HSHS802: Professional Supervision 1.

Class Set: Copy No.

Reference:

Simmons Carlsson, C., Coups,C., Mueller,J., Needs, P., & Thronley, L. (2007) Pursuing a framework for quality supervision in an acute hospital setting. In Wepa, D. (ed.) *Clinical Supervision in Aotearoa/New Zealand: A health perspective. Pp. 121- 140.* Auckland. New Zealand: Pearson Education.

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Chapter 10 Pursuing a framework for quality supervision in an acute hospital setting

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Learning outcomes

- To provide an overview of an allied health supervision framework in an acute hospital setting
- To discuss an example of how this framework is implemented for Occupational Therapists, Physiotherapists, and Speech-Language Therapists
- To provide legislative relevance of the Health Practitioners Competence Assurance Act 2003 (HPCAA 2003) to clinical supervision
- To discuss the current model of supervision that is in place in the Women and Children's Therapy (WCT) team

Key terms

- Acute hospital
- Supervision framework
- Tangata whenua supervision
- Ethical supervision
- Role conflict
- Peer review
- Professional codes of ethics

This chapter provides an overview of the development of a supervision framework for allied health professionals employed by the Auckland District Health Board (ADHB). Our particular focus is on supervision as it relates to the occupational therapists, physiotherapists, and speech language therapists within Auckland City Hospital (ACH), including Starship Children's Health and National Women's Health services. The therapists are managed within interprofessional allied health teams, where their supervision is mandated under the ADHB Allied Health Supervision Policy (2004). This chapter offers a contextualised example of a supervision framework for selected allied health professionals in an acute practice setting.

efore a means of focused support and development. Tangata Whenua sion is recognised in the policy as providing opportunities for Maori staff ore and reconcile clinical and cultural issues for using Maori frameworks anga values so that practitioners may retain their cultural identity and y as Maori.

policy also addresses issues related to ethical supervision. Matters ed in supervision regarding clients, colleagues and the employer are seen as ed, therefore kept confidential within the supervisor-supervisee ship. Any exceptions to this are declared in the policy.

dback from the supervisor to the Line Manager must be negotiated with the see; or when the supervisor discusses issues with his or her own supervisor. er, procedures around any concerns about the safety or risk to clients, ues and the employer are stated in the policy, as well as the actions that the sor must follow when the need for disclosure arises. The policy also ledges that it is preferable for the supervisor and supervisee to not have ing roles and relationships which may create tensions within the sion relationship. This is, however, a constant challenge to achieve in the etting as a Team Leader may supervise a Clinical Supervisor (senior oner) for whom he or she also has management responsibility.

es of accountability and issues of power imbalance pose potential threats to sion partnerships (Hawkins & Shohet, 2000; Holley, 2005). To counter e stated expectation in the policy around issues of power imbalance and ty is that these relationships will be clearly declared, discussed and ted as part of the supervision contract and routinely checked throughout the sion process. Under the policy, Team Leaders and Line Managers are ible for ensuring that supervision takes place for their staff. They are also ible for ensuring the suitability of supervisors; agreeing to the supervisor, suring appropriate supervisor-supervisee match, taking into account al practitioner needs where possible. Some Team Leaders are also trained sors, usually supervising allied health staff from other teams. The allied organisational structure requires Clinical Supervisors to have a ibility to monitor discipline-related standards of clinical practice and they onsible, alongside their

m Leaders, for ensuring that practitioners of their respective discipline an interprofessional team are in supervision.

heir designated role, Clinical Supervisors may provide direct clinical sion to their same discipline colleagues. Alternately, they may delegate the supervision to another trained supervisor.

The regulatory framework

The practice of occupational therapists, physiotherapists and speech-language therapists are situated within a legislative regulatory framework which includes the *Health Practitioners Competence Assurance Act 2003* (HPCAA, 2003) and the discipline's respective professional Codes of Ethics. Within the context of the regulatory framework there is variability of supervision requirements from profession to profession.

