# Rapid review and environmental scan of evidence on adequate support and supervision ratios for isolated support work (span of control)

Flinders University

Supported by Government of South Australia

human services

# Acknowledgements

This research was funded by the South Australian Department of Human Services.

The project was conducted by a research team at Flinders University, Dr. Claire Gough, Professor Sally Robinson, Professor Stacey George, Associate Professor Rachel Milte, Dr Valerie O'Keeffe, Dr Alinka Fisher, Dr June Alexander and Ms. Jala Burton. Research assistance from Dr Kiri Lay and Shannon Brown, librarian, was much appreciated.

The team worked closely with the Department of Human Services throughout the process. We acknowledge the advice and support of the Governance Group, the Advisory Group and the DHS project team — Gabrielle Hummel, Joanna Mack, Daniel Hill-Brown and Ella Broadbent.

We thank the stakeholders who contributed to the development of the research by providing feedback and through participating in advisory and focus groups. We particularly recognise the considered input of supervisors and team leaders, support workers, managers of government and non-government disability service organisations, family members of people with disability who use services, and advocates. Their collective expertise and lived experience were integral to shaping these guidelines.

We respectfully acknowledge the tragic circumstances which led to this research.

# Glossary

## 1:1 line-of-sight oversight and support of a person with disability

The practice of maintaining line-of-sight contact at all times with a participant/client and the process of ensuring that continuity of care is maintained.

For clarity, in this report we refer to line-of-sight oversight and support as the activity carried out by workers towards people with disability. We refer to supervision as the activity of supervisors and line managers in ensuring workers are supported and resourced to do this work effectively.

## Continuity of care

The sustained coordination and integration of support for participants with complex or changing health needs, so that critical information is consistently reviewed, communicated and implemented across supports to prevent disruption to care.

## Enforceable Undertaking

A written, legally binding commitment to implement effective work health and safety initiatives designed to deliver tangible benefits for workers, industry and the community as a whole and to resolve the issue that led to the enforceable undertaking (SafeWork SA, 2026).

## Escalation pathways

The step-by-step process for seeking assistance on a clinical, safety or workplace risk when the situation needs additional or specialist support, or higher level, timely decision-making to prevent risk increasing (NDIS Quality and Safeguards Commission, 2019; SafeWork SA, n.d.-a).

## Isolated support work

Work that is isolated from the assistance of others because of the location, time or nature of the work (Government of South Australia, 2012; SafeWork SA, n.d.-b).

## Multimodal supervision

The use of multiple communication modes to deliver supervisory support, e.g. face-to-face, phone, telehealth, video conferencing, or other digital channels.

## Peer supervision

A structured, collaborative process in which support workers provide supervision to one another, drawing on shared experience, reflective dialogue, and mutual problem-solving. It emphasises psychological safety and professional support.

## Span of control

The supervision ratios for staff to ensure adequate support and supervision (SafeWork Australia, n.d.-a).

## Supervision

The oversight, guidance and support provided by a qualified professional to support workers (NDIS Quality and Safeguards Commission, 2023).

## Vulnerable work environments

A work environment where workers are exposed to an increased probability of physical injury, psychological harm, or workplace violence because workplace hazards exceed available protective resources and control measures.

Vulnerability arises from the presence of hazards AND is amplified by deficiencies in organisational safeguards including leadership, training, supervision, psychological safety, workforce capability, communication systems, and incident responses (SafeWork Australia, n.d.-b).

## Table of Contents

# 1. Executive Summary

This research is about how disability service providers can provide quality supervision and support to workers who work alone or away from immediate help. These workers may be supporting people with disability in homes, community settings, shared living arrangements, or other settings where risk can change quickly. The report focuses on worker supervision, not oversight or support of people with disability. It is particularly focused on situations where there is potential risk to people with disability who have high and complex support needs, and how improvement in supervision might reduce this risk.

Flinders University was engaged by SA Department of Human Services (DHS) to conduct a rapid evidence review and environmental scan. The research was conducted as part of an Enforceable Undertaking agreement between SafeWork SA and the DHS to improve practice following the death of a person with disability while receiving service provision in an isolated support work context. It forms part of a wider response to improve safety and service quality. The review looked for existing evidence to help improve the quality of intensive and line-of-sight supervision.

The findings show that isolated support work carries particular risks. Workers may need to make quick decisions without another worker nearby. They may face emotional pressure, uncertainty, safety risks, and responsibility for complex care. These risks may affect the quality and safety of support for people with disability and can also affect workers' wellbeing. Supervision is therefore not an optional extra. It is a core safety mechanism.

The review found that there is very little direct research that gives a numerical ratio for supervision of isolated disability support workers. The contexts in which supervision takes place are complex and diverse. Because of this, the report does not recommend a single fixed ratio that should apply in all settings. A risk-based approach is identified as a more effective approach to respond to the diverse contexts in which support is provided. This means supervision should be stronger, more frequent and more accessible when workers are isolated, when participant needs are complex, when restrictive practices are used, when health risks are present, or when workers have less experience.

Quality supervision should be planned, regular and protected. It should not depend on whether a worker has time left over or whether a supervisor happens to be available. Workers need predictable supervision, timely feedback, and rapid access to decision-making support when situations change or risks increase. This is especially important where workers are providing line-of-sight oversight and support, working alone with people who have complex health or behavioural needs, or using authorised restrictive practices.

The evidence shows that supervision must be relational and psychologically safe. Workers need to feel able to raise concerns, ask questions, talk about uncertainty, and seek help without fear of blame. Trust and continuity matter. Where supervisors change often, carry too many responsibilities, or do not have enough time, supervision becomes less effective.

Supervisors also need the right skills and support. They should understand disability practice, rights-based approaches, trauma-informed practice, supported decision-making, positive behaviour support, worker safety, and the practical realities of isolated support work. Supervisors need training, manageable workloads, and organisational backing to do this role well.

Overall, the findings show the importance of organisations prioritising structured supervision systems to reduce risk and promote accountability. These systems should include clear supervision plans, protected time, regular check-ins, peer or group supervision where appropriate, rapid escalation pathways, and clear role and delegation frameworks. The span of control for supervisors should be manageable enough to allow meaningful contact, timely responses, and quality oversight.

This report explains the key findings from the research. It also provides practice insights to help identify adequate support and supervision ratios ('span of control') and best practice supervision ratios to ensure client and staff safety in three areas:

- Appropriate span of control and supervision for isolated support work
- Best practice supervision ratios
- Implications of the evidence for supervision.

The central message is that isolated support work should be treated as a higher-risk work environment. Supervision arrangements should be designed accordingly. This will better protect worker wellbeing, strengthen continuity of care, support quality practice, and help uphold the rights and safety of people with disability.

# 2. Introduction

This report reviews the available evidence and identifies gaps on appropriate supervision and support ratios for isolated disability support workers employed in 'vulnerable work environments' in Australia. It provides findings and practice insights to improve quality in supervision. The study was conducted by Flinders University for SA Department of Human Services between December 2025 and July 2026.

The research was conducted as part of an Enforceable Undertaking agreement between SafeWork SA and the Department of Human Services (DHS), to improve practice following the death of a person with disability while receiving service provision in an isolated support work context. The study sits alongside a range of practical initiatives by DHS to improve safety for people with disability and provide support and supervision to workers in their roles.

The aim of the research was to investigate adequate support and supervision ratios ('span of control') for isolated support work, and identify best practice supervision ratios to ensure client and staff safety, taking into account:

- Differing regulatory, clinical, administrative and legislative factors which may inform the contexts in which isolated support work is performed, (e.g. authorised restrictive practices)
- Regulatory settings and price limitations relevant to NDIS service provision
- Learning opportunities in similar relevant care or service environments (e.g. youth residential care, mental health intensive support services).

