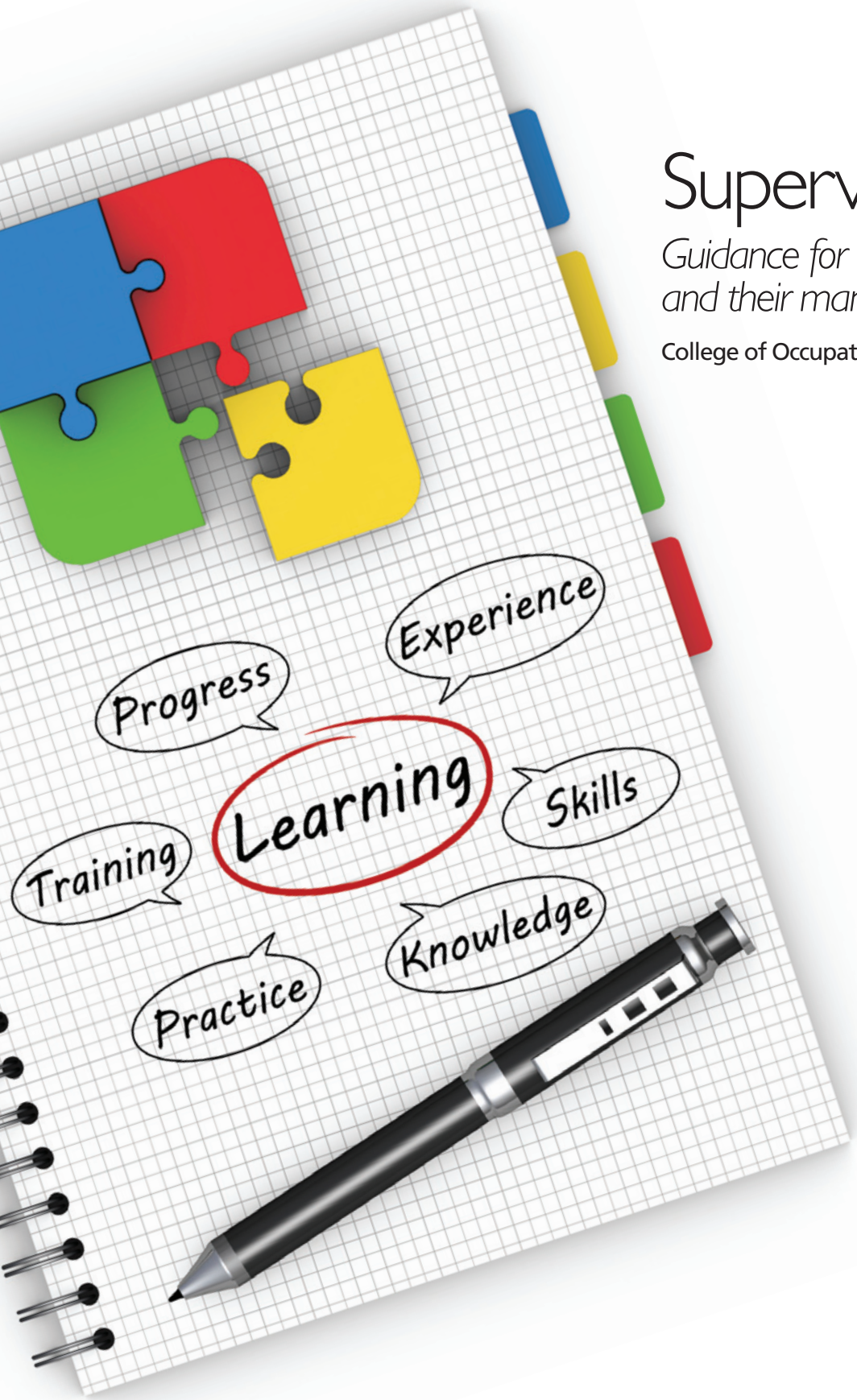

Supervision

Guidance for occupational therapists and their managers

College of Occupational Therapists

College of Occupational Therapists

About the publisher

The College of Occupational Therapists is a wholly owned subsidiary of the British Association of Occupational Therapists (BAOT) and operates as a registered charity. It represents the profession nationally and internationally, and contributes widely to policy consultations throughout the UK. The College sets the professional and educational standards for occupational therapy, providing leadership, guidance and information relating to research and development, education, practice and lifelong learning. In addition, 11 accredited specialist sections support expert clinical practice.

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Contents

1 Introduction

Regulation is no substitute for a culture of compassion, safe delegation and effective supervision. Putting people on a centrally held register does not guarantee public protection. Rather it is about employers, commissioners and providers ensuring they have the right processes in place to ensure they have the right staff with the right skills to deliver the right care in the right way to patients.

(DH 2013, section 5.22)

In the 2012 Mid Staffordshire NHS Foundation Trust Public Inquiry, poor supervision of medical and nursing staff was highlighted repeatedly. The government response to the Francis Enquiry recognised that 'the key to providing safe, effective and compassionate care to patients is supporting and valuing staff' (DH 2013, section 1.26). The support provided and the value demonstrated through supervision has a direct impact upon the quality, safety, appropriateness and effectiveness of service provision.

Recognising this, the College of Occupational Therapists (COT) has developed this guidance to enable practitioners and managers to set up healthy and effective supervision practices. It establishes that supervision is a requirement of quality standards and strategy documents across the four nations of the United Kingdom (UK). It also provides ideas and information that will be useful to those providing supervision and those receiving it.

1.1 What is supervision?

The definition of supervision has matured over time, taking on additional aspects or qualities, reflective of its context and purpose. Different qualifying adjectives are sometimes added, for example 'professional' or 'clinical' supervision, but it can be difficult to find one common acceptance, understanding or use of these.

At its simplest, supervision is a professional relationship and activity which ensures good standards of practice and encourages development.

An early World Health Organization publication defines supervision (as a managerial activity) as the 'overall range of measures to ensure that personnel carry out their activities effectively and become more competent at their work' (Flahault et al 1988, p1).

Ferguson defined professional supervision as 'a process between someone called a supervisor and another referred to as the supervisee. It is usually aimed at enhancing the helping effectiveness of the person supervised. It may include acquisition of practical skills, mastery of theoretical or technical knowledge, personal development at the client/therapist interface and professional development' (Ferguson 1989, in Rose and Best 2005, p294).

Morrison defined it as 'a process in which one worker is given responsibility by the organisation to work with another worker(s) in order to meet certain organisational, professional and personal objectives' (Morrison 2001, p29).

Howatson-Jones states that 'clinical supervision is a designated reflective exchange between two or more professionals in a safe and supportive environment which critically analyses practice through normative, formative and restorative means to promote and enhance the quality of care' (Howatson-Jones 2003, p38).

Skills for Care (2007, p5) defines supervision as 'an accountable process which supports, assures and develops the knowledge skills and values of an individual, group or team'.

