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Junior Occupational Therapy Clinical Supervisors in an Acute Hospital: Experiences, Challenges, and Recommendations

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Abstract

Purpose: Clinical education is important to professional education and various initiatives such as adequate support from senior staff, workshops to upgrade skills or workload reduction, may help junior staff to feel competent in supervising students. This phenomenological study aimed to understand the experiences of junior occupational therapy educators with two to three years' experience as clinical supervisors to better understand their needs, and investigate if any supports were useful for them to become better clinical supervisors.

Method: Individual, semistructured interviews were conducted with five junior occupational therapists who were involved in supervising students in 2015 and 2016 in an acute hospital. Participants answered questions regarding their experiences as a clinical supervisor which were audio-recorded and transcribed verbatim. Data analysis was conducted using the method of phenomenological data analysis described by Giorgi.

Results: Four themes emerged from the data, namely 'juggling and balancing facets of work'; 'holding on to anchors'; 'developing students to their best'; and 'becoming a better therapist'. These themes described the clinical supervisors' sense of responsibility when supervising students, how they depended on placement support structures; tensions between giving students room to try out skills and having to assess their competence; how their knowledge was refreshed and how they were challenged to be better therapists as they learnt to accommodate students.

Discussion: The junior clinical supervisors faced challenges in their roles, and acknowledged that at times they did not know how best to help the students. They appreciated colleagues helping with their clinical load, having a mentor that they could turn to for advice, and various supports and training to guide them. Understanding their perspectives provides insight to support the development and refinement of structures, strategies and resources for future supervisors.

Keywords: Clinical practice education; Junior clinical supervisor; Occupational therapy; Phenomenology; Supervision

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1. Introduction

Clinical education plays an important role in professional education. It is considered "an essential bridge" between academic education and occupational therapy practice, helping students achieve competencies to meet the occupational needs of individuals, groups and society.[1] The supervision interaction between clinical educators and students in clinical education has been described as one of the strongest elements in developing students' expertise, and in forming professional identity.[2] In medicine for example, as defined by Kilminster et al.[3] supervision is 'the provision of monitoring, guidance and feedback on matters of personal, professional and educational development in the context of the doctor's care of patients. This would include the ability to anticipate a doctor's strengths and weaknesses in particular clinical situations in order to maximize patient safety'. Supervision also includes 'ensuring the safety of the trainee and patient in the course of clinical care; giving feedback on performance, both informally and through appraisal; initial training and continuing education planning; monitoring progress; ensuring provision of careers advice; ensuring an appropriate level and amount of clinical duties'.[4]

Turnock et al.[5] identified that for effective practice learning, practice educators require not only the knowledge and skills to facilitate learning and integrate theory and practice, but also insight to the curriculum, and the authority and ability to facilitate the record of learning. Other literature also highlighted that effective supervision of trainees involves skills that are different from the more general competencies expected of a teacher or trainer.[6,7] Hence, practitioners who support, supervise and assess learners for entry to their respective professions need to be prepared and supported in their educational role as practice educators.[5]

In addition to the skills that clinical educators are required to have, the literature states that the success of any clinical placement depends heavily on how well the placement has been planned.[8] An Australian study by Rodger et al.[9] highlighted that key factors to a quality occupational therapy placement include university preparation and processes, a welcoming learning environment, detailed orientation and clear expectations, graded program of learning experiences, quality modelling and practice, consistent approach and expectations, quality feedback, open and honest relationships and supervisor experience and skills.