The Health Practitioners Competence Assurance Act (2003)

The Health Practitioners Competence Assurance Act 2003 (HPCAA, 2003) is a unique piece of legislation for both New Zealand and for registered health-care practitioners around the world and has replaced many outdated, individual Acts governing specific professions. The key purpose of the HPCAA is to protect the health and safety of the public through seeking to ensure a high standard of treatment and health-care provided to clients and patients by registered health practitioners. The Act includes mechanisms to assure the public that a health practitioner, who is registered under the Act, is competent to practise and includes consistent procedures across the professions for handling complaints against health practitioners, co-ordinated with the provisions of the Health and Disability Commissioner Act (1994). The Act covers many professions including dietitians, doctors, nurses, midwives, occupational therapists, physiotherapists, pharmacists and psychologists.

The Act contains key statements of intent which are of particular importance to health practitioners when considering issues of competence, fitness and safety to practice, as well as supervision requirements for individual practitioners. This includes the need to provide a uniform approach to all health professions, with changes applying automatically to all professions; the provision of a supportive environment for health practitioners to maintain their competence and for the Act to be flexible enough to meet changing skill sets, roles, diagnostic regimes, and treatments.

The occupational therapy and physiotherapy professions are registered under this Act and speech-language therapy has commenced the process to become a registered profession. The HPCAA incorporates three key aspects for health practitioner competence: practitioners must demonstrate their ongoing competence to practise within their gazetted scopes of practise; designated authorities must be notified by another health practitioner (or an employer) of any concerns regarding practitioner competence to practise; and designated authorities must be notified by another health practitioner (or an employer) if practitioners are not able to maintain their mental and physical fitness to practise.

Professional Codes of Ethics

Professional Codes of Ethics specify each profession's principles for acceptable standards of professional and ethical behaviour and all professions practice according to their respective Codes of Ethics. The occupational therapy and speech-language therapy codes stipulate a requirement for occupational therapists and speech-language therapists to engage in supervision while the physiotherapy code differs in that it does not mandate supervision. Physiotherapists are encouraged to participate in peer review' (New Zealand Society of Physiotherapists Inc., 2003: 2) a requirement similar to that of the medical profession. Although peer review is not the same as supervision, 'live' supervision with clients and peer review are occasionally deemed synonymous with supervision, or confused as supervision, signalling the confusion that exists around supervision understandings amongst the professions.

Occupational Therapy Profession and Supervision

The Occupational Therapy Code of Ethics has long mandated that occupational therapists be engaged in supervision yet the uptake of supervision has been variable. Since HPCAA the occupational therapy profession has seriously and critically engaged in revisiting the quality of the supervision they provide and receive. The New Zealand Association of Occupational Therapists Inc. (NZAOT) has a Special Interest Group for supervision discourse and has written a Position Statement on supervision (NZAOT, 2004). For the occupational therapy profession, 'supervision is an important component both in the process of developing awareness of self and abilities, and in critical reflection' (OTBNZ, 2004: 8). Moreover, because it also affords the practitioner the opportunity to receive feedback and guidance, it is considered by the profession to be a critical component of continuing competence.

Supervisors of occupational therapists are not restricted to their same profession. A supervisor may be chosen from another profession (Occupational Therapy Board of New Zealand, 2005), as in cross-discipline supervision. All supervisors, however, are expected to be able to provide effective supervision relevant to the individual therapist's work setting (OTBNZ, 2004) and must be willing to comment on seven occupational therapy competencies as it relates to their continued registration and competence as part of the supervision process. The supervisor inputs directly into the therapist's electronically-based *Continuing Competency Framework* for Recertification (CCFR). Line Managers are not recommended as supervisors (OTBNZ, 2005) and the Occupational Therapy Board encourages occupational therapists to be proactive in choosing their supervisor. In many instances, however, choice of supervisor is often employer-directed. Accordingly, occupational therapists are charged with being active partners in their supervision and being accountable for ensuring that the supervision they receive is both effective and high quality. For example, in

Competency 5, criteria exist which require all occupational therapists to assess the effectiveness of their supervision and seek changes as required. They must also provide evidence of use of supervision to improve their performance (OTBNZ, 2004). In addition to the expectation that therapists engage in supervision, the Occupational Therapy Board also stipulates three regulatory conditions for the supervision of occupational therapists which specifically relate to the occupational therapy general scope of practice (OTBNZ, 2005) for newly graduated occupational therapists, return-to-work occupational therapists and overseas qualified therapists in their first six months of their practice. In these instances, the supervisor must be a New Zealand Registered Occupational Therapist (NZROT). This is because the supervisory relationship in these instances has an overt monitoring and reporting component that sits alongside standard supervision.