Some common elements can be drawn from these definitions:

- Supervision involves a professional relationship.
- It is a process.
- It is active/dynamic, having objectives.
- It may involve a range of activities.
- It is supportive.
- It relates to standards, effectiveness and competence.
- It relates to the acquisition and development of knowledge, skills and values.
- It can incorporate personal, professional and organisational elements.
- It can be reflective when related to practice.

The content of supervision changes according to its context and the working relationship of those involved. Supervision enables the supervisee to develop professional, organisational and personal capabilities which promote and maintain the quality and effectiveness of their work. The end purpose almost always remains the same, being the promotion of the wellbeing and best interests of the service user, within a clinical, educational or any other context. The benefits are even wider, as the Social Care Institute for Excellence (SCIE) states:

> *Good supervision should result in positive outcomes for people who use services as well as similar outcomes for the worker, the supervisor and the organisation as a whole. An example of a positive outcome would be an improvement in the quality of life for a person, while for the organisation a similar outcome would be an improvement in the quality of the service.*
>
> (SCIE 2013, p6)

Table 1 shows how the kind of support/guidance provided, and the person providing it, will depend upon the context for, and function of, the supervisory relationship.

Table 1

Supervision for:	Covering:	Provided by:
Professional matters	– areas of work related to the occupational therapy profession, e.g. professional standards, registration, code of ethics, etc. Also continuing professional development (CPD) in occupational therapy-related areas.	– an experienced occupational therapist or someone with an adequate knowledge of the profession and its requirements.
Clinical work/ activity knowledge and skills	– the skills and knowledge needed to do the work confidently and safely, management of particular cases, service-user-related matters. Identifying solutions to problems, improving practice and increasing practice-related understanding and knowledge.	– a person/people with a higher level of knowledge and skills in the relevant area. This is most likely to be an occupational therapist but, depending on the area of work or particular activity, it may not be.
Organisation and management	– elements of work related to the organisation and management of the service; supporting the objectives of the organisation, ensuring the safe working of its staff, e.g. service policies and procedures, general training such as health and safety, annual leave, etc.	– a person who deals with the organisation and management of the service – not necessarily an occupational therapist.
Performance management	– the management and optimisation of elements of a person's performance.	– a person with a high level of ability in the relevant area of performance. Depending upon the area or activity involved, it may not be an occupational therapist. If across a number of elements, it may involve more than one person.
Tutor support in higher education institutes	– ensuring students have adequate knowledge and skills to meet the requirements of graduate entry to the profession.	– a tutor with adequate experience, competence and teaching skills in the relevant field.
Placement education	– enabling the students to gain knowledge, skills and experience to become fit for employment as a professional graduate.	– an occupational therapist with adequate experience and competence to provide this support. Input may also come from a range of other professionals, especially in a diverse practice placement.

Supervision for:	Covering:	Provided by:
Preceptorship or newly qualified graduates	– supporting a new registrant through their first year of practice, enabling the development of professional identity, facilitating access to clinical practice and knowledge.	– an occupational therapist with adequate experience and knowledge to provide this support (ideally a minimum of two years' practice).
Returning to practice	– enabling a returner to regain confidence, meeting any identified learning needs, experiencing and becoming familiar with the current working environment.	– an occupational therapist who has been registered continuously for the previous three years, without any fitness to practise concerns.
Peer support	– exploring cases, sharing experiences, studying published literature, using group discussion and shared knowledge to problem-solve, develop and provide support.	– through a group of similarly experienced occupational therapists.
Group support	– facilitating the learning of the group, helping members to observe, reflect, analyse and plan. Using group discussion and shared knowledge to problem-solve, develop and provide support.	– (facilitated by) an experienced practitioner who is skilled at managing group dynamics. This will need to be an occupational therapist if the focus of the group is profession-specific.

1.2 Professional and clinical supervision

Professional supervision and clinical supervision inevitably cross over in many circumstances and may well be supplied by the same person. Both enable the supervisee to underpin and root their practice in a sound understanding of the core values, beliefs, knowledge and skills fundamental to occupational therapy. The material in this guidance can be applied to most supervision contexts, although it will relate most clearly to professional and clinical supervision.

Such supervision may be done in a number of ways according to the function it is fulfilling at the time. To take time to reflect and discuss, a one-to-one 'sit down' meeting may be used. To demonstrate an activity, observe a particular situation or oversee the supervisee carrying out an activity, more practical 'on the go' supervision may occur. Both provide support, allow reflection and learning, develop skills and knowledge and promote good practice.

1.3 Theoretical models for supervision

Models are a way to organise and thereby structure an approach to supervision. Use of a model can facilitate interaction and ensure continuity. There are a number of models for supervision. Practitioners are advised to research a number of them and select one that would fit comfortably within their particular workplace and organisation. There may already be a chosen model in place locally.

Proctor proposed a conceptual framework for clinical supervision which is often referred to in later papers and publications. It is sometimes called the Functional Interactive Model. It identified three main functions: normative, formative and restorative (Proctor 1987). It could also be applied to professional and management-type supervision:

Normative – this is the enabling of the supervisee to reflect on the quality, effectiveness and appropriateness of their practice. Although the supervisor retains ultimate responsibility for ensuring that the supervisee's work meets all the legal, ethical and professional requirements or 'norms' of practice, they are also developing the supervisee's own awareness and sense of responsibility.

Formative – this is the 'formation' of knowledge, skills and attitudes/behaviours. The supervisor uses a range of means (facilitation, feedback, instruction and demonstration), enabling the supervisee to develop their competence.

Restorative – this is the provision of support and affirmation, enabling the supervisee to cope with the emotional aspects of practice.

Each function will at times be more evident than others, but they frequently cross over and supervision becomes a mixture of all three.

Nicklin's Clinical Model of Supervision focuses on the roles and functions of the organisation (managerial, education and support) working together, where a change in one will impact on the others. The model presents supervision as a cyclical process of analysis, problem identification, objective-setting, planning, action and evaluation (Nicklin 1997).

1.4 Reflective practice

Reflective practice goes hand in hand with supervision. It means:

taking the time and conserving the energy to think critically about your practice. It means stepping outside the action in order to see how to improve what takes place. You can then assess and plan what you need to learn in order to develop and improve your practice.

(COT 2010a, p6)

Finlay (2008) states that reflective practice:

tends to involve the individual practitioner in being self-aware and critically evaluating their own responses to practice situations. The point is to recapture practice experiences and mull them over critically in order to gain new understandings and so improve future practice. This is understood as part of the process of life-long learning.

(Finlay 2008, p1)

A very simple reflective model is a cycle of three questions – 'what?', 'so what?' and 'now what?'

It is usually attributed to Borton (1970) as a model for learning, and continues to be used (Rolfe et al 2001). The questions direct the practitioner through a reflective cycle of describing the experience, analysing and evaluating the experience and

finally looking at how the experience can be used to change and improve future practice.

These questions are prompts to encourage reflection and discussion, either when carrying out an activity with a service user, or when later talking about it. It is a useful tool for the supervisor to challenge the views or actions of the supervisee, enabling them to adjust their own perception or understanding of a situation and thereby change their actions. The supervisee can use the model as a pattern for independent reflection and a structure for recording learning, where needed.