In some work contexts, an occupational therapist is considered to be a new graduate for two years of practice post-graduation, and feelings of clinical competence are recognised to continue to develop from six months to two years post-graduation.[10] Providing support to new graduates during this time allows them to develop both clinical and professional skills vital to support their transition from student to practising professional.[11] Research has also shown that junior staff, with adequate support such as from senior staff, workshops to upgrade skills, and workload reduction, may feel competent in supervising students.[12,13]

Clinical learning frameworks, such as that reported in a paper by Fitzgerald et al.[14] can also contribute to the professional development of new occupational therapy graduates by helping them to reflect on their performance, develop learning goals, and link them with existing learning supports, resources and opportunities that support their professional development. Other ways through which health professionals can develop their competence as faculty members include participation in formal workshops, seminars or courses; and informal teaching and learning such as in the contexts of mentorship, role modelling, learning from peers and students, and by observing and reflecting on practical experiences in the work place.[15]

In Singapore, students are required to complete both academic and clinical practice education as part of their occupational therapy education requirements.[16] Clinical education is commonly provided by clinical supervisors at various healthcare institutions for example, the Institute of Mental Health[17] and Tan Tock Seng Hospital[18]. In the literature a variety of terms are used to refer to persons involved in providing clinical supervision and training to students on placement, such as supervisor[4], practice educator[19], clinical instructor[20], clinical educator[21] and clinical teacher[22]. For the purpose of this paper, the term junior occupational therapy clinical supervisor, as used at the institutions at which the authors work, will be used to refer to occupational therapy clinical supervisors with between two and three years of clinical experience who had taken on the role of clinical supervisor to occupational therapy students.

Junior occupational therapists are often nominated by their clinical unit team leaders to take on the additional role of supervision based on their work experience and performance. However, they may not have clinical prior experience in supervising students and no local data is available about the experiences of clinical supervisors in their supervisory role. Generally supervisors have the opportunity to attend a workshop before each placement, and they are sent written documents in which they are introduced to the minimum standards for each placement. Prior to students' arrival, the occupational

therapy school also provides opportunities for questions pertaining to student placement to be addressed.

Currently no data is available on the structures and systems used, and whether support is sufficient for the junior occupational therapy clinical supervisors. With increasing numbers of students attending placement and more new staff providing supervision, it is crucial that the experiences of junior occupational therapy clinical supervisors are understood. Information from junior occupational therapy clinical supervisors is important to reveal their experiences of supervising students, as well as to understand any challenges faced, or coping strategies used to support their work. Phenomenology is 'a philosophy that is concerned with the question of how individuals make sense of the world around them and how in particular the philosopher should bracket out perceptions concerning his or her grasp of that world'.[23] The use of phenomenology is consistent with this study's purpose as the intent was to derive meaning from a human experience.[24]

2. Method

2.1. Participants

Criterion sampling was used in which all individuals who met the criteria were invited to participate in the study.[23] They were sent an email invitation, providing them with information and requesting for voluntary participation in the study. Junior occupational therapists with between two and three years of clinical experience who had taken on the role of clinical supervisors to occupational therapy students at the occupational therapy department in 2015 and 2016 were invited. The phenomenological method recommends recruiting at least three participants for sufficient variation and for a typical essence to be obtained.[25] Twelve people from the occupational therapy department satisfied the criteria and were invited to participate in the study. Five junior occupational therapy clinical supervisors volunteered. Informed consent was obtained from the participants prior to data collection through interviews.

2.2. Instruments

A semi-structured interview was designed based on the literature,[26] and questions that the researchers were interested in understanding from the participant that were consistent with the purposes of the study. The questions were used to provide a structure to the interview and were pertaining to their experiences as junior occupational therapy clinical supervisors, the difficulties they encountered as well as their views of support services received. Some of the questions asked are shown in Table 1.

Table 1
Sample questions in interview guide.

1. How do you prepare yourself for the student's arrival/ How does your department prepare for the students' arrival?(Probes: describe/ name any resources or courses related to supervision; contents of resources or courses that were helpful/ unhelpful.)
2. Please describe your experience of supervising occupational therapy students in (name of hospital).(Probes: how you supervise students; what takes place; positive and negative experiences you have had.)
3. Were any challenges or difficulties encountered during your supervision?(Probes: what you did; would do differently.)
4. What recommendations do you have for strategies/ interventions/ tools/ future efforts to support students and supervisors?(Probes: recommendations/ examples to be sustained/ scaled up/introduced to support clinical supervisors? Is there anything more you would like to add?)