Two forms of supervision are typically recognised within the occupational therapy profession: clinical and professional. Clinical supervision primarily focuses on clinical practice and should be provided by a registered occupational therapist with suitable experience, knowledge and skill that will enable growth and development in the clinical skills domain of the practitioner. Professional supervision on the other hand is likened to supervision which assists practitioners to increase their understanding of oneself; one's relationships with others; to develop fulfilling and more resourceful ways of providing occupational therapy; and to bring about change in professional behaviour and practice. Both types of supervision aim to foster reflection, practitioner competency, efficacy and ultimately practitioner self-supervision (NZAOT, 2005). The processes for and model of supervision used by the occupational therapy profession tends to be influenced by factors such as the supervisor's background, experience and training in supervision. Some occupational therapists may have more than one form of supervision at any given point in time of their career paths, with the frequency of supervision ranging from fortnightly to monthly.

Reflective questions

- Do you agree with this professional group's definitions of clinical and professional supervision?
- If so, why? If not, why?
- What other types of supervision would meet your needs?

Speech-language therapy profession and supervision

As a professional group speech-language therapists have long recognised that clinical supervision should form an integral part of their initial training. In addition it should form part of their continued professional development through all levels

d in all work settings (American Speech Hearing Association-ASHA, 1985). peech-language therapists in Aotearoa/New Zealand have developed a growing terest and recognition of the relevance of supervision to their professional actice in response to awareness of supervision practice in other professional oups including occupational therapy, psychology and social work. Subsequently, the 2002 New Zealand Speech-Language Therapists Association (NZSTA) nference, a consultative workshop developed a working definition of pervision. This definition included key elements such as the need for pervision to be conducted within a formalised, structured, regular, confidential d contractual relationship. The definition also recognised the need for pervision to be a reflective process, driven by the supervisee; that the supervisor ould be skilled in supervision and that supervision may take place on a group or dividual basis, as well as within or outside the discipline.

The NZSTA Code of Ethics (2005) requires its members to fulfil their ofessional responsibilities through six ethical principles. These principles corporate professional competence and integrity, personal conduct, relationships ith clients and other professional, confidentiality and research (NZSTA). The de directs members to 'recognise the limits of their own professional mpetence' and throughout their careers to 'participate in continuing professional evelopment' (p. 6). The code also directly instructs NZSTA members to be gaged in supervision via Ethic 6, which requires members to 'freely accept the ofession's self imposed standards' (p. 10). These standards are outlined in ommunicating Quality 2 (Royal College of Speech and Language Therapists, 996) which are incorporated into the NZSTA Code of Ethics. Knowledge of and dherence to these standards is an imperative of NZSTA's members' professional ractice. As with the NZSTA working definition, these standards also recognise at in order to provide a quality therapy service it is essential that professional upervision is in place for all speech-language therapists.

Two forms of supervision are recommended within the standards. The first is anagement supervision, which should seek to enable the therapist to fulfil the equirements of their position description and forms part of the performance evelopment and appraisal process, or both. It is a forum for discussing and romoting ongoing professional development. This form of supervision should lso facilitate a speech and language therapist's adherence to their professional tandards. The second form, non-managerial supervision, allows for the pportunity or need to engage in supervision that is outside of a direct line anagement or reporting structure. This may be via individual or group upervision. The overall aim of non-managerial supervision should be to ncourage 'a learning environment which promotes critical appraisal and problem olving skills' (RCSLT, 1996: 249). The standards also state that training should e made available for supervisors or group facilitators.

Supervision has been found to be a growing practice in speech-language

high importance speech-language therapists place on the role of supervision in the maintenance and development of their professional standards. However the survey also highlighted some of the challenges which face speech-language therapists and other professional groups to overcoming barriers to maintain effective and productive supervision practice, such as allowing 'time' for supervision ensuring the availability of suitable supervisors and making training available for supervisees and supervisors.

