SUPERVISION REVIEW REPORT FOR THE OCCUPATIONAL THERAPY BOARD OF NEW ZEALAND

Authors:

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Conflict of Interest Statements

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Executive Summary

Nau te raurau	*With your input*
Naku te raurau	*And my input*
Ka ki te kete	*The basket will be full.*

Under the Health Practitioner's Competence Assurance Act (2003), the Occupational Therapy Board of New Zealand requires all occupational therapists to be in supervision. A review of supervision was commissioned by the Board in 2011 to provide clarity around the different types of supervision and better consistency in the wording in the various Board documents that refer to supervision. This report provides the findings of the review.

A literature review was conducted and members of the profession consulted via a short anonymous email survey. Data was thematically analysed and interpreted, matched against the literature, and used to inform the recommendations with specific emphasis on addressing the following questions:
1. What are the requirements of each type of supervision?
2. Is the current terminology related to supervision appropriate?
3. What issues (actual or potential) impact negatively on the various forms of supervision required by the Board?
4. What solutions might address the barriers?

Different types of supervision are clarified and a recommend a supervisory framework which takes into account the unique requirements of Aotearoa/NZ practice contexts and the Treaty of Waitangi and which clarifies terminology and the various types of supervision is posited.

Three main types of supervision have been identified that sit within Board requirements; namely clinical/professional supervision (in some instances these are split); supervision for the Continuing Competence Framework for Recertification (CCFR) plans, and supervision related to when a practitioner has a Condition on Scope of Practice (CSP). A fourth type of supervision is also identified; referred to here as supervision for a 'Board-imposed CSP' resulting from a competence review. Whilst there is general consensus within the profession about the purpose, scope, and benefits of supervision and that supervision is primarily centred on reflective practice processes, misunderstanding and misinterpretation is evident regarding the latter two types of supervision. Furthermore there is confusion in the profession as to how many supervisors one should have.

The recommendations include:
1. That the term 'professional supervision' and definitions from the Code of Ethics be used by the Board to consistently describe and define supervision for the profession.
2. That the Board draws from the Te Pou o Te Whakaaro Nui supervision guidelines as a guide to best practice in supervision.
3. Further work is required to unravel the confusion within the profession related to the following roles: a) CSP supervision, and b) the Third Party role.
4. That supervisor and Board accountabilities are further defined in relation to CSP supervision; supervision should not be used as the sole evaluative aspect in monitoring and reporting on a Board-imposed CSP.
5. Kaupapa Māori and cultural supervision needs to be explicitly included in Board documents related to supervision.
6. Suggestions for core components to develop a Board-related supervision framework include definitions, scope, goal, tasks and elements of supervision, and minimum expectations of the supervisor role.

Introduction

The Occupational Therapy Board of New Zealand (the Board), as stated in the Code of Ethics (2004), requires all occupational therapists who hold a current Annual Practicing Certificate (APC) to receive effective professional supervision relevant to their work setting. The Board defines professional supervision in the Code of Ethics as a:

> *"Structured intentional relationship within which a practitioner reflects critically on her/his work, and receives feedback and guidance from a supervisor, in order to deliver the best possible service to consumers. Professional supervision may incorporate any aspect of a professional role e.g., clinical, managerial, or cultural, and be one to one, one to group, or take the form of peer review."*

The Board also defines a supervisor as a person who:

> *"Has sufficient self-awareness, interpersonal competence, and knowledge of processes relevant to the area of practice of the supervisee to facilitate that person's professional development."*

However, under the Health Practitioner's Competence Assurance Act (2003) (HPCAA), supervision means:

> *"… the monitoring of, and reporting on, the performance of a health practitioner by a professional peer"* Part 5(1) (HPCAA, 2003.).

Taken at face value, there is a mismatch between what the Code of Ethics (2004) states about supervision and what the HPCAA states (2003). Apart from misconstruing that 'peer review' and 'supervision' are one and the same, the Code of Ethics refers to a developmental process involving reflection and dialogue which facilitates professional growth, whilst attending to professional accountability. The HPCAA refers to the task of monitoring performance and reporting on said performance. Whilst the latter may be an intrinsic process in supervision, it is a highly narrow portrayal of supervision and fits better with performance management systems. Although commensurate with the process of 'competence assurance', the HPCAA meaning of supervision takes into account only one aspect of supervision; the task of *evaluative* supervision (Figure 1.).
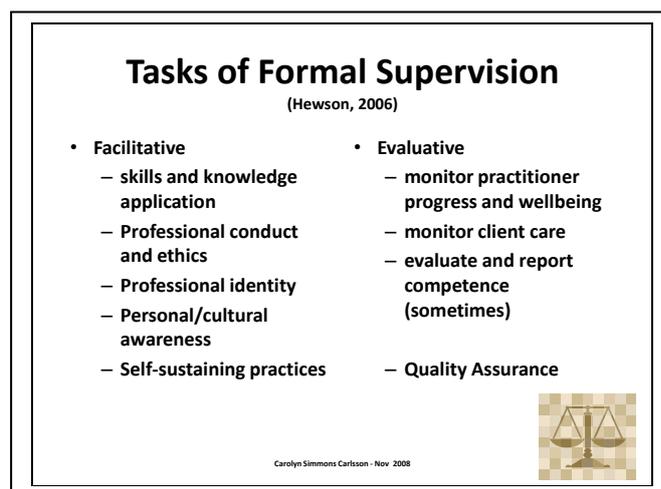
Figure 1. Tasks of formal supervision (Source: Supervision Training – ADHB)

Furthermore, the HPCAA meaning is at odds with the current practice of supervision (Morris, 1994; Hawkins & Shohet, 2007; Hewson, 2002, 2006; Carroll & Gilbert, 2005) which encompasses a much broader perspective, including both *facilitative* and *evaluative* tasks (Figure 1.); the goal of formal supervision being to develop and

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maintain practitioners' competent professional functioning and well-being, while safe-guarding client care, as well as to evaluate and feedback via report (Hewson, 2006). Reporting in supervision may be verbal and written, or both, and may be completed for the supervisee, employer, and other identified persons, or all of these. Within the Board's recertification framework, the Third Party attestation role is the one role that seems most aligned with the HPCAA meaning of supervision, however unlike the supervisor role, it is not an ongoing role within the CCFR. On the other hand, the supervisor role has a monitoring element to it, given it requires more frequent contact between a supervisor and supervisee. Little is known however as to the uptake of such frequency with the profession.

CCFR Supervision

The Board requires occupational therapists to name their supervisor as part of its mandatory *Continuing Competence Framework for Recertification* (CCFR) and to engage with their supervisor in relation to their individual CCFR plans for each competence area. Three performance criteria specifically relate to the requirement for the provision of supervision in the Board's *Competencies for Registration as an Occupational Therapist* (OTBNZ, 2000, p.3). Competency 5: 'Management of Self and People' stipulates that occupational therapists must:

- *5.2:* Participate in regular individual or peer supervision in a manner which supports on-going development.
- *5.11:* Assess the effectiveness of supervision, support and guidance and seek changes as required.
- *5.12:* Use feedback, supervision, support, & guidance to improve own performance.

This aspect is most aligned with the Code of Ethics (2004) definition of professional supervision. In addition, a supervisor who is a registered occupational therapist with a current APC may also be the practitioner's Third Party sign-off for the APC recertification attestation process. Anecdotally, we have found that the Third Party role is not clearly understood by the profession in relation to the CCFR. The Board may wish to address this aspect of the CCFR at a later date.

Condition on Scope of Practice Supervision

Supervision is an integral element of the Board's requirement for practitioners with a Condition on Scope of Practice (CSP) and these practitioners must comply with the Board's mandated supervisory frequency. With the implementation of the HPCAA (2003), three forms of supervision were identified by the Board relative to maintaining ongoing competence, these being:

1. New Graduate CSP
2. Return to Practice CSP
3. Overseas Trained Therapist CSP.

A fourth CSP is also identified, being:

4. CSP imposed on practitioners who are under review by the Board.

Under these conditions, supervision for a CSP has a strong focus on competence oversight, monitoring, and evaluation. The supervisor is required by the Board to write a satisfactory supervisor's report at the end of the specified supervision period and the practitioner must apply to the Board to have the condition removed. This aspect is aligned with the HPCAA meaning of supervision and requires clarification and more robust systems for accountability, especially for the fourth type.

