PRACTICE NOTES

Interdisciplinary supervisor development in a community health service

Ellice Rains

Ellice Rains, Social Work Professional Leader and Supervision Development Leader, Home and Older Adults Service, Waitemata District Health Board.

Abstract

The Health Practitioners Competence Assurance Act 2003 defines Supervision as the 'means of monitoring of, and reporting on, the performance of a health practitioner by a professional peer'.

This changing climate within which health practitioners now work has brought about a renewed interest in the role that clinical supervision plays in developing practitioners who are competent and fit to practice in their chosen profession. This article presents an account of the ongoing learning and development of the skills of supervision by way of combined nursing and allied health supervisor groups in a community health service. The background to the creation of these groups will be described along with their development over a two year period. Some of the difficulties encountered in implementing this initiative will also be discussed. Results of an evaluation of their effectiveness will be presented, and suggestions for future initiatives will be provided.

Background

Although the HPCA Act 2003 defines supervision in very managerial terms, it does reflect the political context of health professionals' work in the 21st century and the need for robust processes that will support clinicians in this environment. Clinical supervision and reflection on practice are key processes identified in Waitemata District Health Board's Home and Older Adults Service for the development of staff, and the intention of this article is to share with the wider community how a service initiative supported by senior management has enabled a culture of supervision to become embedded in practice.

Supervision has been in place in the Home and Older Adults Service (HOAS) for a number of years, yet structures for firmly establishing supervision into practice and the ongoing development of clinicians as supervisees and supervisors had not been approached in a formal way prior to 2005. Managers and clinical leaders from different professional groups had implemented supervision around similar principles, but there was no consistent approach to the practice of supervision. O'Donoghue (2002: 4) points out that social work and nursing already have an established supervision literature and culture and that the establishment of supervision in allied health is likely to draw on the literature and training of those professions where supervision is already embedded in the professional culture.

In HOAS, social work and nursing supervision theory and models have contributed to the development of a strong culture of supervision, embracing allied health and their district nursing colleagues.

Learning and development culture

Hawkins and Shohet (2000) emphasise the importance of the culture of an organisation and whether it supports the learning and development of its staff, from new graduates through to senior managers. Although an organisation's attitude to supervision will be reflected in its policy (or absence of policy) the real test lies in how a policy is enacted. Important questions to assess this may be: is there protected physical space for supervision to occur; which staff members become supervisors; how they are selected; and what happens to supervision time when there are other pressures?

A key factor to the success of a culture of supervision is when the goals of the individual practitioners and their managers are aligned with those of the organisation. This requires policy and strategies to support policy implementation, to be in place to ensure success.

Clinical Supervision Strategy

Since the 2004 HOAS Clinical Supervision Strategy there has been a more focused approach to the implementation of clinical supervision. The Strategy was developed by a working party consisting of a manager, a nursing professional leader, physiotherapy professional leader and social work professional leader. The intention behind the Clinical Supervision Strategy was to build a culture where employees want to be supervised and supervisors want to supervise. The purpose of the strategy was also to provide a framework for embedding clinical supervision into the practice of nursing and allied health professionals in HOAS. This was part of a wider service strategy – Client Centred Care: Changing the power relations between consumers and the health care system – instigated by our Service Manager of the time. In this strategy the relationship between health professionals and their clients was identified as a 'mode' for development, with the intention of building high levels of interpersonal competence in all HOAS clinicians. The Client Centred Care Strategy identified the need to create 'safe learning environments for staff. Learning strategies are likely to be based on adult learning theory and critical reflection on practice'. This strategy recognised the role of clinical supervision as one of the key processes whereby clinical staff can learn and develop through reflection on practice.

Key concepts underpinning the Clinical Supervision Strategy were consistency of supervision training and practice across the service and the efficient and effective use of training as a resource. The Strategy stated that all supervisors initially receive minimum two day training with an external trainer and are then required to participate in an eight-weekly supervisor development group, which would be multidisciplinary in composition.

The Clinical Supervision Strategy defined the goals of our Service with regard to supervision. Although we had a policy on clinical supervision, the Strategy set out the 'how to' for embedding supervision into the culture of Home and Older Adults Service. Two key processes were identified to bring this about. The first was the training of all new staff in how to be supervisees and the second was to provide an opportunity for supervisors to attend eight-weekly groups for their ongoing learning and development as supervisors.

Hawkins and Shohet (2000) identify five organisational cultures which can impact on the effective development of supervision – namely the 'Hunt the personal pathology; strive for bureaucratic efficiency; watch your back; driven by crisis and the addiction organisation (p.170). They maintain that in order for health professionals to gain ongoing learning from supervision, organisations need to create 'learning pathways' for this to develop. Such a pathway has been created in Home and Older Adults through the implementation of Supervisor Development Groups.