Developing a reflective approach to practice and learning can help practitioners record and demonstrate how they are meeting the continuing professional development requirements of the Health and Care Professions Council (HCPC).

1.5 Evidence-based practice

Practitioners are expected to base their intervention on evidence, best practice and/or local/national guidelines and protocols where available and appropriate (COT 2011b, section 4.6, COT In press, section 2.2.5). This requires an awareness of the evidence available and the ability to review and then apply it. It can be difficult to do this within the business of the working day. Supervision provides protected time in which 'it may be possible to move from a change in knowledge to a change in practice' (Steventon et al 2012).

2 Providing supervision

2.1 Supervision policies

An organisation's or service's policy should define its approach to and rationale for supervision. It should define the aims and functions of supervision within the context of that particular work setting. It should explain how supervisors are selected and trained, what their rights and responsibilities are, and those of the supervisee, including confidentiality. It might include a recommended structure and model, frequency, system of recording and a model agreement for supervision. Supervision policies may cross over significantly with supervision agreements. If no such policy exists within an organisation, it may be an opportunity for an occupational therapist to propose one, but it should not stop practitioners from using or seeking supervision.

2.2 Ways or structures to provide supervision

There are various ways to provide supervision. The choice of approach will depend upon a number of factors, including the nature of the support required, personal preference, access to a supervisor, the experience and skills of those involved, local organisational policy and commitment, and the degree of management/organisational support:

- One-to-one supervision is the structure that most practitioners are familiar with. The supervision may be a mixture of working together, working under direction, being observed working and also having regular 'sit down' meetings together.
- Peer supervision is different in that it is not led by a more senior practitioner. When formal, its members are committed to meeting regularly. It can be occupational therapy specific, or across professions. Peer support can be an opportunity for the sharing of resources, knowledge, skills and ideas. It can also be less formal, with support and sharing across a group or team as needed.
- Group supervision is when a more senior practitioner meets with and facilitates a group for specific problem-solving and team development. This approach not only encourages open and professional attitudes to learning and uses the various abilities within the group, but also supports the concept of collective practice and service delivery. It requires a planned approach and places a shared responsibility on all members of the group to support the learning of colleagues, helping them to observe, reflect, analyse and plan. The supervisor tends to take a role in managing the group dynamics. Those participating in group supervision will need to be well prepared and clear as to what they want to give to, or receive from, the group. Using a reflective practice model can help to structure discussions.
- Long-arm supervision is when supervision is provided by an experienced clinician who is not based at the same location. Support and advice are provided through a mix of face-to-face meetings and distance communication, via the telephone, Skype, email, or other means depending on the supervisee's preferences. It is most likely to be used where the practitioner is the only occupational therapist within a service or locality. This is increasingly happening with the growth of diverse practice and diverse placements for students.

In this situation, there should be a line of management or responsibility on site also, providing local and immediate support, although this local manager need not be an occupational therapist. The nature and content of both the long-arm and local supervision should be discussed and formally agreed between all parties involved. The long-arm supervisor and the practitioner should work within an agreement, as with any other supervision.

More information about supervision for students who are on diverse (role-emerging) placements is available from *Developing the occupational therapy profession: providing new work-based learning opportunities for students* (COT 2006a, p9).

2.3 The participants

The focus for a supervisor is on supporting staff in their personal and professional development and in reflecting on their practice. The kind of supervision needed by each practitioner will be dependent upon the role that they hold and their level of experience.

In a number of papers regarding supervision, the importance of adequate training and knowledge of models of supervision is mentioned in relation to making supervision effective (Sweeney et al 2001, Gaitskell and Morley 2008). This is not exclusive to supervisors but includes supervisees. Also highlighted is the confidence needed by supervisors to make positive use of more directive and challenging interaction. The supervisor needs to have effective supervisory strategies, a 'toolbox' of techniques and skills to use, in order to enable the personal and professional development of the supervisee. It is suggested that occupational therapy managers have a responsibility to consider how effective supervision skills are developed and maintained in the workplace (Gaitskell and Morley 2008, p120).

For personal study, there are numerous publications which describe in detail the techniques and skills necessary for a supervisor. For this reason they are not included here. The *Preceptorship handbook for occupational therapists* (Morley 2012) also highlights a number of these.

The supervisee is not a passive participant in the supervision process. In order for it to be effective, the supervisee needs to be an active learner, seeking and utilising the support and learning opportunities available. The use of a structured learning plan, with clear objectives, may help the supervisee to optimise the process, much as is used in the preceptorship programme (see sections 2.8 and 3.4).

2.4 Supervision and delegation

When in a supervisory or leadership role, a practitioner needs to be aware of their responsibilities in relation to delegation. When the delegator asks or instructs another person to carry out interventions or other procedures, they should be satisfied that the person to whom they are delegating is competent to do so. In these circumstances the delegating occupational therapist retains responsibility for the occupational therapy care provided to the service user (adapted from section 5.2 of the *Code of ethics and professional conduct* (COT In press).

The *Professional standards for occupational therapy practice* (COT 2011b) state:

5.5 You ensure that those to whom tasks or actions are delegated – such as students, support workers and volunteers – are competent to carry them out

Criteria

5.5.1 You provide adequate information, supervision and training to other members of staff, volunteers and carers if they are to provide intervention

5.5.2 You monitor the competence of those to whom you delegate tasks

5.5.3 You do not ask other staff to carry out tasks that are outside their professional competence, terms of employment or workload capacity.

(COT 2011b, section 5)

This is supported in section 5 of the COT *Code of ethics and professional conduct*, which also adds:

You should provide appropriate supervision for the individual to whom you have delegated the responsibility.

(COT In press, section 5.2.1)

The supervisor/delegator will need to judge the level of supervision that is provided while the person is carrying out the task, depending on their ability and level of experience. It is the delegator's responsibility to monitor the activity and its outcomes. This includes ensuring that care records are fully and accurately kept.

The Health and Care Professions Council (HCPC) lays particular emphasis on the importance of supervising those to whom tasks are delegated. Its *Standards of performance, conduct and ethics* (HCPC 2012) states:

You must effectively supervise tasks you have asked other people to carry out. People who receive care or services from you are entitled to assume that you have the appropriate knowledge and skills to provide them safely and effectively. Whenever you give tasks to another person to carry out on your behalf, you must be sure that they have the knowledge, skills and experience to carry out the tasks safely and effectively. You must not ask them to do work which is outside their scope of practice.

You must always continue to give appropriate supervision to whoever you ask to carry out a task. You will still be responsible for the appropriateness of the decision to delegate. If someone tells you that they are unwilling to carry out a task because they do not think they are capable of doing so safely or effectively, you must not force them to carry out the task anyway.

(HCPC 2012, section 8)

You have a duty to make sure, as far as possible, that records completed by students under your supervision are clearly written, accurate and appropriate.

(HCPC 2012, section 10)

Further information is available from the most recent version of the COT briefing on *Delegation* (COT 2014a), available for members to download from the College website.