2.3. Procedure

A single individual semi-structured interview was conducted by the first author with each of the participants. Participants who met the inclusion criteria were invited to participate via email, and a poster was visible at the occupational therapy department for advertisement of the study. The protocol was approved by the Domain Specific Review Board of the institution. The participants were then contacted by the first author who is not a member of the occupational therapy department for informed consent. The interview was conducted on the scheduled day, as arranged with the potential participant. All the interviews were conducted in meeting rooms in the institution where the participants worked.

2.4. Data analysis

We employed a phenomenological approach to data analysis, using the methods described by Giorgi.[27,28] Phenomenology is the research tradition that best suits the aim and research question of this study as it is concerned with the lived experience of individuals, and the meanings associated with how they interpret and respond to their experience of the social world.[24] The interviews were audio-recorded and transcribed verbatim. Copies were given to each researcher for analysis based on the procedures by Giorgi[27,28] and Creswell[29]. As data analysis requires a method that seeks a description of the world experienced by the partici-

pants, Giorgi's[27,28] method was used. The steps included reading the data interview to get a general sense of the data, and reading as often as necessary to understand the junior occupational therapy clinical supervisors' language; discriminating the natural "meaning units" from our perspectives as researchers and with the focus on the phenomenon being researched, and describing meaning units whenever we became aware of a change of meaning of the situation; going through all the meaning units and expressing insights contained more directly on their experiences as clinical supervisors, and synthesizing all the themes or meaning units of the entire interview into a consistent statement regarding the clinical supervisor's experience.[27]

Words and phrases served as the units of analysis and each meaning unit and transformed meaning unit was compared with the original data. Initial codes were discussed among two of the researchers and discrepancies were resolved through deliberation and consensus. A statement was considered significant if it contained an idea related to the junior occupational therapy clinical supervisors' perceived roles and teaching behaviours when interacting with students. Each researcher indicated the main idea associated with a significant statement by writing memos in the text next to the highlighted statement within each transcript that captured his or her reflection of and justification for choosing a meaning unit. After individual analysis of each interview was completed, significant statements and memos were carefully compared amongst the research group to ensure that all identified significant statements were examined by all researchers. The researchers then discussed and compiled a master list of significant statements accumulated from each participant. Each researcher individually re-read each interview once more to compare her analysis of significant statements.

2.5. Trustworthiness

Peer checking, reflexivity, and bracketing were used to minimize individual bias during data analysis and to improve accuracy, conformability and credibility of the study.[29] Peer checking was conducted by having the authors read the raw data and having in-depth discussions on the findings. Parts of the data are also presented in the findings section so that readers can evaluate the trustworthiness of the findings and potential applications to other contexts.[24]

3. Results

Five occupational therapists (four women and one man) with between two to three years of experience participated in the study. The reflexive and creative approach used during data analysis generated rich data about their lived experiences as clinical supervisors. The research findings are presented as an account of key themes, and how these themes illumine the participants' experiences. Pseudonyms are used to protect the identity of the participants, and quotes are included to give voice to the participants and provide evidence of the researchers' representation of the findings.

3.1. Juggling and balancing facets of work

In the first theme, 'juggling and balancing facets of work', the junior occupational therapy clinical supervisors gave insight on the sense of responsibility they had when taking students, negotiating with colleagues for their students, blocking off time in their schedules for their students, juggling clinical and supervisory work and planning for students' supervision. The junior occupational therapy clinical supervisors negotiated with their colleagues in order to maximise their students' learning, as explained,

> "For example, home visit, sometimes I'll just ask my colleague, "Is there any home visits that you guys are going? Then maybe my student can go?"" (P5)

> "… on off we also help to take other people's students as well… we would just communicate. We just plan week by week then swap our students so (that for) week one I take (student) A then week two she takes (student) A. You know, swap so they both get equal exposure, as much as possible" (P1).