Like Hawkins and Shohet, Beddoe (2001) emphasises the role of organisational culture in influencing the effectiveness of supervision as a tool in a learning and development framework. Beddoe identifies eight critical issues to be explored when thinking about the training of supervisors. These are:

> …the development of specific skills and knowledge for supervision; The management of authority and power; Recognizing cultural frameworks – decolonizing supervision; Ethical practice in complex contexts; Emotional awareness; The integration of theory and practice-teaching in supervision; The management of risk; Self-care and intellectual refreshment' (Beddoe, 2001: 68).

It is these issues that the Supervisor Development Groups are designed to address.

Supervision development hroups

Prior to the Supervision Development strategy there was an across-site Allied Health supervision development group which had been running successfully on a six-weekly basis for over two years. There was also a locality based District Nursing supervision development group which had been running for just over one year. It was the benefits supervisors were experiencing from sharing common challenges that led to the growth of these groups and gave impetus to the growth of supervision in HOAS.

In the Strategy, all District Nurses (and in the early stages Inpatient Nurses) were to be included into a group development process. The purpose of these groups was to facilitate the development of good quality supervision in HOAS; support a culture of self-reflection; resolve issues encountered in the practice of supervision and to support wider service strategies.

The principle underlying the formation of these interdiscplinary groups was the recognition that being a supervisor requires ongoing support and development. Many of the issues encountered by supervisors were common across disciplines and particular to supervision as a process. Initially many supervisors were unable to set contracts with their supervisees. Some supervisors struggled to stay focused during sessions and were unable to set agendas or a sense of structure around their sessions. Others found difficulty with exploring emotional aspects of the work with their supervisees. A few of the supervisors simply did not understand the process of supervision and how it could be helpful to either supervisor or supervisee and felt they were frequently letting sessions fall into a 'chat'. Many found supervisees were bringing issues related to their colleagues and felt drawn into collusion around workplace dynamics. Others felt overwhelmed by their supervisee's need to 'dump' and found they tended to fall into 'fix-it' mode. The reluctance of supervisees to be supervised at all was another common issue with supervisors who were finding it difficult to engage them in a meaningful process.

The groups provide opportunities to discuss, reflect and practise supervision skills in an environment of support. They are facilitated by the Supervision Development Leader, whose role is to maximise the learning of supervision skills in each group.

Initially eight groups of eight supervisors were formed and timetabled to accommodate inpatient nurses, who could only attend towards shift changeover which necessitated 2-4pm session timing. However, inpatient nurses withdrew from this group process shortly after its inception, for a variety of reasons explored in much of the literature on clinical supervision in nursing. The remaining six multidisciplinary groups consist of allied health, needs assessment and district nursing supervisors. This structure facilitates cross-disciplinary networking, learning and communication. The Supervisor Development Groups are not peer group supervision for clinical practice, but for the practice of the skills of supervision itself. Each group meets eight weekly for two hours, which is additional to the individual supervision each supervisor engages in for their clinical practice.

Group process

Each group was established in accordance with a supervision contracting process, with attention paid to the establishment of ground rules, and clarification of expectations, responsibilities, conflict, evaluation and review.

Zorga (2002) sees supervision as one of the processes of lifelong learning and development in adulthood and identifies two essential elements of supervision, namely the experiential learning process and the role of reflection in it (p. 266). The work in HOAS supervision development utilises this concept and is supported by the adoption of Davys (2001) Action Reflection Model of Supervision which she based on Kolb's Experiential Learning Cycle incorporating 'the elements of experience, reflection, conceptualisation and active experimentation'(p. 90).

Davys' Model of Action-Reflection

Davys' model is also cyclic and broken into four phases: Event, Exploration, Experimentation and Evaluation.

After an agenda has been established and prioritised the Event phase is where discussion centres on what the supervisee wishes to take away from the session, in order words a specific goal is set for the process. Key to this initial phase is to understand why the issue has been presented in supervision. The second phase is one of Exploration and it is divided into two parts, impact and reflection... Of importance in this phase is the need for the supervisee to find the solution his/herself. This involves an examination of how the problem is impacting emotionally on the supervisee, followed by an exploration of practice theory, professional standards and service policies and protocols. This stage of the cycle moves the supervisee from the personal to the political and professional view of the issue and enables them to establish a plan of action. In the Experimentation stage this plan is tested and the supervisee is able to clarify what actions are required to achieve the desired outcome. The final phase of Evaluation explores whether or not the issue has been adequately dealt with by the process.