The key terms have a specific meaning as part of the Enforceable Undertaking. **Span of control** relates to the supervision ratios for staff to ensure adequate support and supervision. **Isolated support work** relates to 'work that is isolated from the assistance of others because of the location, time or nature of the work' (Government of South Australia, 2012). This can carry risks to both clients and workers.

The research applies the results of the evidence review to four priority contexts:

1. Supervision and support of support workers providing 1:1 line of sight oversight and support to a person with a medical/disability need which requires direct supervision as a clinical requirement, where the worker's line manager or supervisor would ultimately be responsible for ensuring continuity of care.
2. Supervision and support of support workers providing 1:1 support to people with disability where workers undertake their role alone (at least in part), but there is no medical/disability requirement for line-of-sight oversight and support or continuity of care.
3. Supervision and support of support workers who may be working interchangeably to provide 1:1 support to multiple participants in a shared setting, where workers may perform some of their work isolated from others.
4. Supervision and support of support workers where their work includes 1:1 'intensive supervision' as an authorised restrictive practice, where supervision is applied to monitor behaviours of concern that create a risk of harm to the person or others.

## 2.1 Scope of the research

The scope of the study was to develop an overview of the existing research globally to identify and analyse gaps relevant to span of control and supervision for Australian disability services settings. The research aim is to identify findings and practice insights which can reduce these gaps considering budget limitations and a regulatory environment that allows for appropriate safety and supervision, which can be used in similar support environments (SafeWork SA, 2026).

The research is focused on the appropriate supervision of workers, not oversight or support of people with disability. Accordingly, 'supervision' in this document refers to paid workers, not recipients (participants, clients, service users) of disability services.

The outputs from the study are

- A review of global academic research and practice-focused (grey) literature, summarised for an Australian context;
- Analysis of gaps from existing research and a report on findings and practice insights for appropriate span of control for isolated support work in the Australian context (this report);
- Summary reports to make the findings accessible to community audiences.

## 2.2 Isolated support work in the policy context

Isolated disability support workers operate within a complex policy environment shaped by the NDIS Code of Conduct, NDIS Practice Standards and Work Health and Safety (WHS) legislation. These frameworks require workers to uphold the rights of people with disability, including autonomy, dignity and choice, while also protecting their own safety and wellbeing. This dual obligation is complicated by the complex support needs of many participants, including cognitive and physical impairment, behavioural complexity, chronic health conditions and communication needs, all of which influence risk in practice (Iacono et al., 2019). Viewed through Bacchi's (2016) "What's the Problem Represented to Be?" (WPR) framework, this dual obligation can be understood as a policy problem concerning how rights, risk and responsibility are distributed between participants and workers.

The NDIS Code of Conduct requires workers to respect rights, provide safe and competent services, and prevent and respond to harm, while WHS legislation places responsibility on workers to protect their own health and safety. Together, these frameworks position workers as both protectors of participant rights and managers of safety risks. In isolated settings, this involves real-time decision-making where participant autonomy must be balanced with strategies that manage risk without unnecessarily restricting freedom (Field et al., 2024). Risk management is further influenced by changing participant circumstances, including behavioural triggers, fatigue, medication effects and cognitive changes, requiring workers to continually adapt their responses (Lokman et al., 2025).

Supporting rights therefore involves enabling **dignity of risk** that supports people to learn and grow, while maintaining participant and worker safety (Piper, 2025). For people who require support for decision-making, this balance becomes more complex because workers may need to interpret and manage risks with and on behalf of participants (Hawkins et al., 2011). At face value, the policy problem appears to be how workers can simultaneously fulfil their duty of care obligations, support participant choice and maintain safety for all parties.

Using Bacchi's (2016) WPR framework reveals that policy largely represents the problem as one of **insufficiently managed risk**. Through risk assessments, incident reporting and compliance mechanisms, responsibility is placed primarily on individual workers to manage competing demands (Cortis & Van Toorn, 2022). This framing does not fully recognise how psychosocial disability, trauma histories, behavioural complexity and changing health conditions contribute to risk environments that cannot always be anticipated or controlled (Lokman et al., 2025). As a result, isolated workers are positioned as **autonomous risk managers** responsible for protecting rights and ensuring safety in diverse and often unpredictable environments.

This representation rests on several assumptions. It assumes that risk can be controlled through formal processes despite the dynamic and relational nature of support work. It also assumes workers possess the knowledge and resources needed to manage participant and personal safety simultaneously, including when responding to behavioural escalation or medical events. Further, although participant autonomy is prioritised, it often becomes **conditional on workers' judgements of safety thresholds** regarding acceptable levels of risk, particularly when participants have impaired communication or insight (Iacono et al., 2019). Finally, policy assumes participant rights and worker safety can be balanced in practice, even when these priorities may conflict.

Bacchi's framework also highlights what remains largely unexamined within policy. Structural factors such as workforce shortages, limited supervision, funding constraints, time pressures and the unpredictability of isolated work settings receive little attention despite their influence on worker safety and participant outcomes. Similarly, the **emotional labour** involved in monitoring health and wellbeing, responding to crises and managing uncertainty is often overlooked as a WHS issue (Jepsen et al., 2025). Responsibility for managing these challenges is therefore shifted towards individual workers rather than being understood as a shared organisational and system responsibility (Gould, 2025).

This framing has significant implications. For participants, workers' sense of accountability may encourage risk-averse practices that inadvertently restrict choice and autonomy, particularly when supporting people with complex behavioural or medical needs (Marsh & Kelly, 2018). For workers, the expectation to uphold rights while ensuring safety can create ethical, emotional and practical strain. In response, workers may increase monitoring, impose stricter boundaries or avoid higher-risk activities to manage uncertainty and potential liability (Terras et al., 2019).

These tensions are particularly evident in community participation. For example, when supporting a participant with cognitive disability to engage independently in community activities, a worker may introduce additional controls, such as increased monitoring or restrictions on unfamiliar activities. While intended to maintain safety, these actions may also limit participant choice. Consequently, decisions about participant autonomy become closely intertwined with concerns about worker safety, wellbeing and accountability.

Bacchi's (2016) framework invites alternative ways of understanding the issue. First, rather than viewing the challenge as the worker's responsibility to balance competing duties, it can be framed as a systemic issue of protecting both participant rights and worker safety within isolated service models. Second, it may also be understood as a policy tension between market-based choice and the realities of delivering safe support, or third, as a structural challenge requiring service designs that enable autonomy without exposing participants or workers to unacceptable risk. These alternative framings focus attention on **organisational**

**responsibility,** service design and system-level supports rather than solely on individual worker decision-making.

Finally, a critical, reflective application of WPR highlights that efforts to "balance" rights and safety may themselves assume that such balance is always achievable. In practice, isolated disability support work often involves unavoidable tensions, particularly when participants experience fluctuating capacity, behavioural risks or significant health vulnerabilities. Worker roles then become shaped by a **policy-produced framing of risk and responsibility**. Recognising these tensions allows for a more realistic understanding of support work and supports the development of policies that better reflect its dynamic, relational and often unpredictable nature. Overall, the analysis demonstrates that isolated disability support workers are constructed as key agents responsible for enabling autonomy while managing safety, often in conditions of uncertainty and complexity. Challenging this representation creates opportunities to develop systems that more effectively support both participant rights and worker safety and wellbeing.