The junior occupational therapy clinical supervisors also often gave the students time to read through materials before discussing with them in detail. They generally spent an hour or so, at least once a week to sit down with their students and have a discussion on protocols used, or certain health conditions encountered. Despite the time spent teaching and supervising the students, the junior occupational therapy clinical supervisors still felt conflicted in not being able to spend more time with them,

> "if I can, I would like to spend more time with the student especially if it is a (name of year 2 placement) because I think they are really very new to a long term placement… because of the time constraint we have, sometimes I cannot go through every single patient with them, with every single framework of how to give feedback, sometimes I still cut it short" (P2).

Other concerns the junior occupational therapy clinical supervisors had regarding managing work and students included the way in which their work and schedules were structured, and the potential impact this may have on the students. They were uncertain about how the students felt about this, mentioning,

> "… managing my caseloads while running back to the student to see how he is doing – "Are you ready for the cases (be)cause if you are not ready yet then I am going back to see my patient", so there is this little back and forth, back and forth… it's a lot of playing by ear sometimes… Sometimes the patients can be unpredictable. You feel that, okay, you are going to have half an hour to set aside and (it) ends up that the session drag(s) a little longer into lunch and then you no longer have that half an hour with the student. So this kind of flexibility to me is okay, but I am not sure whether the student is ok. Sometimes I feel that is the thing that is most challenging." (P3)

3.2. Holding on to anchors

In terms of what worked for them, the junior occupational therapy clinical supervisors described placement support structures that they had, and how they depended on them in the second theme, 'Holding on to anchors'. The junior occupational therapy clinical supervisors highlighted how they depended on guides such as department resources and documents with course material and learning objectives to facilitate their execution of a clinical placement for the students. They often talked about how they benefitted from having a mentor whom they could turn to for advice, and who were good role models for them, providing them with both mentorship and feedback.

Some anchors that the junior occupational therapy clinical supervisors depended on and used as placement support structures included the student care coordinator team from their department in the hospital. This team was in charge of the students, providing guidance to young clinical supervisors and helping to coordinate matters related to the students on placement. Prior to the students' arrival, the junior occupational therapy clinical supervisors had a briefing session in which the expectations and learning objectives from the school were explained to them, and they viewed PowerPoint slides and had a discussion on how to give feedback to students. They described the process in this way,

> "they also send us an email about what the students will go through each week. we have a student's file that we can just look through - what you need to prep(are) them through for each week, what they need to learn, and what are the basic expectations that they should perform… week one: what the students are supposed to learn, how many patients they are supposed to see, what they are supposed to perform" (P1).

> "… it kind of helps you keep track as to like by this week, this is what the student has to achieve and I think they are also in line with what the school expects as well so the learning objectives were more or less the same from what the students have as well as what (name of hospital) has firmed up for the clinical supervisors" (P3).

The junior occupational therapy clinical supervisors also appreciated the feedback and mentorship they had from a more experienced supervisor, who was assigned to them as a mentor in the hospital. Reflecting on their experience of being mentored, one of them said,

> "I think it's very helpful that they actually pair junior supervisors with people with a lot more experience. I think that helps a lot because you can also learn from the way that your colleagues give feedback to the students, and in terms of work processes as well, where to retrieve resources for students and all that" (P1).

The junior occupational therapy clinical supervisors also found it very helpful to have a mentor as a sounding board on things that they were unsure of, and when they encountered difficulties. The mentor was also useful for coaching the occupational therapy supervisor on how best to help their students and served as a benchmark against which they could calibrate their ratings of their students, and have discussions on students' performance and student ratings. As elaborated,

> "I also have a mentor for me to kind of ask her if there's any issues when it comes to mentoring the students as well. So I have some personal mentor. So she's the one who actually sits down with me, (and tells me) what are the things that she looks out for.

And we also have like our, kind of like a mini – not say a course – but just a mini kind of introduction on how to go about it" (P5).