The group process mirrors Davys' Action-Reflection cycle. The group would spend the first 10 minutes connecting with each other, readying themselves for the session and letting go of other distractions. A review of previous session outcomes would also take place at this stage to see how ideas had been transferred into practice. Next an agenda for the session would be established with members bringing issues for discussion and then an order of priority would be set. Often issues would overlap and working with one often helps to resolve another supervisor's issue.

When the agenda has been prioritised, each item is worked through as if it was a supervision session, with discussion, facilitated role play, self reflection, feedback, and action plans. Supervisors not presenting the issue or actively engaged in the 'role play' practice as the supervisors, with the facilitator guiding the process to follow Davys' model. This is a two-tiered approach where practice with the model is incorporated into resolving the difficulties supervisors are experiencing in their role as supervisors.

Themes emerging from the groups

Several common themes have been presented by supervisors in the groups. Common to district nursing is the lack of protected time for supervision, which often takes a back seat in the day-to-day pressure of workload. Lack of trust is frequently identified as an issue, particularly within district nursing, and the maintenance of confidentiality. Concern about being 'Piggy in the middle' between line managers and supervisees also shows its unwelcome face with regularity. The shift from a solution-focused approach in clinical practice to a process of reflection has been difficult for more physically orientated disciplines such as physiotherapy and district nursing. Language skills required for supervision have also been seen as a challenge for many of the nursing and other allied health supervisors who often comment how easy it is for social workers to know how to phrase questions as communication is their 'job'.

Identified benefits of interdisciplinary development groups

The development groups can be seen in terms of an educational development model where supervisors from several health disciplines enter into a learning process with other supervisors. Results from a study by Pullon and Fry (2005) support those found in previous studies that levels of confidence and personal development are enhanced by interprofessional learning as participants gain a better understanding of their own role and that of their colleagues.

It has been widely acknowledged by supervisors in HOAS how much they gain from sharing their experiences with other disciplines. District nursing in particular has felt isolated in the struggle to 'supervise', believing this to be contrary to everyday nursing practice and find support in hearing similar stories from their allied health colleagues. As Davys and Beddoe (2007) found in their recent qualitative study on interprofessional supervision training, the professional differences between supervisors actually enhanced learning, an observation frequently voiced by the supervisors in Home and Older Adults Service. Davys and Beddoe also support the idea that learning to become a supervisor is a generic process. What makes this successful is having a model for supervision that is easy to implement across disciplines. Davys has provided us with such a model as its structure is clear and the process is able to be followed without difficulty by supervisors. Having training in use of this model prior

to engaging in supervision practice has also ensured that supervisors feel ready to take on their new roles. As Home and Older Adults Service has adopted this Reflective Learning in Supervision Model, the primary function of the facilitated development groups is to build greater confidence and expertise in the working with the model.

Through multidisciplinary group work, supervision is becoming recognised as a skill or discipline in itself which can be learned regardless of professional background. District nurses once resistant to the notion of 'challenge' have recognised their potential for growth and development.

One key to the success of the supervision development groups is the fact that no member is in a supervisory relationship with another member, thereby avoiding the pitfalls of discipline-specific hierarchical relationships.

Evaluation

Some of the difficulties experienced in facilitating the groups were that supervisors were often tired at that time of day and frequently came unprepared. Many simply did not know what they could bring to the sessions. In the context of a developmental approach this was not surprising as group members initially may have been unaware of their limitations as supervisors. As their learning increased through the group process many expressed their concern at how little they knew when they first began to supervise. It was important to establish early on that these groups were not 'about' supervisees, but rather an opportunity for supervisors to learn to develop the skills to work effectively as supervisors – the focus was on them. Some found this difficult and challenging.

As Zorga so aptly points out:

> The key characteristic distinguishing those who learn and grow from the rest to whom the same does not apply, is self-criticism. Self-criticism is to be understood as a constructive and evaluational stance of the individual, who regularly takes time to reflect on what he/she is doing and permanently educates him/herself professionally. In short this is a professional or a supervisor who actively and aggressively works on improving his/her professional skills and understanding. Only experiences combined with such self-criticism can bring about development (Zorga 2002: 270).

The key to the ongoing success of implementing clinical supervision in this Community Health Service is for the supervisors in groups to continue to develop their reflective practice skills (and self-criticism) within an experiential learning framework. This opportunity for practice in a multidisciplinary environment enhances inter-professional team work and communication as well as providing a model of consistent supervision practice throughout the service.