It is our supposition that the differences and discrepancies outlined above and the profession's beliefs and broader understanding of supervision than is expressed in the HPCCA (2003) AND CCFR is what has given rise to a lack of clarity and confusion around supervision within the occupational therapy profession; this extends to the Third party role.

Background to this Project

The Board has always actively supported the use of supervision for occupational therapists, recognising that supervision is clearly a significant process for maintaining ongoing competence and as such it is a cornerstone of the CCFR, the Board's process for competence monitoring. Moreover, in doing so, the Board acknowledges the value of supervision as an influential process through which practitioner's may perceive and relate to their agency (Morrison, 2001) and that the role of supervisor may also be carried out by members of other professions, but only if the occupational therapist (supervisee) does not have a CSP (OTBNZ, 2010). This inherently suggests that 'being a supervisor' requires more than just occupational therapy training.

Over time, it has become apparent that different types of supervision have different requirements and fulfil different purposes; problems can arise when the differences are not clearly understood. Clarity around the different types of supervision and better consistency in the wording in the various Board documents that refer to supervision is required. This project therefore seeks to produce a recommended supervisory framework that will provide clarity for the Board, practitioners, supervisors, employers, and educators alike. This supervisory framework will take into account the unique requirements of Aotearoa/NZ practice contexts and the Treaty of Waitangi. The purpose of this project, the project team, and project focus are outlined in (Appendix 1); specifically:
1. What are the requirements of each type of supervision?
2. Is the current terminology related to supervision appropriate?
3. What issues (actual or potential) impact negatively on the various forms of supervision required by the Board?
4. What solutions might address any barriers?

It should be noted that the term 'supervision' is not the same as 'peer review', 'peer support', 'mentoring', or 'coaching' (Carroll, 2007; Wright, 2004). However, supervision is frequently interchanged and confused with these processes. This confusion may occur because these processes, depending on the skill of the supervisor, may be brought into supervision in order to work with the supervisee's content within the context of the supervision process.

Key Linkages

The Treaty of Waitangi / Tiriti o Waitangi

Adherence to the provisions, spirit, and intent of The Treaty of Waitangi / Te Tiriti o Waitangi is the foundation for this project; informed by the principles of Partnership, Protection, and Participation. *Partnership* comes through Māori engagement in decision making related to any changes to the Board's policy and practices related to supervision; equal power sharing; and determining appropriate ways for engagement and consultation with Māori. *Protection* lies in ensuring the right to self-determination is retained and that there is access to kaupapa Māori supervision for practitioners, and the protection of

everything held dear. *Participation* occurs to guarantee equity of rights, privileges, opportunities, and outcomes for Māori.

According to Eruera (2010), cultural and tangata whenua models of supervision has been acknowledged as being unique within Aotearoa with specific obligations under Te Tiriti o Waitangi to support 'best practices' when working with Māori. Building a Māori occupational therapy workforce requires that "Māori are supported in their work and environment" (Te Rau Matatini, 2009, p.29) which includes supervision and opportunities for Māori to share best practice and develop their practice. Māori cultural supervision requires a kaupapa Māori model to support practice (Macfarlane, 2010).

Associated Documents

Legislation	• Health Practitioners Competence Assurance Act 2003 • Te Tiriti o Waitangi
Occupational Therapy Board of New Zealand *Kaihamanu Tūtororo o Aotearoa* http://www.otboard.org.nz	• Competencies for Registration as an Occupational Therapist (2000) • Code of Ethics for Occupational Therapists (2004) • Continuing Competence Framework for Recertification (CCFR) • Supervision for Occupational Therapists in the context of the Health Practitioners Competence Assurance Act 2003 (HPCAA) (February, 2006) • An Examination of the Preparedness for Practice of New Zealand New Graduate Occupational Therapists: A report for the Occupational Therapy Board (August, 2011) • Annual Report 2011. Occupational Therapy Board of New Zealand.
New Zealand Association of Occupational Therapists	• New Zealand Association of Occupational Therapists Supervision Position Statement (March, 2005)
Occupational Therapy Key Strategic Stakeholders (OTKSS)	Occupational Therapy Key Strategic Stakeholders Strategic Plan 2009-2015
Te Pou o Te Whakaaro Nui www.tepou.cp.nz	• National Guidelines for the professional supervision of mental health and addiction nurses. (2009) • Professional Supervision Guide: For leaders and managers. (February, 2011) • Professional supervision guide for nursing supervisees (February, 2011) • Professional Supervision Guide for nursing supervisors (February, 2011)
Other	• Te Umanga Whakaora Accelerated Māori Occupational Therapy Workforce Development. Te Rau Matatini (July, 2009).

The History of Supervision within the Occupational Therapy Profession in Aotearoa/New Zealand

By the mid 1980's many occupational therapy services had introduced supervision as a form of professional development and means of monitoring performance. The early focus of supervision was on the support and development of junior staff, with occupational therapists in management posts being the last to be seen as requiring and potentially benefiting from supervision. In the health sector, initially the Charge or Head Occupational Therapist, or a therapist senior to the supervisee, provided supervision, in a

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one-up-one-down arrangement (S. Milligan, personal communication, February 4, 2005), that is a hierarchical model of supervision was used. Little is known about the private and education sectors and supervision from the 1980's, however it is noted that the Ministry of Education, Special Education (MOE-SE) committed to a robust national supervision framework in the mid 2000s (Holly, 2005; MOE, 2005), beginning with a 'train the trainers' programme (Hewson, 2006).

The NZ Association of Occupational Therapy (NZAOT) first acknowledged the importance of supervision in the 1980's in its Cornerstone programme (NZAOT, n.d.), which endorsed the professional development activities of occupational therapists and described supervision as including "structured, on-going reflection on practice, monitoring and feedback, coaching, preparation of professional development plans, and other contracted learning experiences" (NZAOT, p.12). The NZAOT Council ratified its Position Statement on Professional Supervision in 2000; this was revised in 2005 (NZAOT, 2005) and states that supervision is "a supportive, empowering and constructive process, [which] promotes anti-discriminatory, culturally safe and gender appropriate practice" (p.2). The Position Statement also identifies two main types of supervision: clinical and professional supervision:

- *Clinical supervision* is seen to "reflect on clinical practice" (p.2) with the primary purpose being "to enable the therapist to address the occupational therapy needs of the client as effectively as possible" (p.2).

- *Professional supervision* is described as a process that "assists the therapists to increase their understanding of themselves and their relationships with others and/or to develop more satisfying and resourceful ways of delivering occupational therapy and/or bringing about a change in professional behaviour" (p.2).

NZAOT acknowledges the overlap of clinical and professional supervision and that practitioners should receive the kind of supervision most suitable to their own needs.

The replacement of the Occupational Therapy Act (1949) and its various amendments, in September 2003, with the Health Practitioners Competence Assurance Act changed the Board's role from a registering body to a regulatory body. The revision of the Act resulted in the Board placing significant emphasis on supervision within a competence monitoring framework, including the monitoring of those occupational therapists with a CSP. This has impacted on the workforce both for employees and employers; many have actively worked to incorporate the CCFR and supervision into their quality and professional development systems for occupational therapists in order to minimise duplication by therapists when setting objectives and to ensure professional development time is well focused and utilised.

It is interesting to note, however not surprising that the Board definition (OTBNZ, 2004) and HPCAA (2003) meaning and the literature published by the NZAOT reflect different tones for supervision; the Board having more emphasis on monitoring and administrative supervision as directed by the HPCAA (2003). These differences, the range of functions and the emphasis of supervision, and terminology also exists throughout the international supervision literature.

Training in Supervision

The first evidence of training associated with supervision processes and skills for the occupational therapy profession was in the early 1990's when the Central Institute of Technology offered a seven day 'Training in Clinical Supervision' course based on the TAPES trans actual analysis approach to supervision, which ran periodically till the early 2000's (O'Donaghue, 1998; S. Milligan, personal communication, February 4, 2005). The content of this course was highly influential in forming a foundation for occupational therapy supervision in New Zealand. Since 2000, a greater range of training courses are available to supervisors in general, and in some settings to supervisees. Such courses include a range of supervision maps and models for example, Hewson's 'Supervision Triangle' (Hewson, 2002), the 'Reflective Learning Model' (Davys & Beddoe, 2010), and the 'Seven Lens Supervision Matrix' model (Hawkins & Shohet, 2007).