### 2.2.1 Supervision as a bridge to good practice

A key strategy to bridge and integrate the multiple, sometimes competing factors of service quality, end-user autonomy and choice, and worker safety and wellbeing in high-risk, complex work environments, is worker supervision. Disability support work is highly relational in nature; first, between support workers and participants, and second, between staff; with the most instrumental relationship being between support workers and their supervisors. Competent support workers require three distinct skill sets: interpersonal, technical and administrative (Gray & Muramatsu, 2013; Gur & Klein, 2025). Supervisors provide fundamental support for technical skills development through identifying needs, providing access to formal training (and linkage with human resources management more generally), building disability and health literacy, and providing coaching, mentoring, feedback and debriefing to promote reflective practice (Cvetanovska et al., 2025). This vital 'on-the-job' tailored support enables integration of technical training and experience into the reality of the support work environment, which exists within an operating system of policy and governance.

Policy and governance involve administrative skills, including digital and document literacy, systems navigation and compliance with standards (e.g. ethics, confidentiality, reporting) (West et al., 2025). Successfully enacting technical and administrative skills requires sophisticated interpersonal skills for support workers and their supervisors. The quality of interpersonal skills between staff (and participants) determines trust, confidence and psychological safety (feeling safe to raise concerns); directly influencing organisational culture (Edmondson, 1999). A supportive culture also benefits worker wellbeing, retention and commitment, with flow-on benefits for participants and services (Gray & Muramatsu, 2013). Supervisors, as leaders, must set expectations of, and enable good practice through being effective communicators, active listeners and problem solvers, who act with authenticity, openness and trustworthiness (Cvetanovska et al., 2025). Supervisors also require advanced technical skills as competent and reflective practitioners who encourage critical thinking and exploration of relationship dynamics (Hallinan & McMahon, 2024). Additionally, capable supervisors also provide leadership, advocacy (for participants and support workers), and organisational support through providing resources to achieve work requirements effectively within funding provisions (Janlöv et al., 2015).

Effective supervisors fundamentally require strong relational skills, along with an interest and satisfaction in developing people. Strong experience in disability-related services provides deep knowledge of the complexities and dynamics of the support role and policy environment, allowing the supervisor to act as a navigator and bridge builder between elements in complex systems. These skills can be learned through combinations of practical experience, formal qualifications, personal development training, and supervisory support. Supervision should be tailored to individual needs through reflective practice, on-the-job experiences, perspective training or role playing, skill analysis and critical thinking to support problem solving (Gur & Klein, 2025; West et al., 2025). The tailored nature of supervision extends on the foundation of formal human resources practices of onboarding, observations of support worker practice, structured feedback and formal performance reviews, ensuring a comprehensive, ongoing and integrated system of skill development and support.

# 3. Methods

## 3.1 Research and Scoping

Published evidence and resources were reviewed to identify findings relating to appropriate span of control to guide supervision of isolated disability support workers.

### Rapid Reviews

Rapid reviews were carried out to scope the landscape for evidence related to span of control specific to supervision of isolated disability support workers and the use of restrictive practices. The aim of systematically reviewing the existing literature was to find the best available evidence to inform an appropriate span of control. In addition, scoping the grey literature and available guidelines allowed us to identify resources focused on practical elements that guide appropriate supervision and span of control.

## 3.2 Literature sources and search strategies

To identify relevant published evidence specific to the key components of this project, three scoping reviews were carried out that focused on:

1. Appropriate supervision
2. Working in isolation, and
3. Restrictive practices.

### Search 1: Appropriate supervision

The search was conducted on the 18th of February 2026 in CINAHL, SCOPUS, ProQuest Central Premium and ProQuest Dissertations and Theses databases. The search terms included four concepts and are provided in Table 1:

Table 1. Appropriate supervision search strategy

| Concept | Search Terms |
|---|---|
| 1 | (((Supervis*) NEAR/2 (ratio OR "1:1" OR "one to one" OR "one-to-one" OR "line of sight" OR standards OR "multiple staff")) OR ((Staffing) NEAR/2 (safe* OR minimum OR benchmark* )) OR "stable staff team*" OR "continuity of care" OR "adequate support" OR "span of responsibility" OR "span of control" OR "duty of care" OR "regulation practice" OR ((Quality) NEAR/2 (indicator* OR safeguard* OR control*))) |
| 2 | (caregiv* OR "care giv*" OR caretak* OR "care tak*" OR carer* OR "personal care assistant" OR "care attendant*" OR "practice leader*" OR "staff manage*" OR "frontline manage*" OR assistant* OR ((support OR disability) NEAR/2 (worker* OR staff* OR provider* OR professional* OR attendant* OR assistant* OR professional*))) |
| 3 | (Disab* OR "service user" OR client OR customer OR consumer OR "rights holder" OR "person at centre" OR patient* OR "community services") |
| 4 | (Australia* OR "New South Wales" OR Queensland OR Tasmania OR Victoria* OR Canada* OR New Zealand* OR NZ OR Aotearoa OR "United Kingdom" OR UK OR England OR English OR Scotland OR Scottish OR Wales OR Welsh OR Ireland OR Irish OR Netherlands OR Dutch OR France OR French OR German* OR Sweden OR Swedish OR Denmark or Danish OR Norway OR Norwegian) |

## Inclusion and exclusion criteria

Articles were included in the review if they reported on; disability services, youth residential care, mental health intensive support, community nursing, aged care, supervision ratios, supervisory requirements, supervisory responsibilities, adequate support, staff ratios, or quality indicators. Articles published from 2012 to search date were included.

Excluded articles were those reporting on in-patient hospital care, primary outpatient care (via GP), specific to COVID-19 responses, articles not reported in English or studies that did not report results in full (including abstracts, conference proceedings and protocols).

After reviewing 1367 original articles identified in this search, 14 met the inclusion criteria and were included in the review (Figure 1).