The success of the interprofessional development group process in addressing Beddoe's eight critical issues has been refreshing. Urdang (1999) cited in Beddoe (p. 69) found that supervising others increased supervisors' self-awareness of their own practice. The group process has provided an environment where supervisors can practise together the skills needed to enhance their confidence in supervising their supervisees. As one district nurse announced in her group one day, 'I wish we had learned all this years ago, it would have

made such a difference to everything'. Previously she had been resistant to both her role as a supervisor and the inherent authority of that role, as well as to the group process itself. As Beddoe states: 'As a supervisor becomes a more confident practitioner there will be a higher degree of personal, critical reflection in their learning' (Beddoe 2001: 75).

Evaluation of the Supervisor Development Groups was undertaken by distributing questionnaires to the 23 District Nursing and Allied Health supervisors. Seventeen responses were received by an independent project manager for purposes of collation and also to maintain the anonymity of respondent.

The results were rated in terms of strength of agreement to each question. No 'strongly disagree' answers were returned in the survey. The results show that the time of each meeting can be problematic and this may need to be addressed in future scheduling. The lower score on question 11 would fit with the developmental framework in so far as many supervisors are more aware of how much they need to learn and this awareness may bring about a lowering of confidence. The lower score on question 6 may be related to the score on question 11. The lower score on question 8 reflects the difficulty in establishing trust and rapport in a mixed discipline group with differing experiences and learning styles. This result provides opportunities for development in terms of the group process with regard to facilitation.

Figure 1. Table of results.

		Mean (n)	Strongly disagree % (n)	Disagree % (n)	Neutral % (n)	Agree % (n)	Strongly agree % (n)
Q1	Time of meeting is suitable	3.7 (17)	0% (0)	24% (4)	0% (0)	59% (10)	18% (3)
Q2	Atmosphere is conducive to learning	4.2 (17)	0% (0)	0% (0)	6% (1)	71% (12)	24% (4)
Q3	Assists you to resolve issues with supervisory practice	3.9 (17)	0% (0)	6% (1)	6% (1)	88% (15)	0% (0)
Q4	Supports you to manage challenging supervisees	4.1 (17)	0% (0)	12% (2)	0% (0)	71% (12)	19% (3)
Q5	Enhances self-reflection on your supervisory practice	4.2 (17)	0% (0)	6% (1)	12% (2)	65% (11)	19% (3)
Q6	Supports you to resolve issues with supervisees	4.0 (16)	0% (0)	12% (2)	19% (3)	56% (9)	12% (2)
Q7	You feel supported in the supervisors' group	4.5 (17)	0% (0)	12% (2)	6% (1)	35% (6)	47% (8)
Q8	You are able to be honest and open in group	4.2 (17)	0% (0)	12% (2)	12% (2)	65% (11)	12% (2)
Q9	Your thinking is constructively challenged	4.5 (17)	0% (0)	6% (1)	6% (1)	71% (12)	19% (3)
Q10	Feedback is helpful to your development as supervisor	4.5 (17)	0% (0)	6% (1)	6% (1)	76% (13)	12% (2)
Q11	Your confidence as a supervisor has improved	4.3 (17)	0% (0)	6% (1)	24% (4)	65% (11)	6% (1)

Challenges to ongoing development

It has been recognised that supervisees learn to be good supervisors by receiving good supervision. When the supervision resource becomes widely spread, skills become diluted and there are fewer opportunities for supervisors to learn through regular practice of skills.

There is a need to dedicate space and time for supervision, and its ongoing priority in terms of professional, personal and service development. Supervisor development has been summed up by one nursing supervisor recently who stated at the end of a session:

> I always feel that I don't have time to come to the group. I think what on earth are we going to talk about for two hours – but then the time always goes so quickly and at the end I feel as though I have been given a gift.

Future initiatives

Cross disciplinary clinical supervision, while controversial, has already been requested by some district nurses, who in particular see this as a way to address historical hierarchical models of nursing 'supervision'. It seems this may be a logical step forward, particularly if supervision is starting to be seen as a 'generic' skill.

The role of supervision in supporting an organisational culture to move away from those identified by Hawkins and Shohet would present an interesting area for future research, particularly as a process to support change management and health professionals in the increasingly pressurised environment of health care work in this century.

The Supervisor Development Groups implemented in Home and Older Adults Service has been an area of practice development in relation to clinical supervision skills training. They provide supervisors from District Nursing and Allied Health with an ongoing opportunity for learning and development by way of group process and form the 'learning pathway' identified in the HOAS Clinical Supervision Strategy.

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