Postgraduate courses on supervision have also been developed, for example at Auckland University, AUT University, and Otago Polytechnic. Similarly, larger organisations and agencies have arranged formal training opportunities that are in line with their own supervision policies and requirements, for example District Health Boards, the Ministry of Education, and some private practices. This increase in the variety and range of supervision training acknowledges the importance that the occupational therapy profession and allied health professions alike place on supervision.

Although supervision is emerging as a practice in its own right, the practice and profession that is growing around the provision of supervision is still in its infancy, with its models and research base still evolving. To date, the Board has not recommended a minimum level of training for supervisors or supervisees related to its CCFR. The NZAOT has some guidelines on its website which support best practice principles for finding a supervisor and engaging in supervision; however this information is in the member only section.

Literature Review

In reviewing the Aotearoa/New Zealand literature, the first occupational therapy specific journal article on supervision was published in 1983 and describes the nature and process of supervision available at Christchurch Hospital (Campbell, 1982-3). This article provides insights into some of the key issues and concerns associated with the provision of supervision; identified in the article as a joint process where responsibility was shared, weekly sessions, monitoring and feedback of projects, brainstorming, facilitating of problem solving, observations sessions, and demonstration of techniques. Most of these features are still seen today within supervision practice; however the theoretical base and processes have been considerably developed.

In a search of the profession's literature in New Zealand, only a small number of peer reviewed publications on supervision can be found in the last 10 years:- research articles Herkt & Hocking (2007; 2010) and general articles literature - Simmons Carlsson et.al (2007), Simmons Carlsson (2009), and Simmons Carlsson & Mueller (2011). Additionally there have been some features, discussions and comments in the NZAOT monthly Newsletter *OT Insight* and on NZAOT Special Interest Group (SIG) list serves, for example the Supervision SIG. We know from these publications, as well as anecdotally and from personal communications, that occupational therapy supervision in New Zealand has developed in line with the national and international literature on supervision, more so than along the lines of the HPCAA (2003) definition of supervision.

According to the international literature, supervision has multiple purposes (goals) or functions (tasks), including professional development (Mosey, 1986; Howatson-Jones, 2003), competence (Ung, 2002), and personal growth, and creativity (AOTA, 1999). With regard to client service, the goal is to increase effectiveness (Hawkins & Shohet, 2007; NZAOT, 2005), to "promote, establish, maintain, and/or elevate a level of performance or service" (AOTA, p.592), or "develop a high quality of practice" (Bond & Holland, 1998, p.12). From a managerial or administrative perspective, these purposes are reframed as performance and accountability (Morris, 1995; Bernard & Goodyear 1998). Tension between these differently focused purposes has been recognised.

In the mid 1970s to 1990s Kudushen (1992) described three main functions of supervision:- administrative, educational, and supportive roles, and many of the models of the time used similar groups, for instance 'normative'[1], 'formative'[2], and 'restorative'[3] (Proctor, 2001), which are still broadly referred to today. However over time there have been shifts in emphasis or priority. In the 1980's and 1990's there was a strengthening of the supportive and educative functions of supervision with greater emphasis on the empowerment of supervisees (Bond & Holland, 1998; Mosey 1986; Ung 2002), with Yegdich (1998; 1999) warning that personal growth issues might eclipse client care. Grauel (2002) and O'Donaghue (2003) suggest that the last decade has seen a strengthening of the administrative/managerial functions.

In New Zealand this has been led by health policy and the introduction of the HPCAA (2003) where there was a strong push for quality assurance, competence, and accountability. The literature also acknowledges a tension between clinical and managerial supervision Morris (1995) states:

> "The tension between focusing on action and performance is a critical distinction between clinical and managerial supervision. Focusing on performance brings its own agenda and criteria and can be limiting both in terms of the supervisory relationship and the degree to which issues can be explored. Supervision focuses on professional action and any blurring of roles should be considered carefully" (p.2).

At the same time there has also been a strengthening of the need for practitioners to be self-directed learners and through the use of reflection/reflective learning (Davys 2001; Driscoll, 2007) to come to new learning and new knowledge of practice (Davys, 2001). Types of supervision and their purposes have been summarised in Appendix 3.

These concepts are now dominating the supervision literature. The emphasis on reflective learning fits with the high trust model of supervision that the Board has adopted in the CCFR with its focus on the continual on-going development of occupational therapists'; evidenced via engagement in ongoing competence objectives and activities. However, the nature, quality, and outcomes of such supervision is currently unexplored and unknown for New Zealand occupational therapists.

Historically, supervision began by being offered to those the occupational therapy profession believed most needed supervision; the new graduates. Supervision research

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[1] Normative processes encourage recognition of professional, ethical, organisational contexts and factors such as rules and norms to develop competency and accountability and assist the practitioner to 'see beyond'.

[2] Formative processes focus on learning and development in relation to knowledge, skills, abilities and understanding through reflection.

[3] Restorative processes focus on resourcing and sustaining the practitioner, including dealing with reactions to clients' stories and situations and acknowledging the emotional effects of work, including organisational processes, structures, and relationships.

supports the value of supervision for this group in particular (Sweeny, Webley, & Treacher 2001a; 2001b). In 2010 the Board commissioned a report in to the preparedness for practice of New Zealand new graduate occupational therapists (Nayar, Blijlevens, Gray & Moroney, 2011). This report discusses the importance of supervision in the transition of students from education to practice, recognising and accepting that undergraduate training cannot fully prepare graduates for practice and that learning needs to be gained on the job. This report states that "supervision is necessary to prepare new graduates for practice" (p.60) and that supervisors can "play a powerful role in shaping new graduates" (p.59). The report also states that supervision "can take many forms such as formal or informal, individual or group, face to face or via phone or email, and even vary in the amount, whether it is hourly, weekly or of other frequency" (p.59). However, this is at variance to the supervision literature which suggests that supervision is a formal, contracted arrangement with mutually negotiated and agreed upon goals and foci.

Supervision rests on a learning partnership (Carroll & Gilbert, 2005; Hawkins & Shohet, 2007) where confidentiality is important. For supervision to be productive, it is essential that the environment is set such that the supervisee comes to supervision feeling safe to disclose and willing to use the space created by supervision to discuss, "the client, the organisation, themselves and the interaction processes" (Ung 2002, p.95). Confidentiality is therefore essential in such a transformational learning environment. So too is the need for a clear written agreement/supervision contract that is mutually negotiated and agreed upon as to what information is to be shared and the grounds on which this may be breached (Carroll & Gilbert, 2006; Herkt, 2007; 2010; Sweeny 2001a; 2000).

Defining Supervision

Definitions of supervision
Supervision is

> *"An intervention provided by a more senior member of a profession to a more junior member or members of that same profession. This relationship is evaluative, extends over time, and has the simultaneous purposes of enhancing the professional functioning of the more junior person(s), monitoring the quality of professional services offered to client(s) she, he, or they see(s), and serving as a gatekeeper of those who are to enter the particular profession."* (Kadushan 1992 p.6).

> *"Clinical supervision is regular, protected time for facilitated, in-depth reflection on clinical practice. It aims to enable the supervisee to achieve, sustain and creatively develop a high quality of practice through the means of focused support and development."* (Bond & Holland, 1998).

> Supervision is *"A process in which two or more people participate in a joint effort to promote, establish, maintain, and/or elevate a level of performance and service. Supervision is a mutual undertaking between the supervisor and the supervisee that fosters growth and development; assures appropriate utilization of training and potential; encourages creativity and innovation; and provides guidance, support, encouragement and respect while working toward a goal."* (AOTA, 1999a, p.592).

Supervision is

> *"An essentially interpersonal interaction between two people with the general goal that one person (supervisor), meets with another (supervisee) in an effort to make the latter more effective in helping people."* (Hawkins & Shohet, 2007, p.225).

The Ministry of Health (MOH) of New Zealand defines professional supervision for mental health nurses (applicable to allied health professions in mental health services) as:

> *"A formal process that provides professional support to enable practitioners to develop their knowledge and competence, be responsible for their own practice, and promote service users' health, outcomes and safety."* (MOH, 2006, p.22).

