we now?

- Compliance with agreed frequency of supervision sessions
- Guidelines, documentation fully implemented
- One supervisor
- Supervisees taking responsibility for supervision
- Improved staff satisfaction and attitude towards supervision
- Integration of credentialing, PDPs
- New team structure

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Did we reach best practice?

- Literature supports delineation of supervision from mentoring in the workplace
- Supervisor not direct line manager
- Use of supervisory contracts
- Structure is agreed upon by both parties
- Clinical issues as well as supervisee issues drive the process
- Does not include performance management, teaching or counseling
- Confidentiality is maintained
- Lessons learnt transferable to all Allied Health

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References

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