Physiotherapy profession and supervision

The Physiotherapy Board of New Zealand (PBNZ, 2005) registration requirements outline a set of 10 competencies and subsequent learning objectives. These competencies and their general learning objectives are embedded with core elements which lend themselves to exploration through supervision. For example, Competency 5.7 states that physiotherapists will be able to 'recognise barriers to communication and modify practices appropriately' (p. 56). Competency 5.8 states that the therapists will be able to evaluate and modify their communication skills as appropriate. These given examples are often the content for supervisory inquiry for therapists in the acute setting who engage in multiple interprofessional relationships on a moment-to-moment basis.

Whilst the Board does not stipulate that physiotherapists must be in supervision, in essence aligning legislative, professional requirements and organisational policy on supervision serves to support the achievement of practitioner competency through the physiotherapist being in quality supervision. The current requirements to maintain competency for registered physiotherapists requires evidence of continuing professional development (CPD) in four categories: work-based learning, professional activity, formal education and self-directed learning (PBNZ, 2005). Reflective practice, mentoring, peer review and direct supervision of staff/students are all identified as appropriate CPD activities under the work-based learning category. If the CPD record from a physiotherapist is audited by the Board, they will also need to provide three reflective statements regarding their learning.

Historically for physiotherapists, supervision has meant live supervision of colleagues and observing each other in practice. This is a model that physiotherapists are comfortable and familiar with; forming much of the assessment of clinical practice at undergraduate level within the profession. Learning through self-reflection, a process often utilised in supervision, however, is a relatively new concept for physiotherapists, although it is now taught at undergraduate level. In general the professional culture of physiotherapists tends to be action-oriented. As long as they are treating clients or patients using the correct technique, issues such as supervision may be seen to have lesser relevance to the practice of physiotherapy. Consequently as a profession there is limited, although growing, acknowledgement that clinical and professional issues may be

best served, understood and dealt with through the processes of supervision. For example, recognising and dealing with problems of personal/professional boundaries and identity in relation to clients, patients and colleagues may be addressed early in supervision. Furthermore, because physiotherapists are traditionally comfortable and familiar with concepts of peer review, they may find an individual one-to-one model of supervision not only unfamiliar but also potentially threatening. In other words, they may view it as too 'touchy-feely', a position that is uncomfortable for many physiotherapists.

Reference to the literature

The literature review excludes any literature pertaining to the clinical supervision of undergraduate occupational therapist, speech-language or physiotherapy students. Our interest relates to the practice of supervision as defined by the ADHB Allied Health Supervision Policy (2004). Whilst there is ample literature pertaining to the practice of supervision (Borders, 1994; Carroll, 1996; Carroll & Gilbert, 2005; Falvey & Bray, 2002; Hawkins & Shohet 2000; Holley, 2005; Inskipp & Proctor, 1993, 1995), few publications exist that are specific to registered occupational therapists, speech-language therapists or physiotherapists per se. Drysdale & Martin (2003) found that information on supervision and speech-language therapy is not easy to locate in the literature. Grover (2002) however, offers helpful insights into supervision of allied health professionals including the valuable properties of supervision. For example, facilitating practitioner development, competence, and ethical and quality practices. In addition, the benefits of supervision are raised such as job satisfaction, increased practitioner competency, opportunity for debriefing, casework reflection and conceptualisation, and the value of exploring lived experiences, to name but a few. Lastly, the need for supervisors to be trained in supervision skills is highlighted by Grover.

Most of the supervision literature is published in the fields of counselling, mental health, social work, psychology and the psychotherapies, with some in nursing. Current trends in Aotearoa/New Zealand supervision practice have recently been presented at supervision conferences (Beddoe & Worrall, 2000; Beddoe, Worrall, & Howard, 2005) and during local courses on supervision. A few articles have been published in the occupational therapy literature (Berger Rainville, Cermak & Murray, 1996; Hanft & Banks, 1999; Hunter & Blair, 1999; Johnson, Lamere-Wallace & Gardner, 2000; Sweeney, Webley & Treacher, 2001a, b, c), however the scope and extent remains limited. One known qualitative study (Herkt, 2005), focusing on exploring the nature and process of supervision in this country, is pending publication. Other published articles have included topics on supervision as a support system in continued professional growth (Mosey, 1986); supervision and consultation for paediatric occupational therapists

(Berger Rainville, Cermak & Murray, 1996); collaborative processes in supervision (Hanft & Banks, 1999), and supervisor preparedness (Johnson, Lamere-Wallace & Gardner, 2000). In addition, some professional bodies have published guidelines for supervision (American Occupational Therapy Association, 1999; Australian Association of Occupational Therapists, 1997; NZAOT, 2005).