This definition is adopted by Te Pou o Te Whakaaro Nui (Te Pou, 2011) in its National Guidelines for the professional supervision of mental health and addiction nurses (Te Pou, 2009). Te Pou is a charitable company with a number of funding sources including the MOH, Health Workforce New Zealand (HWNZ), non-government organisations, district health boards, and the education sector. Te Pou's work includes supporting and developing the mental health, addiction and disability workforces in New Zealand. Its supervision guidelines are highly applicable to allied health practitioners in mental health. In the authors' opinion, the principles of the Te Pou supervision guidelines are equally applicable across the multitude of allied health professions regardless of setting, and including occupational therapists.

Towards Best Practice: Te Pou o Te Whakaaro Nui

As an organisation, Te Pou is committed to advocating and ensuring best practice supervision through research and guidelines. Te Pou decided to adopted the term 'professional supervision' rather than the terms supervision or clinical supervision seeing professional supervision as encompassing all aspects of supervision:

> *Professional supervision is essential for clinicians who work within the mental health and addiction area. It allows space and time to reflect on practice, professional identity and to develop a wider view of the area that clinicians work in. It allows for the 'extra' vision, the wider view that can occur when engaged with a professional supervisor, and reflecting on one's work.* (Te Pou, 2011, p.*i*).

Te Pou therefore provides a robust set of guidelines from which the Board may draw to inform its thinking and decisions regarding supervision for the occupational therapy workforce. Of note is that the team developing the Te Pou guidelines are representative of allied health. It is the authors' belief that these guidelines equally apply to the occupational therapy profession.

Te Pou also recognises the significant role that professional supervision has to play in developing practitioners' cultural competence. Commitment to the principles of the Treaty of Waitangi means that it is essential in New Zealand for therapists to receive supervision that promotes cultural competence. Such supervision places importance on the development of relationships and an understanding of self. More specifically, practitioners who identify as being Māori need to be "supported, nurtured and encouraged to continue to develop and integrate their clinical and cultural skills" (McKenna et al., 2008 cited in Te Pou, 2011, p.9; Te Rau Matatini, 2009). This form of supervision sits alongside existing models of professional supervision (Te Pou, 2009).

Survey Findings

As part of this review the project team devised and implemented a simple qualitative descriptive survey ([Appendix 2](#)) using open-ended questions. The survey was distributed to all registered occupational therapists via the Board's email system. The survey sought to draw from practitioners' perspectives to inform the recommendations of this review. Participation in the survey was voluntary and responses were treated as confidential and anonymous to protect the privacy of the respondents. Of the 2757 registered therapists, 56 people responded including graduates, overseas-trained therapists and experienced practitioners and people who are supervisors and supervisees. Their voices are collectively and thematically described in this section.

Defining Supervision, its Purpose, Types, and Scope

The findings from the survey are mixed and varied with no clear cohesive or collective worldview from the profession. However, pulled together as a data set, there are some similarities in themes within the findings that may be seen as aligned with the literature and the Board's definition of professional supervision as stated in the Code of Ethics (2004). However, there is also a great degree of confusion. Overall, the group perceives supervision as an integral part of professional development activity; however the term supervision is sometimes used interchangeably with other processes such as mentoring and coaching, suggesting confusion about the different processes.

Professional Supervision

Of all the survey questions, responses to this section were the most cohesive. Professional supervision is mostly seen as something that is carried out in a more formal one-to-one relationship, and may also involve group and peer supervision. However some believe that supervision can be formal or informal. The place of reflective practice in supervision is definitely acknowledged. New graduate practitioners are seem to require a more directive process of supervision to begin with. Pastoral care within supervision is recognised and valued, one person stating this is about "... looking after the self in practice", referring to the well being of the practitioner at work. Some clearly recognise that supervision is not the same as performance management.

- *... not the appropriate forum for performance management, though may be included in performance management plans, under the direction of a manger/professional advisor.*

Looking at the data set as a whole, supervision may be summarised as a structured, regular process between a supervisor and a supervisee, providing opportunities for some and/or all of the following functions:

- Professional development and support:
    - Discussing and identifying professional development needs
    - Brainstorming and problem solving; using the supervisor as a 'sounding board'
    - Advice, guidance, and assistance
    - Receiving constructive feedback
    - Career progression and planning
    - Professional safety
    - Self directed learning
    - Growth and learning opportunities
    - Gaining a better understanding of the profession (new graduate)
    - Developing confidence in role and practise
- Addressing clinical issues:

- o Development of clinical skills
- o Caseload discussions; discussion of clinical scenario's and intervention planning
- o Enabling reflection/evaluation of casework and role responsibilities
- o Service planning
- o Client/team issues (figure out solutions or responses)
- Opportunity for critical reflection:
  - o To actively reflect on practise (understand why and what underpins our decisions; guided reflection)
  - o Self critique of own practice
  - o To be challenged to critically look at practice to evoke change
  - o Reflection on professional practice including behaviour, attitudes, and safety
  - o Exploring and reflecting on practice/work issues
- Addressing self care / self management:
  - o Stress management
  - o Celebrations of good work
  - o Assisting with experiencing better work satisfaction
  - o Developing self-confidence
  - o Looking at day-to-day work activities which may include clinical, managerial, systems and time management
  - o Safe practice, safe workloads, satisfaction
- Ensuring accountability:
  - o Consolidation of practice style and competence in relation to role and experience
  - o Maintaining good work ethics and practice
  - o A quality assurance measure
  - o Ensuring clients and business needs are met
  - o Discussing workplace issues and clinical/ethical issues
  - o Ensuring safe clinical practice and skills; improvising performance
  - o Ensuring professional standards and policies are met
  - o Ensuring high quality service provision
  - o Ensuring accountability, and
  - o Delivering the best possible service to consumers; effective interventions; and critical analysis.

Some of the core elements of the supervisory relationship and process are highlighted. For instance, supervision needs to be safe, that is, "not with the line manager" and be a "safe place to raise issues related to performance for in-depth exploration" and it must be structured and occur at regular intervals. In addition, supervision is a confidential process and involves supportive and facilitative processes with collaboration between the supervisor and supervisee. Supervision is therefore relational in nature. Clear boundaries are required, such as in a supervision agreement and sessions need to be documented. Dialogue is important in the supervisory partnership, with a supervisee led agenda. There was no mention as to how the confidential nature of supervision is reconciled with the requirement to report on the supervisee to the Board.

CCFR Supervision

The Board stipulates that "it is mandatory to have a CCFR supervisor" (OTBNZ, 2011, p.25). In line with the supervision literature, the CCFR supervisor's role is to aid the process of practitioner critical reflection, alongside providing feedback and guidance that assists the practitioner to maintain and develop their ongoing competence.

- *This type of supervision supports the practitioner to ensure competency is met in all 7 areas; if not, why not; what is lacking and what needs to be done about it (which taps into professional supervision).*

Many respondents highlight the integration of their CCFR supervision with their professional supervision; the supervisor being the same person for both:

- *I think professional supervision and supervision for the CCFR should essentially be the same.*
- *CCFR supervision should be implicit in [professional supervision] ... otherwise becomes onerous and lacks the links to the area's service delivery,*

and that CCFR supervision assists the practitioner to specifically look at their objectives and activities to:

- *Make sure they are effectively utilising the CCFR and updating this fairly regularly, and monitoring competence in relation to the CCFR.*

However, there is wide variation in the degree of expected supervisor accountability, from "discussion" through to "having oversight" through to "assisting the choosing and achieving" objectives.

There are also mixed perceptions of the supervisor's role and degree of involvement in the CCFR. For instance the supervisor is:- "limited to giving feedback"; "should not need to prompt me to keep CCFR up to date"; ensures the "undertaking of ongoing relevant professional development"; "affirm and coach", and "more directive". There is also lack of clarity and understanding about the reflective nature and purpose of CCFR supervision:

- *Purely for the purpose of registration - another level of paper work.*
- *I am not clear that supervision for CCFR is required as its purpose can be met in another forum.*
- *... does it relate to the setting of self assessments, objectives and activities etc. for the CCFR?*
- *Unsure … would prefer not to have this category unless clearly differentiated from the others.*
- *This supervision is not related to my professional behaviour.*
- *... there is a place for coaching/mentoring to establish and review CCFRs*
- *Needs more flexibility and less bureaucratic, the time taken to complete the tasks is not cost effective ... [CCFR] is clumsy ... process is too long ... undermines our professionalism ... frustrating process to have to follow.*

The regulatory nature of the CCFR is highlighted by a few; it being "a method by which the Board can be sure that occupational therapists are being monitored ... maintain their professional competencies". However again, there is no consistency in understanding of the purpose of CCFR supervision. As one respondent aptly puts it, "I feel that supervision for the CCFR seems to be so varied". Another person states, it is "best to find an occupational therapist for this" role; and another states, "this relationship feels more like a checking or auditing role."