When an occupational therapist is line managed or supervised by someone from another profession, or an occupational therapist line manages/supervises someone from another profession, the manager needs to be aware that they are still responsible for

ensuring that the practitioner is competent to carry out any tasks (whether clinical or otherwise) that they delegate to them.

Occupational therapists must act within the limits of their knowledge, skills and experience (COT In press, section 5.1, HCPC 2012, p3). When a supervisee recognises that any task is above their capability level, they must highlight this and seek help from the supervisor.

2.5 The supervisory relationship

The nature of the supervisory relationship is key to its effectiveness. It should be supportive and enabling, building confidence and reducing stress. It also needs to balance support with challenge, so that, when necessary, it can be directive. It must be accommodating enough to allow each participant to provide comment, opinion and feedback to the other without a negative outcome. Supervision should provide a straightforward means for constructive two-way communication.

In a supervisory relationship, both or all parties play an active role in making it healthy. Perhaps some of the more obvious characteristics of such a relationship are trust and honesty, listening, empathy, acceptance and respect. Cassedy (2010) looks at this in some detail. The supervisor, being in a leadership or more senior role, needs to initiate and model these qualities.

A supervisor has the responsibility to identify poor practice to the supervisee, but to do this in a way that enables them to change without losing confidence. Likewise, if a supervisee finds something difficult, if they are struggling with their work, with an element of supervision, or with the supervisory relationship, the supervisor should enable them to share this, to explore their difficulty, and then to make whatever changes are necessary and possible. To enable this, both the supervisor and the supervisee need to take responsibility for their part of the supervisory relationship.

Sometimes it can be difficult for the supervisor or supervisee to empathise with, accept and respect an individual who seems very different from themselves. In such a situation it can be useful to draw on professional skills. When working with a service user, irrespective of their nature or behaviour, a practitioner would be expected to act professionally at all times. This ability can be transferred into a difficult supervisee/supervisor relationship.

When a relationship goes wrong, it may be useful to involve a third party. This person needs to be skilled in mediation. They may need enough authority or confidence to make recommendations if required. Each person will need to reflect on the situation, to identify what they see as the difficulty, to suggest resolutions, to be open to accepting criticism and potentially to accept compromise. It is important that each party is heard and believes they have been treated reasonably. It is likely that some changes will need to be made. The situation will need to be monitored and revisited for as long as necessary to ensure that it is resolved to the satisfaction of all concerned.

Where the relationship seems irreparable, it may be necessary to change the supervisor. In this case the new supervisor will need to understand the history of the situation to be able to provide appropriate ongoing support. Both parties in the original relationship will need to be encouraged to move forward in a professional manner.

2.6 Starting supervision

Before supervision begins, there are a number of elements that need to be discussed and agreed, in order to obtain the best outcomes for those involved.

Each party needs to understand the purpose, function and content of supervision. Where a supervisee has more than one line of responsibility, it is especially important to clarify this.

The content of supervision will depend upon its context and purpose. It may also reflect the competence and confidence of the supervisee and supervisor. The participants may need to define what should or should not be included in supervision. Proctor's model can be used as a guide. If potential content cannot be fitted into any of the normative, formative and restorative elements of supervision, it may be that it is not appropriate (see section 1.3).

Where appropriate, the use of an agreement or contract can help in this discussion. It is good practice to ensure that each person understands and accepts their responsibilities in making supervision effective.

The working relationship, the degree of direction given, the level of hands-on supervision, the styles of communication used, the supervisee's best learning style etc. all need to be discussed, as these will be different in each supervisory relationship. What works in one situation may not work in another. With open communication and a constructive feedback system, changes can be made over time, recognising that the supervisee's needs may also change as they grow in capability and confidence.

2.7 Supervision agreements

Supervision agreements or contracts are not always used, but they can be a very useful tool to support the structure and quality of supervision. The use of the term 'agreement' rather than 'contract' emphasises the collaborative nature of the process (SCIE 2013). The use of a written agreement has been described as 'an essential component of professional supervision. It constitutes a working agreement between the two parties who are the supervisor and the supervisee.... It will monitor the progress and success of supervision and can parallel the process of therapy' (Rose and Best 2005, p295). Supervision agreements should always be set within the context of the local supervision policy, where one exists.

Learning agreements for students are a requirement of the *College of Occupational Therapists' learning and development standards for pre-registration education* (COT 2014b, p19).

One aim of the agreement is to clarify the duties and expectations on both sides. It emphasises that supervision is a dual responsibility. The presence of an agreement can add security, creating a safe and secure supervisory relationship in which those involved can review the individual's practice, work through problems or concerns and discuss professional development needs. Each person involved should have a copy of the agreement.

When drawing up a supervision agreement, the following should be considered and could be included:

- Who the agreement is between.
- Who holds copies of the agreement.
- When the agreement will be reviewed.
- The types of supervision that might be used; for example, hands-on demonstration or close overseeing of a task, one-to-one meetings, group meetings and so on.
- What model might be used.
- The frequency and length of supervision events/meetings.
- The location for supervision events/meetings.
- Who takes responsibility for organising the supervision events/meetings.
- In what limited circumstances supervision might be cancelled.
- The content of supervision, what may or may not be brought to a supervision event/meeting by either party, also how much material may be brought.
- What each party might need to prepare prior to any event/meeting.
- Who will record formal supervision, and how.
- How records will be kept.
- What will happen to the record if the supervisee leaves, changes job or has a different supervisor.
- The extent of confidentiality and when or how it might/should be broken.
- What the supervisee can expect or have a right to.
- What the supervisor can expect or have a right to.
- What the supervisee's responsibilities are.
- What the supervisor's responsibilities are.
- How conflict, or the inability to maintain the agreement, will be managed and resolved.
- Reference to a local supervision policy if present.

Agreements can be quite formal and business-like or written in a more personal style. There are a number of differing templates for supervision agreements available on the internet. The style and content of any agreement need to be adapted for use in the particular location and with those involved, to suit the needs and working relationship of all parties.

The agreement should be reviewed periodically as part of an evaluation of the supervision. Do those involved in the supervision process adhere to the agreement? If not, is this a problem with the supervision, or the agreement itself? Does the agreement support the supervision process, or hinder it? There is nothing wrong with amending a supervision agreement, post review, so long as any changes are to enhance the supervision process, experience and outcomes.

2.8 Setting objectives for and in supervision

The effectiveness of supervision in itself needs to be monitored. To do this it is necessary to identify what it should be achieving or providing to all participants. Different kinds of supervision will have different objectives, but these should be identifiable. Consideration needs to be given as to how they could be monitored or measured.

A key purpose of supervision is to enable the supervisee to develop their personal, professional and organisational knowledge and capabilities. In order to monitor the development of the individual and to give structure to their learning, it is important to set objectives. These might be relatively concrete, such as gaining a new skill or increasing knowledge. They might be less tangible, such as gaining in confidence or changing attitude or behaviour. It is important that the supervisee agrees with and takes responsibility for their part in meeting these objectives (see section 2.3).