The junior occupational therapy clinical supervisors also appreciated the support from the students' schools in their supervision experience,

"I feel that the lecturers are quite supportive also because I can actually email them, and even talk to them and ask them – "What are the expectations that the students are required – not say to pass, but also to learn? What is it that they need to learn, to be a better clinician?"" (P5)

Apart from the informal roles that mentoring and coaching played in the development of the junior occupational therapy clinical supervisors, training also featured frequently in the descriptions provided by the occupational therapy clinical supervisors. For example, they commented about how they felt unprepared for their roles as they did not have formal training. They described this as,

"I think that was the part that was a bit scary, I think because we had no formal training per se… I think what was nice was I remember having this preparatory workshop that was run by some of the mentors in (hospital and department name) about what to expect when having a student and just a very brief understanding about student learning profiles and how you can facilitate each part. It was helpful in terms of preparation, how to start the supervisory process. The other thing that I found useful was that they have some resources on the topics or modules that a student at this stage has gone through and what is expected of them at a certain stage of the clinical attachment. I think that was very basic for helping me to prepare what needs to be expected." (P3)

3.3. Developing students to their best

The junior occupational therapy clinical supervisors also described the tensions between letting students try, and assessing their competence in the third theme, 'Developing students to their best'. The junior occupational therapy clinical supervisors focussed on their students' learning, and in using learning opportunities and reflections. They also described the efforts they made to help their students gain more exposure in other clinical areas, to facilitate their development, as well as how they considered students' learning styles in their efforts to create learning opportunities for them.

The junior occupational therapy clinical supervisors had the role of facilitating students' learning, and used learning opportunities whenever they arose and students' reflections as they made plans for students to gain more exposure in other clinical areas. They commented on how the onus shifts to students to plan their placement sessions, and how they determined the progress of their students' learning based on their performance and facilitated their learning, for instance,

"it is like when they say 'oh thank you for showing me this' or when you know that you see him from Day 1 and you see him at Day 8 for example and he wasn't making the same mistake that he was doing, and you know that he progressed to learning something new" (P3).

The junior occupational therapy clinical supervisors saw patients together with their students and through this; they were able to get a sense of how their students were performing. They also used a scaffold approach to help their students develop skills and gain competence. They explained this process as,

"throughout the day they will be attached to me or my colleague. They will see patients together, so that's basically how we can assess them as well. We slowly let them try, let them increase their contact with patients until we feel that they are competent then we will let them do more interventions and all that" (P1).

The junior occupational therapy clinical supervisors were keen on ensuring that the students had learnt and wanted to see this through changes in their students' performance, as a development on subsequent sessions. This process was not always straightforward and the occupational therapy clinical supervisors had to navigate this by,

"… I try to facilitate his learning in that sense but a lot of it is not always hitting the target right sometimes. You could just have this inkling that he doesn't know but when you ask "you know?", the student makes a 'yup yup I'm fine'… but it's only when you start noticing that oh certain facilitation skills are not right or there is a certain gap, that is when you step in" (P3).

Additionally, the junior occupational therapy clinical supervisors faced tensions in trying to determine whether students' performance should be assessed based on their current knowledge, or ability to learn,

> "this was another thing that I was having difficulties with. Do you score a student based on what he doesn't know or give him a chance to learn, and then a few sessions later, or a few weeks later revisit the same thing and see whether or not there has been initiative to kind of bridge that gap? I think it is ok if you don't know but I feel that attitude kind of turns me off very fast. Like if one week later you still haven't done it, then to me it's like, it's either you just can't be bothered with it, so attitude was also something I had to kind of keep revisiting" (P3).

Taking a more developmental approach to the students' learning, the clinical supervisors considered students' reflections on their progress, and also tried to make time to discuss students' progress with them, and give them time and space to reflect on their performance. Feedback for students was also planned to occur in a timely fashion, and the clinical supervisors focussed on the students' learning, facilitating their performance and giving them feedback,

> "every week, whatever they learnt and what not, (and) everyday, almost after every other session, we have time to feedback (on) how they perform, what is good, what's not so good, then they also have their own case presentation, so we just facilitate their process… evaluation wise we would sit together and discuss about our perspectives of the student before we actually express this to their (name of school) supervisor" (P1).