Taking the findings as whole set, the data can be sifted to highlight that CCFR supervision is a process that primarily supports practitioners to address and fulfil their CCFR requirements to "ensure that the individual is doing what they should to maintain competence to practice" and to "meet legal requirements". It is important to note that two tenuous themes come through; firstly that CCFR supervision is related to professional development, and secondly that the CCFR is recognised as a monitoring process:

- *... proof that occupational therapists are keeping up their practical and reflective competencies to be practising as competent professionals.*

Given these findings, the Board should revisit the artificial separation between the different types of supervision and clarify this for the profession.

Supervision for a Condition on Scope of Practice

The Board states that practitioners with a CSP "should not commence practising until the required supervision is in place" (OTBNZ, 2011, p.26) and prescribes the frequency, form and nature of supervision along with who may provide such supervision for all occupational therapists with a CSP. CSP supervisors must be registered occupational therapists who hold a current APC and who do not themselves have a CSP. A supervision log must be kept by the practitioner to record details of the nature and frequency of the supervision. Following the Board decreed supervisory period, a Supervision Report must be written by the supervisor using the Board's template and submitted to the Board by the practitioner, which provides "an assessment of the practitioner's actual practice, and should provide the Board with evidence of the applicant's competence to practise". This report should not be cross-referenced to the supervisee's CCFR. The supervision log and report must satisfy the Board with respect to the practitioner reaching a standard of safe and competent independent practice in order for the condition to be removed (OTBNZ, 2006, p.6). This function links with the task of evaluative supervision.

CSP supervision is delivered according to the below frequency and form:
- New graduates – provision of "direct supervision in the context of a role and task emergent novice practitioner new to occupational therapy practice" (OTBNZ, 2006, p.7).
- Return to practice in NZ practitioners – provision of "opportunities for self-development, identification of gaps and areas to address and redevelop to update practice skills in the NZ healthcare environment, and building on current and previous skills and experience" (p.8).
- New to practice in New Zealand practitioners (overseas-trained) – provision of similar opportunities as above, with particular emphasis on cultural and contextual practice.

Graduates who completed the survey state that they benefit from and find supervision helpful.

For this section, the survey findings reveal that some people are generally clear about the purpose of CSP supervision. Some feel (as above) that a combined approach to supervision is applicable:
- *Supervision for a scope of practice should include both "professional supervision" and lots of "clinical supervision, mentoring and preceptorship".*

Of interest, no specific reference to any supervision-related Board publications is evident; however there is the overall understanding that CSP supervision is different to CCFR supervision.
- *... really focusing on observing and feedback on their practise*
- *... specifically related to the persons area of practice, and ensuring that they are effectively delivering occupational therapy input and ensuring they develop the skills needed to meet the practice requirements.*

Some suggest that there is more to this type of supervision than the process of reflective supervision and in doing so, reveal that this type of supervision is inconsistent with the concept of supervision as stated in the literature. For instance CSP supervision:
- *... requires a variety of observational, formal, peer review types of supervision*
- *... definitely needs live supervision and auditing of files and applications*

- *... has to be a very structured, monitored and frequent supervision ... and would involve a lot of specific case load discussion.*

For others, this type of supervision remains unclear:

- *... to learn the scope of the role*
- *... ensure the practitioner is supported while transitioning from positions such as new graduate or return to practice*
- *... provide information sources or assist in finding information sources*
- *... huge focus on education and enhancing knowledge in the clinical field of practice.*

Overall, interpreting the findings as whole data set, the implication is that further clarifying documents, developed by the Board and specific to CSP supervision, may be helpful for the profession and no doubt for employers and practitioners who resource the cost of CSP supervision. It may also be prudent for the Board to take more accountability for this aspect of supervision or rather consider implementing processes that align better with monitoring and evaluation. This will require the implementation of additional competence measures, for example peer review and live observation or both, rather than the sole reliance on supervision as the evaluative process for the CSP. In this way, the integrity of supervision may be retained and the power balance that is necessary within its relational process may be restored.

Finding a Supervisor

In terms of 'finding a supervisor', those who have no difficulty finding a supervisor and those who have difficulty list similar considerations, such as:

- Supervisor skill level for the provision of quality supervision experiences
- Limited availability of supervisors, especially in rural areas, non-traditional settings and settings with limited staff to provide supervision
- Time demands and constraints
- Having to travel for supervision
- Having to pay for supervision, and
- Lack of clarity as to who would be a supervisor for a CSP for overseas-trained practitioner.

Some people get around the barriers of finding a supervisor by combining all the types of supervision with one supervisor, who is also the Third Party person. One person states that "non-occupational therapist supervisors can offer more challenge and therefore be useful in supervision". The confusion between the CCFR supervisor and Third Party sign-off role is also evident in this section of the findings.

General Comments

Lastly, some of the general comments elicited from the survey are worth noting:

- *... these questions about supervision are very important. I would like a reply or some ongoing conversation about this, so it is not just another survey that doesn't achieve anything for therapists on the shop floor ... [supervision] is such a big issue that it would be good to have a teleconference or something similar with leaders from a range of occupational therapy practice areas.*
- *I thank you for the opportunity to reflect regardless, it just reminds me of the amazing people out there and just what it takes to be an occupational therapist and manage, balance, life.*

Discussion

Currently, the Board requires that occupational therapists engage in three types of supervision: - a) professional supervision; b) CCFR supervision, and c) CSP supervision,

which includes supervision as a result of the Board imposing the condition for practitioners under review by the Board. These different types and their regulatory meanings whilst less confused within the profession than perhaps at the infancy of the Board's requirements post 2003, appears to have led to a great deal of confusion about supervision within the profession.

The survey findings reveal that many practitioners tend not to separate the types of supervision and generally prefer to have one supervisor for the different types, linked to the purpose and function of their supervision. The authors' see this as a wise decision by practitioners given the impact and costs of supervision in terms of time, resource, and funding. However the quality of supervision received is unknown.

The burden of cost for supervision is borne by practitioners, employers, and organisations. Whilst not addressed in this report, the Board should also note a further cost, which is the cost of practitioners not being in quality supervision which can directly impact on both the public's safety and the practitioner's work and professional accountability.

All three elements of supervision (as outlined above in Figure 3 below) are exposed in the survey findings. Thus, adopting an ecological scope for supervision encompassing the three elements may be prudent for the Board to consider. Well-articulated documents that clearly define the types of supervision, within the broad scope of supervision, are required. Such documents need to be readily accessible and practitioners need to be routinely informed of their availability on the Board's website through good communication systems.

Other aspects that may be prudent for the Board to articulate in writing include "what is reflective practice" and the difference between a standard condition on scope of practice and a Board-imposed condition resulting from a competence review. Further, the use of supervision for oversight and monitoring of persons with a Board-imposed CSP, where the focal length is firmly on the evaluative and monitoring functions/tasks of supervision (see Figure 1.) should be reconsidered. It may be prudent for the Board to look at more robust evaluative and reporting processes *alongside* supervision such as the use of peer review of practice, audit, and article reviews, and reflective writing for example. This system is being implemented by the Physiotherapy Board and lends itself well to keeping the integrity of the supervisory partnership and process intact (personal experiences). Supervision for a CSP, be it a standard CSP or a Board-imposed CSP, is always a three-way contract between the Board, the practitioner with the CSP, and the registered practitioner who agrees to supervise the person with a CSP, therefore some clear guidelines for information disclosure and reporting would be prudent.