2.9 Content and confidentiality

The content of a supervision meeting/event and how the time will be used should be discussed as part of the agreement. The degree to which personal issues are included needs to be considered. They are usually only included when they have implications for the workplace, for example the supervisee's health.

Information that is shared within supervision must be kept confidential, except where it is revealed that a person or persons may be at risk. Instances that might override the need for confidentiality might include revelation of dangerous practice or criminal activity (i.e. when it is in the public interest to share the information). Information should only be shared on a strictly need-to-know basis. If the supervision involves an element of performance management, this need only be shared with those who are involved in monitoring performance. It is not a matter for general discussion.

The supervisee should be able to discuss with other colleagues appropriate content from supervision as a means of further reflection. For example, if the supervisor makes a suggestion for how to manage a practice situation, the supervisee may then talk this through with another colleague.

If the supervisor finds that they are unable to answer a particular problem or situation raised by the supervisee, consent should be gained from the supervisee to discuss the situation with a more senior/experienced colleague.

2.10 Frequency and timing of supervision meetings

There is no set standard or recommendation for the frequency of formal supervision sessions within occupational therapy. It will vary according to individual requirements, but needs to be guided by the experience, competence and confidence of the supervisee, along with the complexity and demands of their role. Students and less experienced practitioners can expect to receive more frequent supervision. Those who demonstrate poor performance will also need greater support. Whatever frequency is decided upon, supervision should happen regularly and consistently.

The College cannot define a minimum requirement for supervision, as every individual and location will be different. The following could be used as a starting point for consideration or negotiation:

- Weekly supervision for those who require more support, even for a limited or initial period:
  - Students
  - New graduates
  - New employees with limited experience
  - Practitioners lacking in skills and/or confidence.
- Bi-weekly supervision for those who have more experience and work more autonomously but may still need guidance:
  - Those new to their grade – i.e. with additional/unfamiliar responsibilities
  - New employees with experience
  - Employees with a complex or high-risk caseload.
- Monthly supervision for:
  - Experienced and confident practitioners.

The agreed time set aside for supervision should be protected by both parties. We would suggest that supervision time is at least an hour and sufficient to cover all necessary topics. It should not be delayed or cancelled, if at all possible. It should start and finish at the prearranged times and should not be interrupted while happening (either by phone calls or individuals). Ideally the meeting should be conducted in a quiet, private room with the door closed.

2.11 Recording supervision

As with care records, recording supervision enables safe, effective and high-quality practice.

It can be decided, as part of the agreement, who records the supervision, how the content of records is agreed and how the records are kept. Formalising the process in this way protects both parties from any future perceived differences (by either party) of the discussion points and/or decisions made. A formal structure can be seen as threatening if it has been introduced in negative circumstances, but if used as a matter of course with all staff members, this need not be the case. It is likely to make the task of keeping records easier and less time-consuming in the long run.

The records should include key topics discussed, with any outcomes or decisions taken, identifying who is responsible for any future action. The record, when complete, should be agreed by both parties and a copy may be held by each person. Supervision records need to be kept confidential, with the proviso that if access is needed for the purpose of public interest, this should be enabled.

Decisions made in a supervision meeting concerning the care provided to a service user can be seen as part of the care process. Such decisions need to be recorded in the care records (COT 2010b, section 2.2). Identifiable service user information should not be recorded within supervision records. If cases are discussed, these need to be anonymised in any supervision record.

2.12 Feedback for both parties

> *Feedback is a way of learning more about ourselves and the effect our behaviour has on others. Constructive feedback increases self-awareness, offers guidance and encourages development, so it is important to learn both to give it and to receive it. Constructive feedback does not mean only giving positive feedback (praise). Negative, or critical feedback given skilfully can be very important and useful. Destructive feedback, negative feedback given in an unskilled way generally leaves the recipient simply feeling bad with seemingly nothing on which to build and no useful information to use for learning.*
>
> (University of Nottingham 2012)

Two-way feedback is an important part of successful supervision. The supervisor needs to provide feedback to the supervisee on their performance as a practitioner and as a participant in the supervision process. In a practice setting, working with service users, there needs to be a rationale for all the practitioner's actions. Providing feedback, reflecting on and looking at the consequences of actions all help the supervisee to develop the habit of identifying the rationale for their practice and ensuring it is the best option.

The supervisee also needs to give feedback on the style, content and effectiveness of the supervision provided. Regular evaluation of the supervision process and experience itself is essential to ensure that the aims of the process are met and that any difficulties are discussed. The giving and receiving of constructive feedback on a regular basis can help to improve the experience and outcomes of supervision for both the supervisee and the supervisor. The supervisor can use those feedback experiences as development content for their own supervision.

If the supervision is not meeting the needs of the supervisee, or the aims of the process are not being met, those involved may need to look more closely at the different elements of the practical process, along with the working and supervisory relationship, to identify what needs to change in order to make the process work.

Feedback should be open and honest, but should not need to feel threatening. Time set aside at the start of the process for discussing and planning the supervision, identifying its purpose and objectives, and developing the supervision contract, can pay dividends if the agreed factors are used as a structure against which to monitor and feed back on its effectiveness.

Regular feedback ensures that the supervision process can be tailored to meet the needs of both parties; potential problems can be dealt with at an early stage, preventing unwelcome surprises.

There are some common techniques that occur when constructive feedback is described:

- Consider the purpose of the feedback so that it is focused and has a positive outcome.
- Always balance any negative feedback with positive, and start with the positive.
- Be specific about what has been observed and do not be judgemental. Focus on the activity, not the person.
- Find out what the individual was attempting to achieve.
- Describe the actual impact or consequence of the person's actions.

- Discuss/offer alternatives.
- Give time for the individual to respond/feed back.
- Stress the support available.

2.13 Supervising a person with additional needs

Occupational therapists are experts in analysing activity, assessing needs and adapting tasks and/or environments to enable a person to function as well as possible. These skills may be needed when working with and supervising colleagues who have additional needs, such as dyslexia, depression, a hearing deficit or long-term condition. A practitioner or student with additional needs may find work more of a challenge than their peers; for example, they may have difficulties with concentration, communication, organisational skills, periods of ill health and so on. This is unlikely to be resolved by performance management processes, as the underlying difficulty is not being recognised and accommodated.

The Equality Act 2010 requires employers to be flexible and to make 'reasonable adjustments' for people with disabilities to enable them to do their jobs. These adjustments need not always be in relation to the environment or particular equipment, but may need amendments to practice processes, communication methods, time management and so on.

It is vital that, if the supervisee has additional requirements, these are shared and discussed. It does not help to hide or lessen the extent of any difficulties. The supervisor needs to create a relationship that supports disclosure and discussion. This can increase the supervisor's understanding of a condition and how it affects the individual's function, enabling any support required to be tailored to the person's needs. Preferred learning styles should be taken into account with students and practitioners. Solutions to difficulties may be simple and very practical. For example, for someone with dyslexia it may help to have a clock clearly visible, represent required processes diagrammatically (flow diagrams) and provide a quiet space for those who find the noise of a busy office difficult to cope with. Help with moving and handling from a therapy assistant can enable a practitioner with musculoskeletal limitations to fulfil their work obligations.