The junior occupational therapy clinical supervisors were really pleased whenever the students used the feedback given to improve on their performance,

> "positive experience is when you give them feedback and during the next session, they actually really take your feedback into practice, they will improve on the next session and they will really take the effort to improve themselves and to do their own research to find out more about condition and stuff" (P2).

3.4. Becoming a better therapist

Finally in the last theme, 'Becoming a better therapist' the junior occupational therapy clinical supervisors commented on how taking students helped them refresh their knowledge, expand boundaries and learn to accommodate students. They also found themselves questioning if they had done their best and appreciated the opportunity to keep in touch with what was happening in the school, mentioning,

> "Mainly students come to placement to work on their clinical skills. Not only we have to help them to work on that, but we also have to be a good role model for them, whenever we communicate with patients or other healthcare professionals, we have to be, I have to be very mindful of that" (P4).

They also spent time and effort improving their own knowledge, to better help the students on placement,

> "they make me learn as well… because like as I was supervising them I also had to process the information myself... and then make sure that its clear and understandable to them… as well as running through processes with them so that…. so as I was doing that I am also refreshing myself" (P1)

> "I was like reading, I was reading more on the theories and also the application of, cause my student was going for all those, so I also read up more... (name) So for him to learn what are the things that he needs to learn, and what are the things that I can actually contribute to his learning also. So it's more of like revising what I have learnt from school, and also applying there" (P5).

While the junior occupational therapy clinical supervisors acknowledged difficulties with having to deal with an extra person for 8 h a day, which they were not used to, they took their role seriously, and always put the students' learning needs above their own,

> "first and foremost is really a facilitator of learning, which I find is difficult in that sense sometimes because as a supervisor, you also want them to get out of the session in each day, or get out of the entire placement having learnt something and having brought something that is useful to (bring) them forward to the next placement" (P3).

The junior occupational therapy clinical supervisors were also keen to have feedback on their performance to improve themselves to become better supervisors,

> "I don't know whether there should be a flow… instead of a follow-up with the students… a feedback from the therapist as well… who is supervising the students… because there is not only one right… there is like many supervisor as well… so they can come together and also do feedback on what else we can improve for the students" (P2).

4. Discussion

This study described the experiences of five junior occupational therapy clinical supervisors who reflected upon their experiences of providing supervision and clinical education to students on placement at an acute hospital. Similar to the descriptions by Kilminster et al.[4], the occupational therapy clinical supervisors in this context performed various roles and functions and gave the students guidance and feedback on personal, professional and educational aspects to facilitate their development as emerging clinicians. In line with the literature, these occupational therapists with two to three years of clinical experience were still in the process of developing their clinical and professional skills as practising professionals,[10] and described the challenges faced as new clinical supervisors, and methods they used to manage and fulfil their various roles.

Additionally, support structures were described to be important and depended on by the junior occupational therapy clinical supervisors. They appreciated the practical resources and supports such as information from the school, department resource guides, and briefing sessions prior to students' arrival, as well as professional development opportunities through mentors who facilitated their informal learning, and attendance at formal training workshops. Having a mentor whom they could turn to for advice was an important source of learning and support for the junior occupational therapy supervisors. This finding is similar to that of a study by Hunt,[13] in which the novice occupational therapists identified having the opportunity to observe a more experienced supervisor and to hear from others' experience; among a range of supports that they believed would be helpful for improving their readiness to undertake fieldwork supervision.