Terminology and Supervision

The literature on supervision refers to the practice of 'supervision' rather than providing a clear division between 'clinical' and/or 'professional' supervision. The Board definition (OTBNZ, 2000a) and the literature published by the NZAOT reflect different tones for supervision; the Board emphasis is on monitoring and evaluative supervision as directed by the HPCAA (2003). Supervision should always be a formal arrangement with mutually negotiated and agreed boundaries, goals, and foci. There is a tendency for professional supervision to be seen as an umbrella term, with clinical supervision having its focal length on the exploration of clinical practice and the client and immediate clinical practice contexts. Professional supervision also embodies this aspect, however its focal length is

more ecological, moving, for example, between the supervisee, the client, the team, the organisation, resourcing, and even the impact of society and local/global politics on the issue at hand within the supervision session. This ecological or contextual worldview of supervision is depicted in Figure 2.
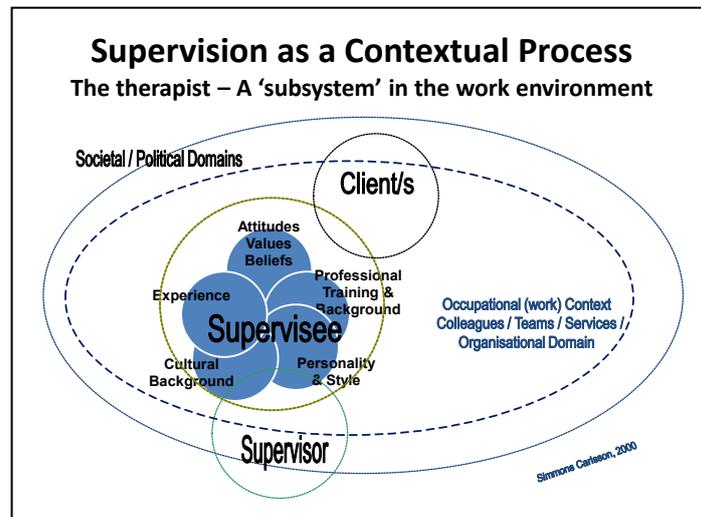
Figure 2. A contextual worldview of supervision (Source: Carolyn Simmons Carlsson)

The literature also acknowledges that supervision should meet the current needs of the practitioner/supervisee and that these needs will change over time. Therefore, there is no stipulation for one type of supervision over another; rather supervision is 'needs driven' and this is appropriate. Thus, it may be more prudent for the Board to consider a 'scope of supervision' rather than 'types', with the emphasis placed on the below three elements of supervision being a requirement at all times (see Figure 3.):
1. Input into client care
2. Professional development and support, and
3. Practitioner professional accountability.
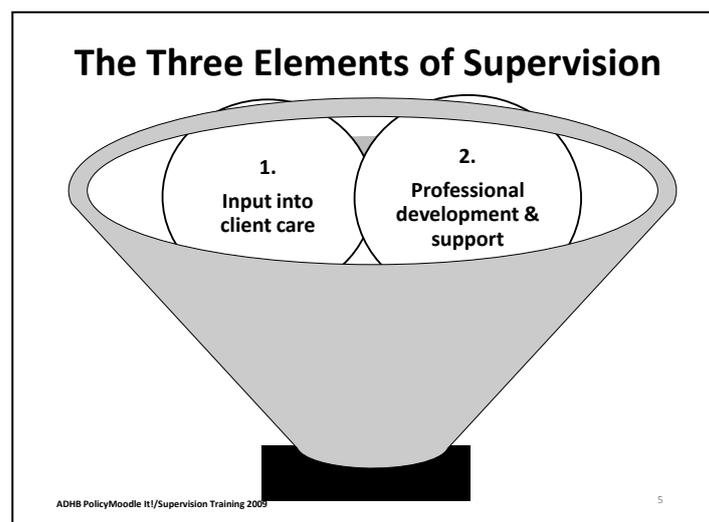
Figure 3. The three elements of supervision (Source: Auckland District Health Board)

The 'type' of supervision (see Appendix 3.) is negotiated and agreed to within the contracting phase of the supervisory partnership and written into the formal supervision agreement. What appears most important is the purpose and function of supervision,

rather than identifying a specific type. The vast work that Te Pou has contributed to defining supervision for the whole of the mental health sector should be taken into account by the Board when considering supervision-related terminology. Therefore, it may be more prudent when looking at which term to use, to apply the term 'professional supervision' in line with Te Pou and as used within the Code of Ethics. This seems to be the least restrictive term for the Board to consider, and will likely avoid discrepancies in terminology across sectors. For example, the new graduate with a CSP will require supervision to have its focal length squarely on oversight and input into client care as he or she transitions from student to practitioner, however the other elements will still also need to be attended to within supervision as the graduate moves towards autonomous practice and the removal of the condition. Alternately, those occupational therapists with vast amounts of clinical experience or in management and educative roles may instead have their focal length more on professional accountability issues related to organisational, national, and global perspectives in relation to the practice of occupational therapy and less so on input into client care. Whichever the greater "focus sphere", all elements must however be attended to as part of the supervisory scope.

Metaphorically, all of the spheres in Figure 3 would be captured during supervision, however the size of any one sphere may vary, depending on factors such as the practitioner's role, level of experience, whether they have a CSP, and whether it is time to focus on and review their CCFR plans, alongside the nature and extent of the issues that may form the content of the supervision session. Adopting this perspective on supervision would perhaps better portray the dynamic interaction of the elements of supervision to include all functions of supervision (clinical, professional, performance and accountability) and thus clearly address professional accountability in relation to regulatory requirements. Kaupapa Māori and cultural supervision may also be captured within this scope/span of supervision.

CCFR Supervision

The CCFR cycle is an excellent example of a tool for self-directed learning and self-supervision by its reflective nature; being both facilitative and evaluative. However, whilst practitioners may take their CCFR to supervision, the role of the supervisor in enacting the task of evaluation as part of the process of supervision is absent given supervisor comments are not required for recertification or CCFR audit processes. Therefore, whilst supervisors may be facilitating practitioners' professional development there is no clear evidence that this is the case. It may be prudent for the Board to revisit this aspect of the CCFR and mandate supervisor comments. It may also be prudent for the Board to revise its document on supervision to better clarify the meaning, purpose, and scope of supervision and to clearly identify the accountabilities of the supervisor, supervisee, and the Board in relation to supervision, given supervision under the HPCAA (2003) is a three-way partnership.

CSP Supervision

The placement of a CSP on a practitioner signals that there is a different supervisory expectation by the Board; namely evaluative in nature. The power balance in this supervisory relationship is skewed towards the supervisor, who must have their focal length, as per the meaning of supervision in the HPCAA (2003), on monitoring, evaluating, and reporting on the supervisee's performance and competence to the Board. Therefore, in this relationship the supervisor has 'power over' the supervisee; this is at odds with the relational nature of supervision (Hawkins & Shohet, 2007; Hewson, 2006). Because of the strong emphasis on evaluative supervision, the authors' believe that CSP

supervision needs the supervisor to possess a certain level of skill, as well as the ability to manage high transparency for supervisory accountability. The accountability for the quality of CSP supervision therefore primarily sits on the supervisor's shoulders. The authors believe this is inappropriate. It would be prudent for the Board to take greater accountability in this aspect of supervision and to use additional methods of evaluation for monitoring and reporting on practitioner performance and competence. Moreover, a clear means for transparency and agreement between the Board and the CSP supervisor is required, and must include issues of disclosure and transparent lines of communication between all three parties: Board-practitioner/supervisee-supervisor, in particular for a Board-imposed CSP.

Cultural Supervision

Māori practitioners who are occupational therapists need to be supported in their work and environment through supervision. To this end, Māori cultural supervision requires a kaupapa Māori model to support practice with access to supervisors who are Māori. Cultural supervision should also be included in any professional supervision. Both are context and content for supervision. Cultural supervision and kaupapa Māori is not explicit within Board writings on supervision and it would be prudent that this is addressed in line with partnership with Māori and the Board's obligations under Te Tiriti o Waitangi.

Summary of Barriers and Solutions

Barriers	Some Possible Solutions
Definition of supervision	• Adopt the definition for 'professional supervision' to describe and define supervision in all Board communications • Describe supervision as being both facilitative and evaluative in accordance with the literature. • Clearly highlight that one of the elements of professional supervision includes professional accountability, which under the HPCAA (2003), forms the evaluative task of supervision.
Terminology and types of supervision	• Use the term 'professional supervision' to describe supervision in all Board communications. • Practitioners receive professional supervision; this encompasses CCFR supervision and standard CSP supervision (e.g. new graduate CSP). • Define the Board's expectations of supervision including a base level of supervisory quality and some recommended frequencies for supervision for the profession. • For a Board-imposed CSP resulting from a competence review, use the term 'Board-imposed CSP Supervisor' to identify those occupational therapists who are specifically contracted for this targeted purpose.
Supervision for a standard CSP	• As above, and • Clarify the mandatory expectations for this type of supervision in a separate document, including clearly outlining the supervisor's regulatory role and the purpose and function of this supervision.
Supervision for a Board-imposed CSP resulting from competence review	• For a Board-imposed CSP resulting from a competence review specifically use the term 'CSP Supervisor' to identify those occupational therapists who are specifically contracted for this purpose.