Most people who have additional needs will understand and can explain their own requirements, especially if they have developed a solution in a previous place of work. It may be the supervisor's responsibility to facilitate these requirements and explain them to other members of staff. The culture and atmosphere of the department needs to be one where asking for help is easy.

If a supervisor or placement educator thinks that the supervisee's/student's impairments are causing difficulty, these concerns should be broached as soon as possible. If a student or inexperienced practitioner is not familiar with how their impairment affects them in a particular setting, an opportunity should be made to work collaboratively to analyse and resolve any possible difficulties.

The practitioner/student, supervisor or service manager may need to work with the local human resources and occupational health departments to find the best way to support the individual, especially if their condition fluctuates. A period of rest during the day, time off to recover from an acute episode, or flexible working arrangements may all need to be considered. A workplace needs assessment may enable the service and the individual to access further support and training.

2.14 Training for supervision

As with other skills, supervision needs to be learnt: 'just as an unqualified individual would not be expected to provide therapy, neither should an unqualified and inexperienced individual be expected to supervise novice clinicians' (Stoltenberg and Delworth 1987 cited in Sweeney et al 2001, p428). Sweeney et al emphasised the importance of appropriate training for both supervisors and supervisees (Sweeney et al 2001, p428).

The *Northern Ireland allied health professions (AHP) supervision policy* (DHSSPS 2013) recognises the need for training in supervision skills, for both supervisors and supervisees. Other local training exists in various places in the UK, but, apart from the scheme described below, there is no other nation-wide recognition of the need for, or provision of, supervision skills training within occupational therapy.

The College of Occupational Therapists introduced the Accreditation of Practice Placement Educators' Scheme (APPLE) in September 2005. This is under licence from the Chartered Society of Physiotherapy (CSP) and has adopted six learning outcomes from the CSP's Accreditation of Clinical Educators (ACE) Scheme.

APPLE is a national scheme for qualified occupational therapists and other health and social care professionals involved in the education of occupational therapy students. While not compulsory, it provides an opportunity for professional recognition of the role of practice placement educators and nationally standardises the varying practices of accrediting educators, as well as providing a means of monitoring and evaluating the numbers of educators in different areas of the UK. This framework of learning outcomes can be recognised as a training opportunity with transferable skills for supervision of junior staff as well as students.

More information and all relevant documents are available on the website of the College of Occupational Therapists: http://www.cot.co.uk (Accessed on 02.10.14).

3 Supervision within the context of other means of development

3.1 Supervision and annual appraisal

The annual appraisal provides an opportunity for practitioners to reflect over the previous year and then consider what knowledge, skills and experiences they require in order to maintain their competency, further develop their work and contribute towards meeting the larger organisation's objectives.

Identified learning objectives may be considered and dealt with in supervision, depending upon their nature. Supervision provides an opportunity to monitor if these objectives are being met. The supervisor may need to provide guidance or encouragement to assist the supervisee in seeking out appropriate learning opportunities.

3.2 Mentoring and coaching

These are both specific techniques which may be used to provide support to a practitioner, either as part of supervision or as stand-alone activities. Choice of their use would be dictated by the needs, preferences and development style of the practitioner. Although many of the terms used to describe these supporting activities are sometimes used interchangeably, the College sees them as different kinds of relationship using different approaches, with differing outcomes.

The College has an *Occasional paper on mentorship* (COT 2010c) which seeks to explain how mentorship can support the professional growth and development of occupational therapists throughout their careers. It is seen as quite a formal relationship where 'mentor and mentee work together to discover and develop the knowledge and skills needed by the mentee to grow' (McKinley 2005, p34 in COT 2010c, p6). The mentor 'shares her or his expertise and provides appropriate support, guidance and encouragement to facilitate the mentee's professional development' (COT 2010c, p8).

Coaching is usually more structured and specific, focusing on the development of a specific skill/skill set or understanding. Coaching can be directive or non-directive; either style aims to enable the individual to learn. Directive coaching may provide specific instruction, whereas non-directive coaching would use more open reflective questions.

3.3 Performance management

Performance may be seen as the manner in which something or somebody functions, operates, or behaves; or the way in which somebody does a job, judged by its effectiveness.

For the purpose of occupational therapy, good performance could be seen as carrying out work that is appropriate and effective; that meets professional, organisational, local and national quality standards and performance targets; and that provides the service user with a positive experience.

> *Effective practice is achieved when an action, intervention or system does what it is intended to do. If it is effective, the practice will bring about the desired result or outcome.*
>
> (COT 2013)

The role of a supervisor always has an element of performance management. The supervisor's aim is to optimise the performance of the supervisee, as defined above. This may be from any starting point along the continuum of poor to excellent practice.

In a situation where there is poor practice, the supervisor may need to work more specifically to enable the supervisee to recognise the poor performance, to set very clear achievement targets, and to develop the skills that are required. To ensure this is effective, the supervisee needs to be engaged and motivated to learn and improve.

Depending on how best an individual learns, the supervisee may need a period of more directive supervision, but this needs to be positive support, enabling them to reflect and learn. The use of continuous monitoring or observation can have very negative effects upon the supervisee. It quickly reduces their confidence, raises their level of stress and may reduce their motivation and performance. It is not something that should be frequently used unless the supervisee is deemed as being unable to work safely and there is a recognised risk to service users without direct supervision.

3.4 Preceptorship

Preceptorship has been defined as:

> *a structured development process, including observed practice and feedback against agreed standards, to support newly qualified practitioners to build their professional identity and competence in order to facilitate their successful adaptation into the workplace.*
>
> (Morley 2007)

It is recognised that making the transition between student and qualified practitioner can be challenging:

> *Although they are competent, knowledgeable and registered to practise, new OTs still need the support and guidance of experienced professional colleagues as they find their feet in professional practice.*
>
> (Morley 2012, p5)

The occupational therapy preceptorship programme provides a structure and process by which to help new graduates to do this. Information to support its use is available in the *Preceptorship handbook for occupational therapists* (Morley 2012).

The programme is very transferable, with some modification, to other non-NHS, local authority, independent and voluntary organisations. Along with new graduates, it can be used with returners to the profession and those who have trained abroad. It provides a structured way to update and ensure adequate professional skills and knowledge.

The new graduate/returner (preceptee) is provided with a preceptor who is a 'qualified occupational therapist, ideally with a minimum of two years' post-graduate experience

and with knowledge of the preceptee's area of work. Usually this is the preceptee's clinical supervisor' (Morley 2012, p12). Thus the skills of a supervisor can be extended into preceptorship.

In England, preceptorship was formally recognised for the allied health professions in the *Preceptorship framework for newly registered nurses, midwives and allied health professionals* (DH 2010). This was designed for the NHS in England and is linked to the Knowledge and Skills Framework for the NHS.