As described by Steinert,[15] peer coaching and mentorship are important components of workplace learning, and can provide contextualised learning to facilitate the development of competence of health professionals, and in this context it was something that the occupational therapy supervisors valued. Notwithstanding, the junior occupational therapy supervisors also placed emphasis on formal training and even considered it "a bit scary" to not have formal training before becoming an occupational therapy clinical supervisor. From their descriptions, they tended to think that they are not trained and equipped for the task if they had not undergone formal training, as on-the-job training and mentoring was largely used to equip them for their roles, although they appreciated the mentorship and other supports provided. In the study by Hunt[13] professional development in fieldwork supervision was also identified as beneficial, and one of the participants in that study mentioned that she would have been more confident if she had undergone the supervisor training provided at one University. Hence, it may be useful to consider how formal training can be incorporated into the professional development of the junior occupational therapy clinical supervisors; and the importance of the informal supports and training could be highlighted to them.

Although this study has provided useful insights to junior occupational therapy clinical supervisor perspectives, this study is not without limitations. The study was conducted in one department as it was the context of interest, and all the junior occupational therapy clinical supervisors who satisfied the criteria were invited to participate, however, less than half of the people who met the criteria volunteered to do so. Hence the views expressed may not be completely representative of the junior clinical supervisors in the department and future studies can consider conducting more interviews in other hospitals to have a better understanding of their experiences, or to include clinical supervisors with more experience to investigate if these findings can be applied to occupational therapy educators more generally. Nevertheless, samples of fewer than twenty increase the researcher's chances of getting close involvement with their participants in interview-based studies and in generating fine-grained data,[23] and the participants of the study were very forthcoming in sharing about their experiences.

In this study, the junior occupational therapy clinical supervisors also seemed to relish the challenges, roles and responsibilities although they were sometimes unsure of their approach towards developing students to their best, and experienced tensions between determining students' progress, letting them try, and assessing their competence. From their descriptions, they valued the role in developing students, gratified when the students showed that they had used their feedback to improve, and strove to improve their capability and practice in their new roles as clinical supervisors. They were also keen to have feedback from other therapists involved with supervising students on how things could be improved and students can be helped to learn and develop more.

5. Conclusion

Junior occupational therapy clinical supervisors face challenges as new clinical supervisors and want to do their best for the students. They value various support structures and having a mentor to approach for advice about the supervision they provide and to guide them when they encounter difficulties with supervision. A better understanding of the perspectives of junior occupational therapy clinical supervisors assists the development and improvement of support strategies for future beginning clinical supervisors.