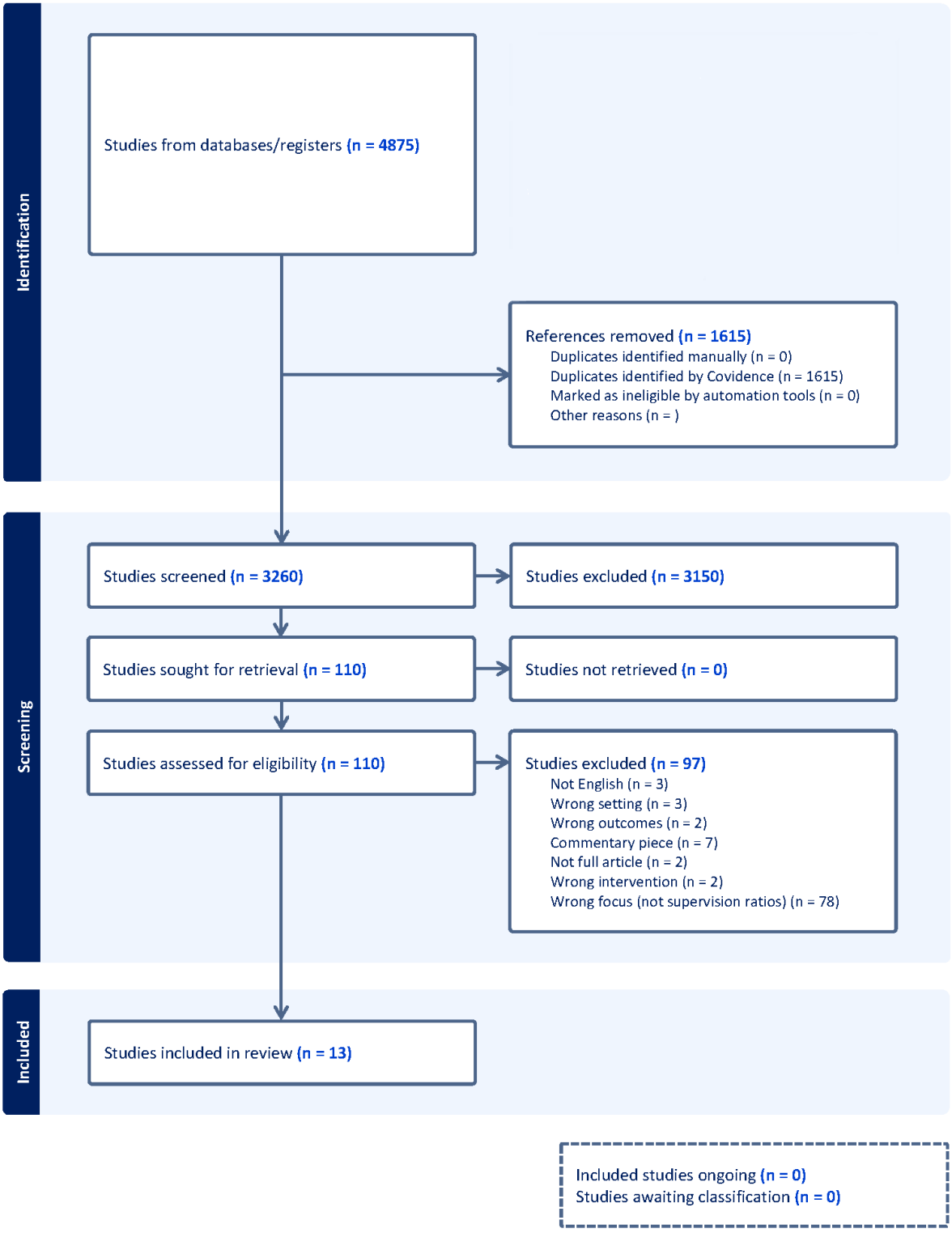


Figure 1: Appropriate supervision PRISMA

## Search 2: Working in isolation

The search was conducted on the 20th of February 2026 in CINAHL, SCOPUS, ProQuest Central Premium and ProQuest Dissertations and Theses databases. The search terms included three concepts and are provided in Table 2:

Table 2. Working in isolation search strategy

| Concept | Search Terms |
|---|---|
| 1 | (((Work* or staff* OR caregiv* OR "care giv*" OR caretak* OR "care tak*" OR carer* OR "personal care assistant" OR "care attendant" OR provider* OR professional* OR attendant* OR assistant OR professional) NEAR/3 (isolated OR isolation OR sole OR " individual support" OR " singular support" OR "unassisted support" OR lone)) OR ((staff OR work* OR occupational) NEAR/3 (safety or safeguard* OR safe OR "duty of care"))) |
| 2 | Home care" OR "home-care" OR healthcare OR "health care" OR "health-care" OR Nurs* OR doctor* OR physician* OR disab* OR "After hours care" OR "After-hours care" OR "allied health" OR NDIS |
| 3 | (Australia* OR "New South Wales" OR Queensland OR Tasmania OR Victoria* OR Canada* OR New Zealand* OR NZ OR Aotearoa OR "United Kingdom" OR UK OR England OR English OR Scotland OR Scottish OR Wales OR Welsh OR Ireland OR Irish OR Netherlands OR Dutch OR France OR French OR German* OR Sweden OR Swedish OR Denmark OR Danish OR Norway OR Norwegian) |

### Inclusion and exclusion criteria

Articles were included in the review if they reported on; disability services, youth residential care, mental health intensive support, community nursing, aged care, isolated support work, sole or lone workers, individual or unassisted support workers, or staff safety (with regards to isolated work or staff ratios). Articles published from 2012 to search date were included.

Excluded articles were those reporting on in-patient hospital care, primary outpatient care (via GP), specific to COVID-19 responses, articles not reported in English or studies that did not report results in full (including abstracts, conference proceedings and protocols).

After reviewing 3260 original articles identified in this search, 13 met the inclusion criteria and were included in the review (Figure 2).

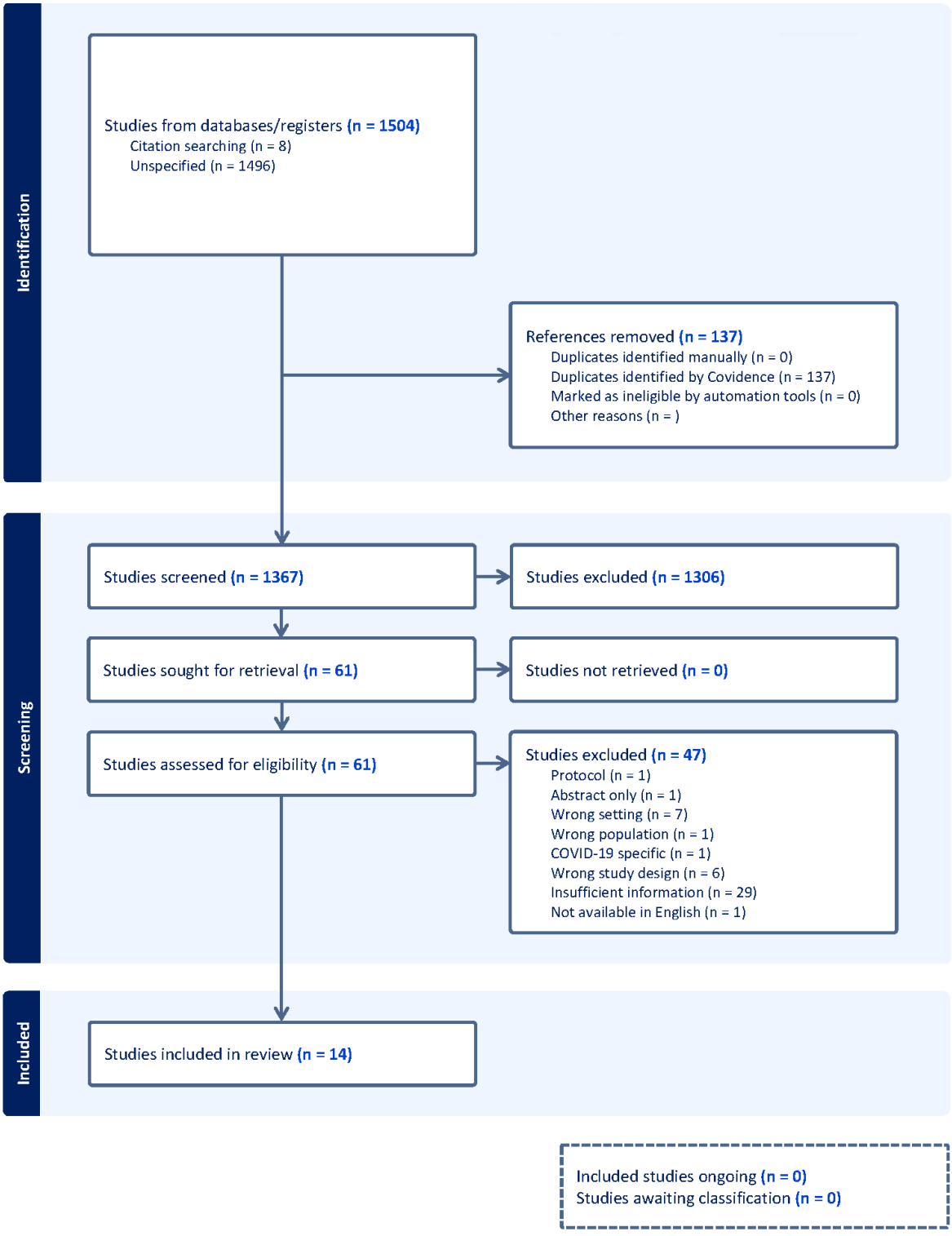


Figure 2: Working in isolation PRISMA

## Search 3: Restrictive practices

The search was conducted on the 18th of February 2026 in CINAHL, SCOPUS, ProQuest Central Premium and ProQuest Dissertations and Theses databases. The search terms included four concepts and are provided in Table 3:

Table 3. Restrictive practices search strategy

| Concept | Search Terms |
|---|---|
| 1 | NEAR/2 (management OR mitigation OR mitigate* OR control*)) OR seclusion OR safeguarding OR ((restrictive) NEAR/2 (practice* OR methods OR procedure* OR approaches OR intervention*)) OR ((abuse) NEAR/2 (prevention OR "safety from" OR prevent* OR intervention*)) OR ((protective) NEAR/2 (practice* OR methods OR procedure* OR approaches))) |
| 2 | (caregiv* OR "care giv*" OR caretak* OR "care tak*" OR carer* OR "personal care assistant" OR "care attendant" OR ((support) NEAR/2 (worker* OR staff* OR provider* OR professional* OR attendant* OR assistant OR professional))) |
| 3 | (Disab* OR "service user" OR client OR customer OR consumer OR "rights holder" OR "person at centre" OR patient*) |
| 4 | (Australia* OR "New South Wales" OR Queensland OR Tasmania OR Victoria* OR Canada* OR New Zealand* OR NZ OR Aotearoa OR "United Kingdom" OR UK OR England OR English OR Scotland OR Scottish OR Wales OR Welsh OR Ireland OR Irish OR Netherlands OR Dutch OR France OR French OR German* OR Sweden OR Swedish OR Denmark OR Danish OR Norway OR Norwegian) |

### Inclusion and exclusion criteria

Articles were included in the review if they reported on; disability services, youth residential care, mental health intensive support, community nursing, aged care, restrictive practices, behaviour support, safeguarding, risk management, or duty of care. Articles published from 2012 to search date were included.

Excluded articles were those reporting on in-patient hospital care, primary outpatient care (via GP), specific to COVID-19 responses, articles not reported in English or studies that did not report results in full (including abstracts, conference proceedings and protocols).

After reviewing 494 original articles identified in this search, 9 met the inclusion criteria and were included in the review (Figure 3).

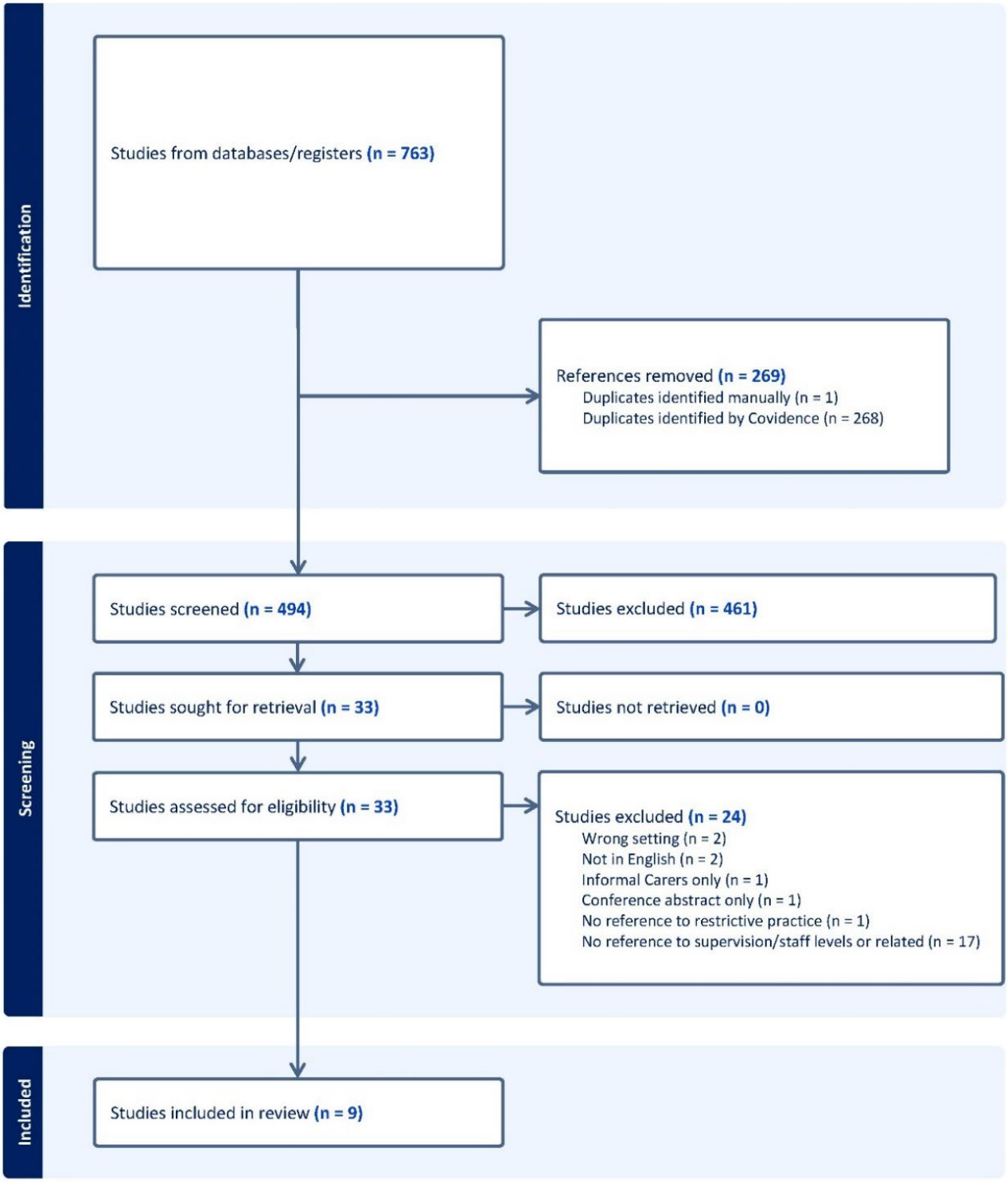


Figure 3: Restrictive practices PRISMA

## 3.3 Grey literature review

A comprehensive grey literature search was conducted to identify resources reporting on 1. Appropriate supervision, 2. Working in isolation, and 3. Restrictive practices. The first 20 pages of Google results (approximately 200 results) were reviewed to maximise resource capture.

The search strategy was designed to capture a diverse range of practical resources outside traditional peer-reviewed literature, such as reports, frameworks and commentaries from reputable sources including: NDIS, NDS, Australian Government Department of Social Services, state disability services, SA Health, Victoria State Government, Lived Experience Workforce Program (LEWP) (Mental Health Coalition of SA), and Safe Work Australia.

The grey literature identified and quality assessments are presented in the evidence review and consultation findings.

## 3.4 Consultation feedback

The evidence review is strengthened by expert advice from a range of perspectives to align it with contemporary practice expectations. This advice is integrated into the evidence review findings to address gap areas and support effective implementation.

An independent advisory group, comprising a range of stakeholder perspectives, contributed advice on the research design, emerging findings and ideas for practical implementation. A governance group within DHS also supported the project with alignment to the Enforceable Undertaking and ensuring the research informed wider goals of the Department.