> *The DH framework states that preceptors need to act as exemplary role models, having insight and empathy with the new practitioner. They have a number of responsibilities, including sharing their knowledge and skills and providing feedback, and developing others professionally to achieve their potential. It also recognises that preceptees need to take responsibility for their own learning and development, accessing support and reflecting on their practice, in order to develop their professional knowledge, skills and values.*
>
> (Adapted from DH 2010, p13)

In Scotland, the Flying Start NHS programme for newly qualified nurses, midwives and allied health professionals aims to support their learning and build their confidence during their first year of practice in NHSScotland. The information is all available online. Support is provided by workplace mentors. See http://www.flyingstart.scot.nhs.uk (Accessed on 04.09.2014).

Welsh health boards have local nursing preceptorship programmes in place linked to the DH 2010 framework and the *Nursing and Midwifery Council preceptorship guidelines* (NMC 2006).

Although Northern Ireland has a published framework, the *Preceptorship framework for nursing, midwifery and specialist community public health nursing in Northern Ireland* (NIPEC 2013), it does not incorporate the allied health professions.

4 What if there is no supervision available?

4.1 Putting together a proposal

As with any new development in a service, the best way of obtaining organisational and possible financial support for supervision will be to put forward a proposal. This will need to demonstrate the requirements for, and benefits of, supervision.

While supervision is to the benefit of the practitioner, any proposal for the provision of supervision needs to highlight the requirements for supervision and demonstrate its benefits to the organisation and the service user. Each service provider wants to provide safe and effective service and to meet its regulatory or quality standards. Supervision is integral to ensuring that practitioners and the services they provide meet the current national standards.

The introduction to this guidance identifies some of the key purposes of supervision and the benefits. The following may also be considered when developing a proposal:

- Benefits to the organisation:
    - Meeting governance requirements
    - Better risk management/decreased likelihood of incidents
    - Better recruitment and retention
    - Better quality of service provided
    - Better outcomes of care.
- Benefits to the service user:
    - High standards of care
    - Best/evidence-based practice
    - Safer care
    - Better outcomes of care.
- Benefits to the individual:
    - Support and guidance
    - Assured development and continuing professional development (CPD)
    - Better job satisfaction.

Section 4.3 identifies a number of key documents from across the UK that support the provision of supervision. They can be used to put together a convincing proposal for the provision of supervision where it does not currently exist.

4.2 Alternative ways to access supervision

In increasingly varied but pressurised working environments there is even greater necessity for support to ensure the safety and wellbeing of both service users and practitioners. If staffing structures are becoming increasingly flat, there will be fewer senior and experienced staff who can provide professional and/or clinical supervision. Where traditional 1:1 supervision is not locally available or not possible, practitioners need to think about alternative ways of fulfilling the functions that traditional 1:1 supervision would have achieved; for example, through peer supervision (see section 2.2).

It may be possible to negotiate periodic access to a more senior or experienced occupational therapist from outside the immediate department or organisation. If there is no one available in neighbouring statutory services, an independent practitioner could be approached. Most of these arrangements will need to be agreed formally and may have financial implications.

It may be possible to make best and most efficient use of an external supervisor through the use of group supervision, phone contact or an internet-based system.

If an occupational therapist is working alone, with no support, there may be increased risk of poor or unsafe practice, particularly if they are less experienced. Practitioners should always work within their professional competence, only providing services and using techniques for which they are qualified by education, training and/or experience (COT In press, section 5.1). Isolated occupational therapists need to have access to support in some way. It may be possible to link in to another local service, or to arrange for support from an independent practitioner, as above. Again, this may incur costs for the employing organisation. If requested, the COT Consultancy Service can usually organise the provision of external supervision by a suitably qualified and experienced occupational therapist.

4.3 Documentation in support of supervision

The requirement for supervision is written into legislation, standards and strategic documents across the UK:

- The Health and Safety at Work Act 1974 enacts a general duty on every employer to ensure, so far as is reasonably practicable, the health, safety and welfare of all its employees, as well as environmental safety. The duty extends in particular to:

  > *The provision of such information, instruction, training and supervision as is necessary to ensure, so far as is reasonably practicable, the health and safety at work of its employees.*
  >
  > (Great Britain. Parliament 1974, section 2c)

- The Care Quality Commission (CQC) is the independent regulator of health and social care services in England. During 2014, the CQC carried out a number of consultations around changes in the way it regulates health and adult social care services.
- New regulations, the *Health and Social Care Act 2008 (Regulated Activities) Regulations 2014* (Great Britain. Parliament 2014), have been introduced, setting out fundamental standards of quality and safety. From April 2015 the new

regulations and guidance will replace, in its entirety, the *Guidance about compliance: Essential standards of quality and safety* (CQC 2010) and the 28 'outcomes' that it contains.

- The new fundamental standards have a number of requirements for employment and staffing:

  > *Staffing*
  >
  > *13. (1) The registered person [individual, partnership or organisation] must deploy sufficient numbers of suitably qualified, skilled and experienced staff in order to meet the requirements of this Part.*
  >
  > *(2) The registered person must ensure that persons employed by the registered provider in the provision of a regulated activity –*
  >
  > *(a) receive appropriate support, training, professional development, supervision and appraisal;*
  >
  > (Great Britain. Parliament 2014, Part 2, section 13)

- The NHSScotland Framework for role development in the allied health professions states:

  > *Local staff governance and clinical governance systems must have mechanisms in place to ensure role development opportunities are appropriate for the specific professions, and that individual AHPs receive the preparation and ongoing supervision and support they require.*
  >
  > (Scottish Executive 2005, p15)

- In 2013, the Scottish Government consulted on a consensus statement for allied health professionals, with regard to quality service values. The final statement now published states:

  > *Allied Health Professionals will have access to support from profession specific professional and clinical leadership and supervision on a regular basis to support professional development planning and clinical practice and will be provided with opportunities for continuing professional development which meets HCPC (Health and Care Professions Council) registrant and professional body requirements.*
  >
  > (Scottish Government et al 2013)

- The 2012–2017 strategy for allied health professions in Northern Ireland recognises that:

  > *Appropriate and effective supervision and support, together with clarity of roles and responsibilities, can provide a structured framework to support good governance.*
  >
  > (DHSSPS 2012, p36)

- It requires organisations to:

  > *ensure that appropriate induction, perceptorship [sic] and supervision are in place to support transitions along the career pathway.*
  >
  > (DHSSPS 2012, p53)

- In 2013, the Department of Health, Social Services and Public Safety published the *Regional supervision policy for allied health professionals*. This

  > *sets policy direction for AHP staff, their professional leads and line managers to ensure processes and systems are in place to support professional supervision.*
  >
  > (DHSSPS 2013, p8).

- *Doing well, doing better: standards for health services in Wales*, published in 2010, is broader, including more detailed elements of care provision which recognise and address the needs of patients, service users and their carers, providing them with safe, effective treatment and care.