	- Consider implementing other overt evaluative monitoring processes and activities for monitoring the CSP such as peer review, practice audit, written reflection, and article reviews, for which the Board would be accountable, for instance via the Professional Advisor, and which the CSP supervisor would not be responsible for implementing. This would provide a more robust and transparent system for monitoring, evaluation, and reporting, and offer the opportunity for triangulation of the evaluation sources. - Ensure that there is a clear written contract negotiated between the Board and the CSP supervisor as to the role, purpose, and function of such supervision, and that the practitioner has been informed and consulted regarding this contract. - The Board should take accountability for informing the supervisor of the issues, with the practitioner's consent.
CCFR supervisor comments	- Add a declaration to the CCFR by the supervisor that the practitioner is actively engaged in formal, regular supervision and/or - Add to the third party declaration attesting that the practitioner is engaged in formal, regular supervision and/or - Consider making supervisor comments mandatory for the CCFR, and/or - Include supervision as a separate competence area with performance criteria related to the elements of supervision.
Distinguishing between the supervisor role and that of the Third Party role	- Make the distinction between the supervisor role and the Third Party role absolutely clear in all Board information. - Further educate the profession as to the regulatory expectations of the Third Party role.
Informing the profession	- Regular communication with the profession is advised to ensure occupational therapists are well informed about their regulatory accountabilities. - More frequent use of communication system such as Board emails, NZAOT *OT Insight,* road shows or conference updates, and regular Board notice boards. This should continue and be sufficiently frequent as to raise practitioner awareness to a level higher than it currently is.

Recommendations

All registered occupational therapists with an APC should actively engage in supervision; the same underlying *principles* (see below Supervision Framework) of supervision practice should apply for:
- Professional supervision,
- Practitioners using the CCFR to evidence engagement in continuing competence,
- Practitioners with a standard condition on their scope of practice, and
- Practitioners with Board-imposed conditions on scope of practice resulting from a competence review.

To the Board:

1. Draw on the works on supervision by Te Pou o Te Whakaaro Nui which provides the Board with a robust set of guidelines to inform its future thinking and decisions on supervision for the occupational therapy profession.

2. Use the term 'professional supervision' in its publications – Code of Ethics, CCFR and any related literature, the words "or take the form of peer review" should be removed in any review of the Code of Ethics.
   Supervision is a

   > *"Structured intentional relationship within which a practitioner reflects critically on her/his work, and receives feedback and guidance from a supervisor, in order to deliver the best possible service to consumers. Professional supervision may incorporate any aspect of a professional role e.g., clinical, managerial, or cultural, and be one to one, one to group* [or take the form of peer review]*."*

   This is aligned with Ministry of Health's (2006) definition of professional supervision:

   > *"A formal process that provides professional support to enable practitioners to develop their knowledge and competence, be responsible for their own practice, and promote service users' health, outcomes and safety"* (p.22).

   and the literature on supervision.

3. See supervision for what it is, primarily a supportive professional development activity; promoting reflective practice whilst attending to three elements:
   a. input into client care,
   b. professional development and support, and
   c. professional accountability.
   This is in alignment with the processes and underlying premise of the CCFR.

4. Include cultural supervision and kaupapa Māori supervision in Board documents.

5. Adopt the supervisory components outlined in Figures 1., 2. and 3. of this report which includes the tasks, goal, elements, and scope of supervision as the basis for the Board developing its supervision framework and policy.

6. Review and revise the 2006 document: Supervision for Occupational Therapists in the context of the Health Practitioners Competence Assurance Act 2003 (HPCAA). Include in this document what it means to supervise and be supervised – another handbook perhaps and include in the document an explanation of reflective practice?

7. Clarify for the profession that professional supervision includes the CCFR and can be carried out with the same supervisor. Standard CSP supervision may also be included in this supervisory relationship.

8. Write a separate document for supervision of persons with the standard CSPs and have this document clearly spell out the regulatory-body accountability of all parties including role, functions, and purpose.

9. The Board to take more active accountability for the monitoring of performance for the Board-imposed CSP resulting from a competence review.
   a. Discontinue placing the evaluative onus on the process of supervision and the supervisor.

b. Supervisor training, skills, and accountabilities for providing this type of supervision should be reviewed given that it is clearly evaluative-focused "supervision".

c. Implement a CSP Supervisor contract between the Board and the supervisor.

d. The supervisor and the supervisee will implement the supervision agreement/contract, a copy to be held by the Board, alongside the mandatory reporting and logs of supervision.

e. Identify and add in other evaluation processes to monitor, evaluate and report on the "performance of a health practitioner by a professional peer" (HPCAA, 2003, Part 5(1)) such as peer review, practice audit, article review, and/or reflective journal.

f. Consult with other regulatory Boards, such as the Physiotherapy Board in relation to this recommendation.

10. If feasible, recommend a minimum level of supervisory training and/or expertise for the profession to provide clarity as to what is required to effect beneficial supervision, and/or negotiate with NZAOT to refer practitioners via hyperlink to their supervision resources which are currently only available to NZAOT members. This would minimise the need for duplication.

11. Conduct research into the outcomes of supervision for the occupational therapy profession.

For establishing a Supervision Framework:

The following guiding principles, modified from the Auckland District Health Board Supervision Policy (ADHB, 2010), are suggested:

- Supervision will be appropriate to both individual and professional requirements.
- Supervision practices will be in accordance with occupational therapy standards, competencies for registration, and the code of ethics.
- Supervision will involve an open and transparent relationship between the supervisor and the supervisee; giving cognisance to the regulatory requirements under the HPCAA.
- There will be a commitment to Kaupapa Māori supervision.
- Cultural supervision for pacific and other groups is acknowledged.
- The content of supervision is confidential to the parties (supervisor and supervisees), except as required by Board reporting policy or by agreement.
- Supervisors and supervisees should not have other roles/relationships which may conflict with their supervision relationship.

The following components are recommended to be included in any Board supervision framework:

1. The term 'professional supervision' as the defining term for all Board-related supervision.
2. The inclusion of the definition of 'professional supervision' and 'supervisor' as defined in the Code of Ethics (excluding the reference to 'peer review').
3. A statement of the 'goal of formal supervision' being to develop and maintain practitioners' competent professional functioning and well-being while safe-guarding client care, as well as to evaluate and feedback via report on this as required by the Board.
4. The 'tasks' of supervision as being both facilitative and evaluative as stated in Figure 1. in this report.

5. The context for supervision, as depicted in Figure 2. of this report which also portrays the breadth of content for supervision which will be commensurate with the supervisee's role, experience, and work setting.
6. The 'scope of supervision' should always attend to 'three elements', as stated in Figure 3. of this report, and that any one element may be given greater emphasis at any point in the supervision process, depending on the content and focal point of supervision, and depending on the type of supervision required by the Board.
7. The minimum expectations of the supervisory role, including any base expectations for supervisory skills and training, or both.
8. Kaupapa Māori and cultural supervision is included in the framework.

In addition, this framework must clearly delineate and indicate expectations, accountability, and processes for the supervision for both a standard CSP and the Board-imposed CSP.

Concluding Remarks

This review finds that the Board currently requires four different types of supervision (Appendix 3.), with different purposes and functions which potentially has resulted in a lack of clarity around supervision for the profession.

Specifically,
a) CCFR supervision has its focal length on the CCFR,
b) Professional supervision has its focal length on the broader aspects of 'self and practice', and
c) Supervision of a standard CSP places emphasis on monitoring, evaluation, and reporting on competence for a finite period and frequency of supervision with supervisor who is a registered occupational therapist with no CSP and with a current APC.
d) The fourth type places much more serious emphasis on monitoring, evaluation, and reporting on competence for the practitioner who is under review by the Board with the same supervisor requisites as for standard CSP.

We suggest that professional supervision should not be the only process for the fourth type of supervision (Board-imposed CSP); other additional evaluative processes need to be implemented to best monitor, evaluate, and report the performance of these practitioners.