Consultation was conducted in the final phase of the project to ensure the evidence aligned with practice. Thirty-one stakeholders took part in consultation, providing advice on the draft report and emerging findings. They represented a range of stakeholder perspectives, including:

supervisors and team leaders

- support workers
- managers of disability service organisations (government and non-government)
- family members of people with disability who use services
- advocates.

# 4. Evidence review findings

This section of the report presents the results of the evidence review and demonstrates how the evidence supports the findings on the appropriate span of control for isolated support workers employed in vulnerable work environments in the Australian work context and the best practice supervision ratios to ensure client and staff safety.

The evidence is presented in three sections: the most appropriate span of control and supervision for isolated support work; best practice supervision ratios to ensure client and staff safety; and implications of the evidence for supervision.

The current evidence base does not directly address risks to the person receiving care.

The available studies focus primarily on supervision of support workers and the organisational factors that shape appropriate span of control. We acknowledge that support staff have a duty of care to the people with disability who they support.

The perspectives and experiences of people receiving care remain essential to defining safe and rights-aligned supervision models. In this report, these insights are in part incorporated through stakeholder consultation and grey literature and embedded in the development of practical case studies. However, we note this missing perspective as a critical gap.

## 4.1 What is the most appropriate span of control and supervision for isolated support work?

### Direct evidence

From the systematic scoping review, only one article (Nickson et al., 2016) explicitly focused on isolated workers and their supervision needs. The study reports that isolated social workers experienced professional isolation, emotional strain, and lack of access to supervisors.

*Peer group supervision, using simple technology* (such as basic teleconferencing) was found to be effective to reduce isolation, enable reflective practice, strengthen practice confidence, provide emotional and professional support and create a shared professional identity for workers providing support to people with disability in rural and remote Australia (Nickson et al., 2016).

Nickson et al. (2016) reported that trust and psychological safety were essential for isolated workers to be able to speak openly about their experiences, *'a positive, trusting relationship is one in which difficulties related to practice could be raised without fear of censure'* (Pack, 2015, p. 1832). Nickson et al. (2016) recommended that *organisations should recognise peer supervision as a legitimate and important need to provide high quality support, protect time to allow supervision to occur and ensure that trust is developed between supervisors and support workers*. This evidence informs finding 1.1.

### Finding 1.1 Organisations should implement structured peer group supervision for isolated workers and ensure that it is delivered within a psychologically safe, trusting environment

| Finding | **Organisations should implement structured peer group supervision for isolated workers and ensure that it is delivered within a psychologically safe, trusting environment.** |
|---|---|
| Studies Contributing to the Finding | Nickson et al. (2016) |
| Methodological Limitations | **Moderate.** Small sample (n = 20); high attrition; data collected 2006–2007; qualitative interpretive design limits generalisability; participants withdrew due to workload pressures, indicating feasibility challenges. |
| Relevance | **High.** This is the only study directly examining supervision needs of isolated disability-related support workers in rural and remote contexts. |
| Coherence | **High.** Findings consistently show that peer supervision reduces isolation, strengthens confidence, and requires trust and psychological safety. No contradictory data found. |
| Adequacy of Data | **Moderate.** Rich qualitative data but limited to a single study; no quantitative outcomes; no data reported on supervision ratios or span of control. |
| Overall CERQual Assessment | Low–moderate confidence |
| Explanation of Confidence | Confidence is downgraded due to reliance on a single small study with attrition and contextual limitations. However, the evidence is directly relevant, coherent, and provides clear insights into effective supervision models for isolated workers. |

#### Limitations

The Nickson et al. (2016) review is limited by a small sample size (n = 20) and notable attrition, with several participants withdrawing due to competing workload demands. Although supervision was highly valued, organisational pressures and limited protected time prevented ongoing participation. As reported by the authors, participants withdrew because of *'competing work pressures on their time and being unable to give one hour a month to participate in supervision*. This finding highlights the practical feasibility challenges of implementing supervision models for isolated support workers, even when the intervention is perceived as beneficial.

## Indirect evidence

Several other studies included in the scoping review provide contextual evidence about supervision challenges in home-based, remote, or autonomous working environments and as such these have been included to support findings relating to an appropriate span of control.

### Finding 1.2 More frequent supervision is needed for isolated workers than team-based staff — Isolated workers require frequent and accessible supervision

Across the evidence, isolated support workers were described as operating with greater professional isolation, higher autonomous decision-making demands, increased exposure to WHS risks, and reduced access to immediate support. These conditions create a structural need for more frequent, accessible, and proactive supervision than is typically required in environments where workers spend most of their team working in teams.

Nickson et al. (2016) reported that isolated workers providing support to people with disability relied on structured peer supervision to counter professional isolation and maintain reflective practice, concluding that infrequent or ad-hoc supervision was insufficient. Similar evidence was described by Ekstedt et al. (2022) where home-care workers who often worked alone required timely decision support because they were routinely making autonomous decisions without access to on-site colleagues. Clibbens et al. (2024) further demonstrated that home-based crisis work required stronger clinical leadership and more intensive supervisory oversight due to the complexity and risk involved with isolated support work.

The evidence indicates that isolated workers face higher cognitive load, emotional strain and safety risk, and therefore require supervision that is not only more frequent but more readily available and responsive than supervision incorporated into work structures for staff embedded in team settings.

| **Finding** | **More frequent supervision is needed for isolated workers than team-based staff** |
|---|---|
| Studies Contributing to the Finding | Nickson et al. (2016); Ekstedt et al. (2022); Clibbens et al. (2024); |
| Methodological Limitations | **Moderate.** Nickson et al. (2016) uses action research with attrition; several studies are methodologically strong but supervision is not their primary focus; reliance on self-report in some studies; no experimental designs. |
| Relevance | **Minor concerns:** All studies involve isolated, lone, remote, or autonomous workers; only Nickson et al. (2016) directly examines supervision of isolated disability support workers. |
| Coherence | **Minor.** Findings consistently describe isolation, decision burden, emotional strain, and the need for structured, frequent support; no contradictory evidence. |
| Adequacy of Data | **Moderate.** Only one study directly examines supervision frequency; however, multiple studies provide rich, indirect evidence about isolation-related risks and the consequences of insufficient supervision. |
| Overall CERQual Assessment | Moderate confidence |
| Explanation of Confidence | Evidence is consistent, coherent, and highly relevant across isolated-work contexts. Confidence is downgraded due to limited direct studies on supervision frequency and methodological limitations in the primary study. |

### Finding 1.3 Support workers should have access to rapid decision-making support.

Ekstedt et al. (2022) reported that home-care support workers frequently encountered unexpected and time-critical situations that required immediate judgement. As they note, *'In unexpected situations, home care professionals had to improvise and make rapid decisions about what to do and who to call, which was not always straightforward.'* Working closely with support recipients, support workers often felt personally responsible for resolving emerging problems, even when these extended beyond their formal scope of responsibility.