  > *They require service providers to ensure that their workforce are supervised and supported in the delivery of their role.*
  >
  > (NHS Wales 2010, Section 25, e)

Along with the requirements laid on the organisation, practitioners themselves are also expected to meet certain standards:

- The College of Occupational Therapists has responsibility for the promotion of good practice and the prevention of malpractice. The College of Occupational Therapists' *Code of ethics and professional conduct* states that:

  > *You should be supported in your practice and development through regular professional supervision within an agreed structure or model. Sole practitioners should seek out professional support and advice for themselves.*
  >
  > (COT In press, section 5.3.2)

The *Professional standards for occupational therapy practice* (COT 2011b) requires practitioners to 'receive regular professional supervision or support within an agreed structure or model' (COT 2011, section 5.3.6).

- The Health and Care Professions Council (HCPC) is the professional regulator. Its key function is to protect the public, setting standards for the training, professional skills, behaviour and health of the registrants. It requires registrants to

  > *understand the importance of participation in training, supervision and mentoring*
  >
  > and
  >
  > *recognise the value of case conferences, supervision and other methods of reflecting on and reviewing practice*
  >
  > (HCPC 2013, sections 4.6 and 11.2).

- The HCPC also lays particular emphasis on the importance of supervising those to whom tasks are delegated (HCPC 2012, section 8).
- When a practitioner registers or re-registers with the Health and Care Professions Council, they are stating that they meet these standards.

5 Resources

The following resources are available:

- College of Occupational Therapists resources: the College's *Occasional paper on mentorship* (COT 2010c) explores what is meant by mentorship, its functions and benefits, and outlines the characteristics of good mentors and mentees.
- COT Library 'hOT topics' papers: these are available to download free from the Library section of the COT website. They list a useful range of literature, from journals, books and theses to a variety of internet resource leads. Those that might be of interest here are:
    - Supervision (COT 2006, February issue)
    - Continuing professional development (COT 2009, June issue)
    - Reflective practice (COT 2009, October issue)
    - Models of supervision (COT 2011, July issue)
- All are available to download from the College website: http://www.cot.co.uk/ (Accessed on 04.09.2014).
- The Social Care Institute for Excellence has a range of material in written and visual format available on its website: http://www.scie.org.uk/topic/developingskillsservices/managementleadership/supervision (Accessed on 04.09.2014).
- The Knowledge Network website of NHS Education for Scotland. This resource will support practitioners and managers to access resources that can help them with implementing supervision: http://www.knowledge.scot.nhs.uk/nmahpsupervision.aspx (Accessed on 04.09.2014).
- Skills for Care and the Children's Workforce Development Council (2007) *Providing effective supervision: A workforce development tool, including a unit of competence and supporting guidance*. Leeds: Skills for Care and CWDC: http://www.topssengland.org.uk/developing_skills/leadership_and_management/providing_effective_supervision.aspx (Accessed on 04.09.2014).

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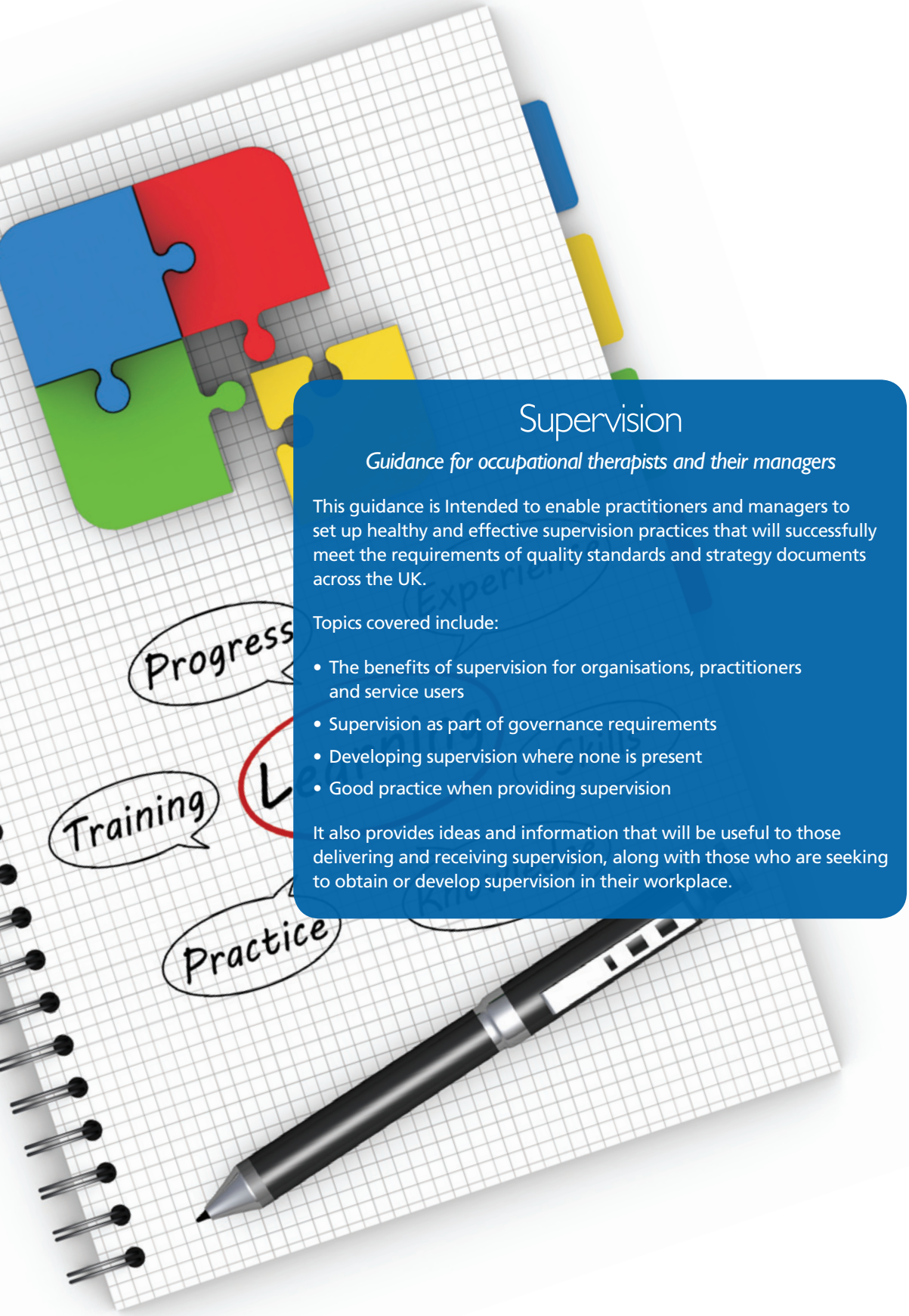

Supervision

Guidance for occupational therapists and their managers

This guidance is Intended to enable practitioners and managers to set up healthy and effective supervision practices that will successfully meet the requirements of quality standards and strategy documents across the UK.

Topics covered include:

- The benefits of supervision for organisations, practitioners and service users
- Supervision as part of governance requirements
- Developing supervision where none is present
- Good practice when providing supervision

It also provides ideas and information that will be useful to those delivering and receiving supervision, along with those who are seeking to obtain or develop supervision in their workplace.

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