The physiotherapy literature has an emphasis on the supervision of students or staff employed in 'assistant' roles to the physiotherapist. There is little comment regarding the supervision practices of registered physiotherapists in clinical practice settings with the exception of The Chartered Society of Physiotherapy (CSP) in the United Kingdom which has a published position paper *'A guide to implementing clinical supervision'* (CSP, 2005). The CSP is one of the few professional physiotherapy bodies internationally to define, recognise and support supervision as an integral element of practice for physiotherapists. The CSP definition focuses on the encouragement of professional skill development, and an enhanced quality of care through an evidence-based approach to maintaining standards of practice. The CSP is also clear that it is not mentorship, appraisal or peer review. The international physiotherapy body, the World Confederation of Physical Therapy (WCPT, 2003) supports supervision in its Declarations of Principle regarding physiotherapy education for entry-level physiotherapists. Statement 7 states: 'The curriculum and continuing professional development (CPD) opportunities should prepare physical therapists with knowledge of educational approaches to facilitate the supervision, education and transference of skills to others'. Once again, there appears to be a limited focus on professional supervision of self, rather the context remains on 'live' supervision of other practitioners, students and/or consumers of physiotherapy services. The WCPT also publishes a set of ethical principles, which refer to peer review as a form of practice evaluation.

Current supervision practice for occupational therapy, speech-language therapy and physiotherapy at ACH

The occupational therapists, speech-language therapists and physiotherapists work in three distinct teams at ACH. This includes the Adult-Surgical, Adult-Medical (including Older People's Health and acute rehabilitation services) and the Women's and Children's Therapy teams. Anecdotally, supervision has occurred in the three professional groups for some time. Historically, however, there have been differences in interpretations of what supervision is and how it might occur in the acute setting. Supervision has been practised in various forms depending on the teams' understanding of supervision and the supervising therapist's exposure to supervision training. For example, hierarchical clinical supervision occurs where a more experienced therapist supervises a less experienced therapist. Here

pervision tends to focus on a therapist's day-to-day clinical practice, clinical ills and any project work the supervisee may be involved in. This form of pervision is often linked with performance management and quality systems, th the emphasis placed more on monitoring the work of the therapist, at times in to 'shop-floor' supervision in the workforce. Peer review of practice is also a cognised system for monitoring performance in the workplace and as earlier ited is often confused with supervision. Furthermore, supervision contracts may may not be in place.

hat is happening now?

) date within ADHB, all three professions engage in some form of supervision th varying degrees of efficacy, and allied health is in the process of working wards fully realising the organisational supervision policy. The goal is to build a stainable and robust culture of supervision for all three professions. This cludes building a quality framework that attends to the following key mponents of supervision practices:

- Ongoing and sustainable training of staff as both supervisees and supervisors, including identifying and determining the most effective training options for the three professions.
- Ensuring flexibility for choice of supervisor wherever fiscally and practically realistic. This may involve a process of guided and negotiated choice in partnership with management.
- Ensuring flexibility for a range of supervision options to occur for the different professions, including individual, peer and group supervision processes. This includes being able to clearly identify and define the parameters of what constitutes effective supervision.
- Raising the level of staff awareness and understanding of supervision at all levels including management.
- Ensuring a consistent supervision contract is used; including a systematic process for negotiating supervision is in place.
- Ensuring supervisors are accountable for their supervision of staff and that their supervision is related to the work of the supervisee. This also involves ensuring that supervisors are themselves in ongoing supervision that is specific to their supervision practice.
- Ensuring that the culture and practice of supervision is sustainable across time for the ADHB.