The study emphasises that while frontline workers exercise significant autonomy in responding to risk, this autonomy cannot safely exist in isolation. Ekstedt et al. (2022) argue that *'increased decision-making autonomy has to be accompanied by functional resources and decision support through multiprofessional teams.'* This highlights the need for a structured decision- making process that supports rapid access to decision-making support**,** enabling support workers to make safe decisions in urgent situations.

| **Finding** | **Support workers should have access to rapid decision making support** |
|---|---|
| Studies Contributing to the Finding | Ekstedt et al. (2022) |
| Methodological Limitations | **Minor–moderate.** Ekstedt is a well-conducted qualitative study, but supervision was not its primary focus. Findings on urgent decision support arise from broader analysis of home-care work rather than a targeted supervision study. |
| Relevance | **Moderate.** The study directly examines isolated home-care workers who make autonomous decisions and face unexpected risks. The context closely aligns with isolated disability support work but reports on support workers for older people. |
| Coherence | **High.** The study consistently reports that workers "needed decision support because they worked alone and made autonomous decisions" and required "rapid access to supervisors when facing unexpected risks." No contradictory findings. |
| Adequacy of Data | **Moderate.** Rich qualitative data, but only one study contributes to the finding. No comparative or quantitative data on supervisory responsiveness. |
| Overall CERQual Assessment | Low–moderate confidence |
| Explanation of Confidence | Confidence is downgraded due to reliance on a single qualitative study and indirect focus on supervision. However, the evidence is direct, relevant, and coherent in showing that isolated workers require rapid supervisory access for urgent decision-making. |

### Finding 1.4 Supervision must be regular, planned, proactive, and provide timely feedback.

The evidence demonstrates that the quality and structure of supervision is critical to effective support work. Gur and Klein (2025) reported that supervision within disability services is often insufficient, inconsistent, or absent altogether, undermining workforce capability and service quality. They argue that supervision should be regular, planned, and specialised, including a clear focus on disability-specific practice. Similarly, Rothwell et al. (2021) identified the regularity of supervision and the timeliness of feedback as core enablers of effective practice, highlighting 'regular supervision with timely feedback' as essential for learning, accountability, and workforce confidence.

Together, these findings support the requirement that supervision should not be ad-hoc or reactive, but instead be structured, proactive, and designed to provide timely, constructive feedback that supports safe, high-quality care.

| **Finding** | **Supervision should be regular, planned, proactive and provide timely feedback** |
|---|---|
| Studies Contributing to the Finding | Gur and Klein (2025); Rothwell et al. (2021) |
| Methodological Limitations | **Moderate.** Gur and Klein (2025) includes heterogeneous studies, some not primarily focused on supervision; reporting quality varies and credibility checks were limited. Rothwell et al. (2021) is a rapid review with inconsistent reporting of primary study designs and no risk-of-bias assessment. |
| Relevance | **High.** Both reviews directly examine supervision practices in disability and health contexts. Gur and Klein (2025) focuses specifically on disability supervision; Rothwell examines enablers of effective clinical supervision across health professions. |
| Coherence | **High.** Both studies consistently identify regularity, planning, and timely feedback as essential components of effective supervision. No contradictory findings. |
| Adequacy of Data | **Moderate.** Only two reviews contribute to the finding; both provide rich conceptual data but limited depth on implementation frequency or models. Evidence is largely perceptual and based on qualitative or mixed-methods studies. |
| Overall CERQual Assessment | Moderate confidence |
| Explanation of Confidence | Evidence is consistent and directly relevant, showing that regular, planned supervision with timely feedback is essential for safe and effective practice. Confidence is downgraded due to methodological limitations and limited volume of high-quality primary studies. |

### Finding 1.5 Supervision must be protected and prioritised

Multiple studies report that when supervision is not formally prioritised, it is frequently displaced by workload pressures, with negative consequences for staff and service quality. Clibbens et al. (2024)

and Deveau and Rickard (2024) report that although supervision and team meetings are valued, staff often lack access to them because time pressures and workload lead to their deprioritisation. Ekstedt et al. (2022) further demonstrate that distance from supervisors in community-based care increases risk, highlighting supervision as essential for timely decision support.

Supervision is identified as a core component of safe staffing (McFadden, Davies, et al., 2024), while its absence contributes to burnout and intention to leave (McFadden, Maclochlainn, et al., 2024). Consistent with these findings, Gur and Klein (2025) report that supervision in disability services is frequently insufficient, inconsistent, or missing altogether, and Rothwell et al. (2021) identify protected time and organisational support as essential enablers.

Together, this evidence underscores the need for supervision to be explicitly scheduled, protected, and prioritised within organisational systems rather than treated as discretionary.

| **Finding** | **Supervision must be protected and prioritised** |
|---|---|
| Studies Contributing to the Finding | Clibbens et al. (2024); Deveau and Rickard (2024); Ekstedt et al. (2022); McFadden, Davies, et al. (2024); McFadden, Maclochlainn, et al. (2024); Gur and Klein (2025); Rothwell et al. (2021) |
| Methodological Limitations | **Moderate.** Several studies use small qualitative samples (Clibbens et al. (2024); Deveau and Rickard (2024); Ekstedt et al. (2022); McFadden, Davies, et al. (2024); McFadden, Maclochlainn, et al. (2024) rely on self-report; Gur and Klein (2025) includes heterogeneous studies with variable reporting quality; Rothwell is a rapid review without risk-of-bias assessment. However, all use appropriate methods for exploring supervision barriers. |
| Relevance | **High.** All studies directly address supervision access, organisational prioritisation, or structural barriers. Evidence spans disability services, home care, mental health crisis work, and social work — all highly relevant to isolated disability support contexts. |
| Coherence | **High.** All studies consistently report that supervision is deprioritised due to workload, administrative burden, distance, or organisational culture. They also consistently identify protected time and organisational commitment as essential for effective supervision. No contradictory findings. |
| Adequacy of Data | **Moderate.** Multiple studies provide rich qualitative data, but few directly evaluate structured or protected supervision models. Evidence is conceptually strong but limited in volume and depth. |
| Overall CERQual Assessment | Moderate confidence |
| Explanation of Confidence | Evidence is consistent, relevant, and coherent across multiple settings, demonstrating that supervision must be scheduled, protected, and prioritised to be effective. Confidence is downgraded due to methodological limitations and limited direct evaluation of protected supervision models. |

### Finding 1.6 Supervision must be disability-specific and be delivered by supervisors with relevant expertise

Evidence indicates that supervision is most effective when it is grounded in disability-specific knowledge and delivered by supervisors with appropriate expertise. (Gur & Klein, 2025) report that many disability support workers felt *'psychologically unprepared'* for their roles, with a low proportion having access to supervisors with autism-specific experience, highlighting gaps in specialist competence.

Rothwell et al. (2021) identify supervisor training as a core enabler of effective supervision, while Deveau and Rickard (2024) further note that frontline managers often lack training in practice leadership and feedback. Clibbens et al. (2024) similarly reported that staff frequently lacked training tailored to their specific service context, undermining confidence and quality of support. The importance of up-to-date, specialist training to support competent, individualised care and support is reinforced by Koelewijn et al. (2023), and MacLochlainn et al. (2025) which emphasises reflective supervision and compassionate, skilled line management as essential components of safe staffing.