The current terminology used by the Board is at odds with the literature and therefore it would be prudent to change this. Issues (actual or potential) that negatively impact on the various forms of supervision required by the Board primarily include confusion within the profession about the types of supervision and the regulatory expectations of these types of supervision, and the role of the supervisor in relation to the types. This has been hindered by how the Board frames up supervision with the discord and disconnect between what is stated in the Code of Ethics and what the HPCAA (2003) states as the meaning of supervision. Kaupapa Māori and cultural supervision is absent in Board documents.

Some solutions to address the identified barriers are proffered in this report for Board consideration, with recommendations made to address terminology, definitions, and better clarity of supervisor and Board accountability as it relates to supervision under the HPCAA (2003). Principles and some of the components that would form the foundations for the development of a robust supervision framework are also identified in this report.

Further work is required to establish a clear and robust supervision framework. Research into the quality and outcomes of supervision is required.

The project team thanks the Board for the opportunity to review supervision and contribute towards the clarification and implementation of best practice supervision for the profession in line with requirements of the Health Practitioners Competence Assurance Act (2003) and in the interest of the profession safely serving the public.

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Appendix 1.

Project Team
All members of the project team signed a confidentiality agreement.

Project leader	*Project team members*
Cynthia Growden	Carolyn Simmons Carlsson
	Jackie Herkt
	Trish Egan

Project Focus
1. Identifying the requirements of each type of supervision.

2. Consideration of whether the terminology currently used is appropriate.

3. Identified issues that do or may, impact negatively on the various forms of supervision required by the Board, and formulate solutions to address barriers.

Appendix 2.

Questions for Practitioners: Board website/email

Review of Supervision

The Occupational Therapy Board of New Zealand (OBTNZ) is reviewing its supervision requirements. A small project group has been established to advise the OTBNZ. As part of this work the OTBNZ Supervision Project Group would like information on how occupational therapists define supervision.

At present the OTBNZ recognises three types of supervision:

- Professional supervision as defined on page 7 of the Code of Ethics i.e.:
     "a structured intentional relationship within which a practitioner reflects critically on her/his work, and receive feedback and guidance form a supervisor, in order to deliver the best possible service to consumers. Professional supervision may incorporate any aspect of professional role e.g., clinical, managerial, or cultural, and be one to one, one to group, or take the form of peer review."
- Supervision for the Continuing Competency Framework for Recertification (CCFR)
- Supervision for a condition on scope of practice, e.g. 'new graduate' or 'return to practice'.

We invite you to answer the following questions:

1/. How would you define each of these types of supervision?
   - a/. Professional supervision
   - b/. Supervision for the CCFR
   - c/. Supervision for a condition on scope of practice

2/. What do you see as the purpose of supervision under each of these categories?
   - a/. Professional supervision
   - b/. Supervision for the CCFR
   - c/. Supervision for a condition on scope of practice

3/. Have you had any difficulty finding a supervisor?
Please select one: Yes   No
If reply is 'yes', please indicate the nature of this difficulty?

Please reply to:
enquiries@otboard.org.nz

Thank you for your assistance.

Appendix 3.

Types of Supervision and their Purposes

The below information is collated from several of the references used in this review.

Types of supervision	Purpose	Requirements
Supervision	An essentially interpersonal interaction between two people with the general goal that one person (supervisor), meets with another (supervisee) in an effort to make the latter more effective in helping people. This interaction may occur within a one-to-one partnership, a supervisor and a group of supervisee, a team, and/or within the context of a peer group: • Group supervision happens within a group with a supervisor present • Peer supervision occurs between peers who reciprocally supervise each other • Team supervision is supervision of a whole team working together	• A supervisor who has supervisory skills (preferably gained via attendance at a supervision skills course) • The supervisee/s • Supervision Agreement which outlines the supervisory partnership / relationship • Supervision records and log of attendance
Clinical Supervision	To enable the supervisee to critically reflect, assess attitudes, skills and knowledge relating to *clinical practice* and provides opportunities for the supervisee to develop clinical and professionally to meet the requirements of legislative and relevant professional standards. Here, the focus is on clinical issues: • facilitates clinical problem solving processes • encourages clinical reasoning and evidence-based practice to ensure safe practice and quality care to clients	• A supervisor who has clinical expertise (and potentially supervisory skills) • Supervision Agreement which outlines the supervisory partnership / relationship • Supervision records • Supervisee/s
Professional Supervision	A protected time for critical in-depth reflection on practice which enables the supervisee to achieve, sustain and develop a high quality of practice. This type of supervision may be aligned to the practitioner's performance and professional development plan. • a means of focused support and development • can include issues of difference, culture and gender • provides the opportunity to review work in the context of the organisation, its values, systems, policies, and procedures	• A supervisor who has supervisory skills (preferably gained via attendance at a supervision skills course) • Supervision Agreement which outlines the supervisory partnership / relationship • Supervision records • Supervisee/s
Kaupapa Māori Supervision	Māori for Māori supervision May occur at the same time as a supervisee's professional supervision, but provided by a Maori practitioner, Kaumatua or Kuia	• A supervisor (Kaiwhakahaere Ahurea) who has supervisory skills (preferably gained via attendance at a supervision skills course) • Supervision Agreement which

	Supervisor is one who understands Māori dimensions of wellbeing.	• outlines the supervisory partnership / relationship
		• Supervision records
		• Supervisee/s (tangata whenua)
Cultural supervision	Strengthens cultural competence across the health workforce; builds the worker's knowledge of a specific culture's values and beliefs; attends to ensuring culturally safe practice and culturally appropriate behaviours. Supervisor may be from a particular culture.	• A supervisor • Supervision Agreement which outlines the supervisory partnership / relationship • Supervision records • Supervisee/s

Board-required Supervision

Type	Reason	Participants
Professional* Supervision mandated by The Code of Ethics *Professional supervision:* a structured intentional relationship within which a practitioner reflects critically on her/his work, and receives feedback and guidance from a supervisor, in order to deliver the best possible service to consumers. Professional supervision may incorporate any aspect of professional role e.g., clinical, managerial, or cultural, and be one to one, one to group, or take the form of peer review. (Borad definition, Code of Ethics, p. 7).	The Code of Ethics presents standards of conduct expected of all occupational therapists registered to practise in New Zealand and states that practitioners should be engaged in *professional supervision:* <u>Section B Code 3:</u> 3.7 ensure formal supervision is provided for other occupational therapy personnel (including registered occupational therapists, occupational therapy assistants/instructors and students) for whom she or he is responsible. 3.8 receive effective professional supervision* relevant to the work setting.	• A supervisor: a person who has sufficient self-awareness, inter-personal competence, and knowledge of processes relevant to the area of practice of the supervisee to facilitate that person's professional development(p. 7) • The practitioner (supervisee) • Supervision log (Board template) • Supervisor can comment on the practitioners CCFR however this is not mandated
CCFR Supervision	A process whereby the identified supervisor comments on the supervisee's CCFR plans. Frequency of commenting is determined by the supervisor. Supervisor comments are not required for the recertification Third Party attestation process nor for the CCFR auditing purposes. Supervisor is notified via the Board website.	• A supervisor • The practitioner (supervisee) • Practitioner's CCFR Plans
Supervision for a Condition on Scope of Practice	Board prescribes frequency and timeframe that supervision is required. The Board imposes standard conditions on the scope of practice of some practitioners. The Board requires that these practitioners receive supervision from a registered occupational therapist with no CSP and a current APC. These practitioners are notified of the conditions on their scope of practice and of the supervision requirements.	• A supervisor who is a registered occupational therapist with a current APC; selected by the supervisee • The practitioner (supervisee) • Supervision log (Board template)

	Conditions include: • Graduate in first year of practice (12 months weekly supervision) • Overseas trained (6 months fortnightly supervision) • Return to practice (6 months fortnightly supervision)	• Supervisor report at completion of the stated supervision period (Board template)
Supervision for a Condition on Scope of Practice imposed as a result of a disciplinary or competence/conduct process	There are no known guidelines for this other than those for above CSP supervision and as known to the Board and Professional Advisor. The Board stipulates the frequency and duration of supervision as well as the frequency of reporting. For competence review Board-imposed CSP, Board vets supervisor.	• A supervisor who has been approved by the Board to supervise the practitioner with a CSP • The practitioner (supervisee) • Supervision log (Board template) • Supervisor report at completion of the stated supervision period (Board template)

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