Currently occupational therapy and speech-language therapy staff are engaged individual supervision with supervisors who have all had some level of training supervision skills, ranging from basic introductory level to advanced pervision skills. Some physiotherapists, especially those working within Women d Children's Health are also in individual supervision. In contrast, the majority physiotherapy staff, especially those who provide services to the adult acute and lder People's Health services are in peer group supervision, called Professional

Peer Review (PPR). This peer group system of supervision was originally based on a model of peer supervision (NZ Mentoring Centre, 2001) which requires regular and facilitated meeting processes to do any of the following:

- review a piece of professional practice that was difficult, or perhaps could have been done better or differently,
- present an incident one may need assistance or support with, and
- seek feedback from peers on one's work performance and professional effectiveness.

Journeying towards a quality supervision framework

There is recognition in the field of supervision practice that several core elements foster the building of a culture of supervision in the workplace (Holley, 2005; Hawkins & Shohet, 2000; Schrader, 2005) and the ADHB allied health vision is focused on building a culture of supervision for all three therapy professions. Whilst much has been achieved towards this goal there is still a way to go in establishing a sustainable culture of supervision.

One of the key core elements is that there must be a group of people who have an ongoing commitment to the goal and such a group resides in allied health. These people are representative of all levels, including management and the staff. They are instrumental in ensuring that staff, management and those who are fiscally responsible understand the needs of the service and the different needs of the professions regarding supervision. For our teams, we have established a working group comprised of the Allied Health Manager, therapy Team Leaders, Professional Leaders, and Clinical Educators with varying backgrounds in supervision practice. In this group, ongoing dialogue and development of supervision frameworks for the three therapies occurs. From here, collaborative outcomes are translated into the practice context. Time is afforded through scheduled meetings to debate and reflect on the implementation of supervision and to engage in an ongoing shared process of learning from experiences.

Reflective questions

- Who could you identify as key people to initiate a similar group such as this one at ADHB?
- What processes discussed at ADHB would you find helpful in terms of establishing buy-in from various professional and management personnel?

Documentation and policies are also vital in building a culture of supervision. The ADHB Allied Health Supervision Policy forms the scaffold informing the development of supervision for the professions. A uniform Supervision Contract has been drafted and is in use, although at times inconsistently, as is a set

upervision Attendance Log. The log records attendance and any key themes nked to a practitioner's key accountabilities, competencies and the ADHB goals. Vhilst the content of supervision remains confidential to the supervisee and ıpervisor, the log serves as part of the evidence for supervision in the erformance review process. It is also part of staff professional portfolios. upervisors are encouraged to document the content of supervision based on their aining, in ways that work for the supervisee. Work still needs to be carried out in :lation to compiling an orientation booklet on supervision with guidelines for aff and access to sustainable training. Review of documents and policies will lso need to be part of an ongoing, rigorous process of discussion and review.

At the time of writing this chapter we were working towards findings ways of asuring that supervisors from the three professions are trained and that they iemselves are supervised for their supervision of others. This means identifying id training suitable people as supervisors. Any external supervisors need to be lentified as appropriate and able to supervise staff in relation to their work ontext. We are yet to develop documentation on supervisor selection criteria; owever, the majority of therapists who are supervisors have attended a basic ıpervision skills workshop, or are experienced in their discipline. Our goal is to nsure that all supervisors eventually attend a standard supervision skills training ourse. This aspect is currently one of our challenges linked to issues of esourcing. To date an ad-hoc system of training has been in operation. We have sed external supervision trainers; consulted other organisations to learn of their ıpervision processes and suitability and attended in-service sessions or ıpervision workshops run by members of the supervision working group. There as been much debate and discussion and we are not yet there.

There is agreement that all staff must be in supervision, supported by both the rganisational supervision policy and the HPCAA requirements. There is also greement that supervision should provide an opportunity to discuss and reflect on ractice and facilitate professional growth in a way that achieves and supports idividual and organisational goals and values in order to develop and sustain safe id effective practice. The issue remains as to whether supervision should be ructured on an individual, one-to-one basis, or on a group (PPR) basis, or a ombination of both. It may well be that some individuals or professions are better iited to one form or another. A big question remains how to affect ongoing and stainable training within current organisational resources.