Disclosure

Ethical approval

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References

1. American Occupational Therapy Association. Occupational therapy fieldwork education: value and purpose. *Am J Occup Ther* 2009;63:821–822http://dx.doi.org/10.5014/ajot.63.6.821.
2. Laitinen-Vaananen S, Talvitie U, Luuka M. Clinical supervision as an interaction between the clinical educator and the student. *Physiother Theory Pract* 2007;23(2):95–103.
3. Kilminster SM, Jolly BC. Effective supervision in clinical practice settings: a literature review. *Med Educ* 2000;34:827–840.
4. Kilminster S, Cottrell D, Grant J, Jolly B. AMEE Guide No. 27: effective educational and clinical supervision. *Med Teach* 2007;29(1):2–19http://dx.doi.org/10.1080/01421590701210907.
5. Turnock C, Moran P, Scammell J, Mallik M, Mulholland J. The preparation of practice educators: an overview of current practice in five healthcare disciplines. *Work Based Learn Prim Care* 2005;3:218–235.
6. Harden RM, Crosby J. AMEE Guide No. 20: the good teacher is more than a lecturer – the twelve roles of the teacher. *Med Teach* 2000;22(4):334–347.
7. Hesketh EA, Bagnall G, Buckley EG, Friedman M, Goodall E, Harden RM, Laidlaw JM, Leighton-Beck L, McKinlay P, Newton R, Oughton R. A framework for developing excellence as a clinical educator. *Med Educ* 2001;35:555–564.
8. Martin M, Morris J, Moore A, Sadlo G, Crouch V. Evaluating practice education models in occupational therapy: comparing 1: 1, 2: 1 and 3: 1 placements. *Br J Occup Ther* 2004;67(5): 192–200.
9. Rodger S, Fitzgerald C, Davila W, Millar F, Allison H. What makes a quality occupational therapy practice placement? Students' and practice educators' perspectives. *Aust Occup Ther J* 2011;58(3):195–202.
10. Hodgetts S, Hollis V, Triska O, Dennis S, Madill H, Taylor E. Occupational therapy students' and graduates' satisfaction with professional education and preparedness for practice. *Can J Occup Ther* 2007;74:148–160.
11. Smith R, Pilling S. Supporting the transition from student to professional – A case study in allied health. *Aust Health Rev* 2008;32:134–138.
12. Jensen LR, Daniel C. A descriptive study on Level II fieldwork supervision in hospital settings. *Occup Ther Health Care* 2010;24 (4):335–347. [2010].
13. Hunt K, Kennedy-Jones M. Novice occupational therapists' perceptions of readiness to undertake fieldwork supervision. *Aust Occup Ther J* 2010;57(6):394–400.
14. Fitzgerald C, Moores A, Coleman A, Fleming J. Supporting new graduate professional development: a clinical learning framework. *Aust Occup Ther J* 2015;62:13–20.
15. Steinert Y. *Faculty Development in the Health Professions: A Focus on Research and Practice*. Dordrecht: Springer; 2014.
16. Singapore Institute of Technology - Occupational Therapy, BSc (Hons). Available at: (⟨http://www.singaporetech.edu.sg/undergraduate-programmes/occupational-therapy⟩); Accessed 14.07.17.
17. Institute of Mental Health - Observerships and placements: Occupational Therapy. Available at: (⟨https://www.imh.com.sg/education/page.aspx?Id=316⟩) Accessed 14 July 2017.
18. TTSH Pre Professional Education Office - Allied Health. Available at: (⟨http://www.ttshppeo.com.sg/⟩) Accessed 14 July 2017.
19. Rodger S, Thomas Y, Greber C, Broadbridge J, Edwards A, Newton J, Lyons M. Attributes of excellence in practice educators: the perspectives of Australian occupational therapy students. *Aust Occup Ther J* 2014;61:159–167.
20. Greenfield BH, Bridges PH, Phillips TA, Drill AN, Gaydosik CD, Krishnan A, Yandziak HJ. Exploring the experiences of novice clinical instructors in physical therapy clinical education: a phenomenological study. *Physiotherapy* 2014;100:349–355.
21. Snodgrass SJ, Rivett D, Farrell S, Ball K, Ashby SE. Clinical educator and student perceptions of iPad technology to enhance clinical supervision: the electronically-facilitated feedback initiative (EFFI). *J Allied Health* 2016;14(4). [Article 4].
22. Chen HC, O'Sullivan P, Teherani A, Fogh S, Kobashi B, ten Cate O. Sequencing learning experiences to engage different level learners in the workplace: an interview study with excellent clinical teachers. *Med Teach* 2015;37(12):1090–1097.
23. Bryman A. *Social Research Methods*, 4th ed., New York: Oxford University Press; 2012.

24. Patton MQ. *Qualitative Evaluation and Research Methods*, 2nd ed, Newbury Park, CA: SAGE; 1990.
25. Giorgi A. Concerning a serious misunderstanding of the essence of the phenomenological method in psychology. *J Phenomenol Psychol* 2008;39:33–58.
26. Creswell JW. *Research Design: Qualitative, Quantitative, and Mixed Methods Approaches*, 4th ed, Thousand Oaks: SAGE; 2014.
27. Giorgi A. Sketch of a psychological phenomenological method. *Phenomenol Psychol Res* 1985;1:23–85.
28. Giorgi A. The phenomenological movement and research in the human sciences. *Nurs Sci Q*. 2005;18:75–82.
29. Creswell J, Plano V. *Designing and Conducting Mixed Methods Research*. Thousand Oaks, California: SAGE; 2007.