Our 'proof of the pudding' that a culture of supervision is emerging is that espite the challenging journey so far, staff have accepted supervision, and want) be in effective and beneficial supervision. The challenge is to ensure that we chieve a workable and sustainable supervision framework where all staff are able) access flexible modes of supervision that are appropriate and responsive to both ie service and the practitioner's needs. Furthermore, our supervision practices ust be of a high quality and provided by supervisors who are trained and

accountable for their supervision. The following section provides an example of how we have achieved this.

Shaping a supervision framework: A work in progress – the women and children's therapy team supervision structure

This section outlines the current model of supervision that is in place in the Women and Children's Therapy (WCT) team. In doing so, the authors wish to acknowledge the considerable commitment and passion, as well as time given by previous and current team members, who contributed to developing a cohesive and all-inclusive model of supervision for the team. This model was nurtured from the individual supervision practices that already existed within the team.

The WCT team provides a comprehensive therapy service to in- and outpatients in an acute tertiary hospital environment. Service delivery is currently structured to cater for two clinical areas: women's health and children's health. As part of the restructure within allied health, the women's health physiotherapy team was integrated with the children's therapy team under one Team Leader. The team therefore comprises women's health and paediatric physiotherapists, paediatric occupational therapists and paediatric speech-language therapists with a Clinical Supervisor for each group. All the team report directly to the Team Leader. Each discipline is supported by a part-time Professional Leader (PL), whose role includes providing professional leadership so that staff understand and meet their professional, ethical and competency requirements.

Whilst the WCT Clinical Supervisors must ensure each member of their discipline group is in regular supervision in line with their job accountability, as was explained earlier they do not necessarily have to provide the clinical supervision. A therapist may be paired with a supervisor of the same discipline or another discipline within the team, or a supervisor who may work in a different clinical or specialist area within the ADHB. This supervision structure allows for flexibility in supervisor-supervisee pairing. This flexibility is also seen as essential in a team with differing levels of clinical expertise and experience and often with vastly different knowledge and experience of supervision.

Beginnings of fostering a culture of supervision

Within the children's health area, the three therapy disciplines have been managed as an interprofessional team for a number of years. This was a major contributing factor in the development of the existing supervision model within the team. The disciplines have worked very closely together both clinically and physically, with shared team office space and clinical areas. This has allowed for a more shared awareness and discussion of the supervision practices with each discipline, which in turn has naturally led to comparisons in approaches and a growing insight across the team to the value of effective supervision. This structure also identified

ıe need for supervision training and an agreed supervision framework for both upervisees and supervisors alike. Given that this was a team of therapists with onsiderable experience and clinical expertise, it was also recognised that a umber of the therapists would be interested in and capable of becoming effective upervisors.

'rocess and training

'owards the end of 2003 supervision workshops, led by an external trainer, were ęld for the WCT team. All team members attended the one-day introductory /orkshop for supervisees. Following this, those team members who were already, r who were to become, supervisors attended a further two-day supervision skills /orkshop. The workshop covered topics such as contracting in supervision; giving ɜedback; and managing the supervision process. The Team Leader and existing upervisors in the team also contributed to the workshops. Following these /orkshops, a trial commenced to implement a model of supervision within the ɜam. The success of this trial is evident as essentially the same model remains in lace today.

Central to the model's functionality is the concept of cross-discipline upervision. In addition, the principle of 'guided choice' is a key component of the ıodel. Wherever possible, new team members are given a choice of trained upervisor. This choice is guided through discussion between the Team Leader nd the therapist's Clinical Supervisor as to the best option of potential upervisors for that therapist. Factors such as level of experience and area of linical speciality are considered, as are the therapist's thoughts about the process nd choice. Occasionally, where it has not been practically possible to provide a hoice of supervisor, a negotiated 'trial' of supervision between the new upervisee and the recommended supervisor is agreed and a time frame for review ɜ determined and built into the supervision contract. Another essential component o the model is the establishment of a supervisor–peer mentoring group. This ;roup is open to practising WCT supervisors and provides a monthly forum for ıngoing learning, development and support of supervision skills and processes. The group works on principles of peer supervision and is facilitated by one of the ıxperienced supervisors.

Challenges to the process

As in any health environment there is steady staff turnover and this poses constant ɜhallenges to maintain a model where appropriate supervision is in place for all eam members. Key challenges include the ability to provide timely training for ıew staff who may have either limited knowledge of supervision because it does ıot form part of undergraduate training, or staff have had previous experience of ɜupervision that is quite different from the reflective learning model of one-to-one ɜupervision used within WCT. Another challenge is that it is also necessary to ensure there are sufficient numbers of 'trained' and suitably experienced

supervisors to be able to provide supervision. It is essential that supervisors are well supported and are provided with ongoing opportunities to develop and enhance their supervision skills. The need for a support group for supervisors within the team (as outlined above) was driven by the supervisors themselves, who are in individual supervision themselves.

Perhaps the biggest challenge to sustaining this model of supervision and ensuring that the culture of supervision is passed on, is our ability to enskill and enculturate new supervisees through access to regular training within the team and wider allied health service. Our expectation as professionals that our supervisors are both skilled and experienced also highlights the imperative that they are able to access appropriate and ongoing training, coaching and support. Obviously this model has been implemented within an acute health environment which, as we are all aware, faces many resourcing (workforce and fiscal) constraints. It is the commitment of the WCT team and the direction provided by those who are providing supervision and those who are responsible for assuring supervision which has allowed this model to flourish to this point. It will be a test of our ongoing dedication as an allied health service to ensure we continue to provide a quality supervision model that is not only flexible but meets the expectations of each discipline's standards.

Conclusion

For the occupational therapy, physiotherapy and speech-language therapy professions who work within the acute settings of ADHB, supervision is here to stay, supported not only by legislative and professional requirements, but also by the organisational policy on supervision. The pursuit of a quality framework for allied health supervision in an acute hospital setting, however, whilst riddled with challenges, is neither insurmountable, nor unattainable, as we have discussed.

Although we have journeyed far and have put in place many of the systems that would support a sustainable supervision framework, there is naturally more to do. We have laid the foundation and erected the scaffold upon which to build our culture of supervision, commencing with the organisational policy to support this practice. We must now focus our work on the building of the culture of supervision and ensuring the competence of the supervisor.

We have learnt that there are many challenges and pitfalls such as time, access to training, workforce issues and resourcing to name a few. As it stands, the achievement of any sustainable supervision framework must align with one of ADHB's three priority goals, Live within our means, and this factor must be addressed as we continue the journey. We have also learnt however, that our vision is sustained by having a dedicated and committed group who will continue to strive towards building a quality supervision framework. This framework will enable occupational therapists, physiotherapists and speech-language therapists to

participate in supervision that is beneficial, not only for maintaining standards of practice and practitioner competency, but also for fostering individual practitioner self-care and critical reflection, interprofessional relationships, the objectives of the organisation as a whole, and ultimately the clients whom we all serve, the consumers of Allied Health services.

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Chapter 11 He korero korari

Moana Eruera

Learning outcomes

- To explore a tangata whenua philosophy for supervision
- To discuss the relevance and application of a tangata whenua phil supervision into the functional supervision process
- To assist understanding of the practical integration of the above princip provision of an exemplar

Key terms

- Kaupapa Maori supervision
- Kaiarahi
- Kaitiaki
- Matauranga
- Whakapapa
- Tikanga
- Tangata whenua
- Mohiotanga
- Nga Uaratanga
- Pukenga

A weaving together of traditional Maori knowledge and processes fro with our current supervision realities of the present as a guide for th of tangata whenua supervision for the future.

Korari as it is known by iwi in Te Taitokerau is a plant indigenous to A is also called harakeke, flax, and is scientifically known as phormium an important natural resource to Maori which our tupuna used for a bro purposes. One of the important uses of korari, both traditionally contemporary context is weaving kete. Traditionally the kete is symboli creation stories about the pursuit of knowledge and is important in the r information, protocols and metaphorical messages to guide future g This writing draws parallels from the knowledge, customs, skills and c used in the kete-weaving process as a guide for an indigenous s framework.