Together, this evidence supports the need for supervision that is disability-specific and delivered by supervisors with relevant expertise.

| **Finding** | **Supervision must be disability-specific and be delivered by supervisors with relevant expertise** |
|---|---|
| Studies Contributing to the Finding | Gur and Klein (2025); Rothwell et al. (2021); Deveau and Rickard (2024); Clibbens et al. (2024); Koelewijn et al. (2023); MacLochlainn et al. (2025) |
| Methodological Limitations | **Moderate.** Gur and Klein (2025) includes heterogeneous studies with variable reporting quality; Rothwell et al. (2021) is a rapid review without risk-of-bias assessment; primary studies (Deveau and Rickard (2024), Clibbens et al. (2024), Koelewijn et al. (2023)) have small samples and contextual limitations. However, all use appropriate qualitative methods. |
| Relevance | **High.** Gur and Klein (2025) directly examines disability supervision; (Rothwell et al., 2021) addresses supervisor training; primary studies highlight the need for disability-specific competence and tailored supervision in disability and community-based contexts. |
| Coherence | **High.** All studies consistently report that workers lack disability-specific preparation, supervisors lack relevant expertise, and training is essential for effective supervision. No contradictory findings. |
| Adequacy of Data | **Moderate.** Multiple studies contribute rich qualitative data, but few directly evaluate disability-specific supervision models. Evidence is conceptually strong but limited in volume and depth. |
| Overall CERQual Assessment | Moderate confidence |
| Explanation of Confidence | Evidence is consistent, relevant, and coherent across reviews and primary studies, demonstrating that disability-specific expertise and supervisor training are essential for effective supervision. Confidence |

| Finding | Supervision must be disability-specific and be delivered by supervisors with relevant expertise |
|---|---|
| | is downgraded due to methodological limitations and limited direct evaluation of disability-specific supervision models. |

### Finding 1.7 Supervisors should be trained, skilled, and supported to deliver effective supervision

To ensure supervisors have the expertise required to provide disability specific supervision (Finding 1.6), organisations need to invest in structured training and ongoing support for supervisory roles.

The evidence indicates that supervisors require formal training in:

- disability-specific practice
- feedback and coaching
- reflective practice
- supported decision-making, and-
- rights-based approaches.

Gur and Klein (2025) and Rothwell et al. (2021) emphasise that effective supervision depends not only on individual capability but also on access to training, peer supervision, and organisational support. In addition, support for training and role development is recommended to facilitate continuity of care (Weaver et al. 2017).

| Finding | Supervisors should be trained, skilled, and supported to deliver effective supervision |
|---|---|
| Studies Contributing to the Finding | Gur and Klein (2025); Rothwell et al. (2021); Weaver et al. (2017); |
| Methodological Limitations | **Moderate.** Gur and Klein (2025) includes heterogeneous studies with variable reporting; Rothwell et al. (2021) is a rapid review without risk-of-bias assessment; primary studies have small samples and contextual limitations. However, all use appropriate qualitative or review methods. |
| Relevance | **High.** All studies directly address supervisor competence, training needs, rights-based practice, or organisational support. Evidence spans disability services, community care, mental health, and social work — all highly relevant to isolated disability support contexts. |
| Coherence | **High.** All studies consistently show that supervisors require training, manageable workloads, and organisational support to provide effective supervision. No contradictory findings. |
| Adequacy of Data | **Moderate.** Multiple studies provide rich qualitative data, but few directly evaluate supervisor training programs or competency frameworks. Evidence is conceptually strong but limited in volume. |

| Finding | Supervisors should be trained, skilled, and supported to deliver effective supervision |
|---|---|
| Overall CERQual Assessment | Moderate confidence |
| Explanation of Confidence | Evidence is consistent, relevant, and coherent across reviews and primary studies, demonstrating that supervisors must be trained, skilled, and supported. Confidence is downgraded due to methodological limitations and limited direct evaluation of training interventions. |

### Finding 1.8 Relational, trust-based, and psychologically safe supervision is high priority, underpinned by continuity of supervisory relationships

Effective supervision relies on strong, trust-based relationships that enable open reflection and psychological safety. Rothwell et al. (2021) emphasise that safe supervisory environments allow workers to raise personal concerns, ethical dilemmas, and practice uncertainties without fear of punitive consequences, and that supervision should be private, protected, and framed for reflective discussion. Gur and Klein (2025) similarly identify relationship-building with a consistent, core supervisor as essential to effective supervision in disability services. This is particularly important for isolated workers, for whom trust and psychological safety are critical enablers of safe practice (Nickson et al. 2016).

Conversely, unstable teams and high supervisory turnover undermine supervision, leadership, and learning Deveau and Rickard (2024). Workforce instability also disrupts continuity of care, reinforcing the role of supervision in stabilising teams and supporting consistent, high-quality practice (Koelewijn et al., 2023; Weaver et al., 2017).

Together, this evidence supports supervision models that prioritise relational continuity, trust, and psychological safety, particularly for workers operating in isolation.

| Finding | Relational, trust based, and psychologically safe supervision is high priority, underpinned by continuity of supervisory relationships |
|---|---|
| Studies Contributing to the Finding | Nickson et al. (2016); Rothwell et al. (2021); Gur and Klein (2025); Weaver et al. (2017); Koelewijn et al. (2023); Deveau and Rickard (2024) |
| Methodological Limitations | **Moderate.** Nickson et al. (2016) has a small sample and attrition; Rothwell is a rapid review with heterogeneous studies; Gur and Klein (2025) includes studies not primarily about supervision; Weaver et al. (2017) and Koelewijn et al. (2023) have contextual limitations; Deveau and Rickard (2024) is a small qualitative study. However, all use appropriate qualitative or review methods. |
| Relevance | **High.** All studies address relational aspects of supervision, psychological safety, or continuity. Nickson et al. (2016) focuses on isolated workers; Rothwell et al. (2021) and Gur and Klein (2025) examine supervision quality; Weaver et al. (2017) and Koelewijn et al. (2023) highlight the importance of continuity; Deveau and Rickard (2024) show how instability undermines relational supervision. |

| Finding | **Relational, trust based, and psychologically safe supervision is high priority, underpinned by continuity of supervisory relationships** |
|---|---|
| Coherence | **High.** All studies consistently show that trust, relational continuity, and psychological safety are essential for effective supervision. No contradictory findings. |
| Adequacy of Data | **Moderate.** Multiple studies provide rich qualitative data, but few directly evaluate relational supervision models. Evidence is conceptually strong but limited in volume. |
| Overall CERQual Assessment | Moderate confidence |
| Explanation of Confidence | Evidence is consistent, relevant, and coherent across reviews and primary studies, demonstrating that relational continuity, trust, and psychological safety are essential components of effective supervision. Confidence is downgraded due to methodological limitations and limited direct evaluation of relational supervision models. |

### Finding 1.9 Staff supervision must address worker isolation as a WHS risk, including structured check-ins, escalation pathways, and proactive monitoring.

Evidence consistently identifies worker isolation as a significant work health and safety risk that amplifies exposure to harm. Jepsen et al. (2025) describes isolation as a *risk multiplier* across hazards, noting that lack of timely supervisory access substantially increases WHS risk. Where formal supervision and safety structures are weak or absent, workers develop informal "buddy systems" to compensate, highlighting systemic gaps rather than resilient design (Farrelly et al., 2019). Distance from supervisors has been shown to deepen isolation and vulnerability (Holen-Rabbersvik et al., 2018), while studies of lone clinicians demonstrate that isolated roles are associated with high stress, unsafe decision burden, and lack of real-time support (Lenthall et al., 2018; Patynowska et al., 2023).

Together, this evidence supports treating worker isolation as a core WHS issue requiring structured supervisory check-ins, clear escalation pathways, and proactive monitoring, rather than reliance on ad hoc or informal arrangements.

| Finding | **Staff supervision must address worker isolation as a WHS risk** |
|---|---|
| Studies Contributing to the Finding | Jepsen et al. (2025); Farrelly et al. (2019); Holen-Rabbersvik et al. (2018); Lenthall et al. (2018); Patynowska et al. (2023); Ekstedt et al. (2022) |
| Methodological Limitations | **Moderate.** All studies use qualitative designs with small samples; some are single-site or context-specific; isolation and WHS risk are primary in some studies (Farrelly et al., 2019; Jepsen et al., 2025; Lenthall et al., 2018) but secondary in others (Ekstedt et al., 2022; Patynowska et al., 2023). However, methods are appropriate for exploring risk and supervisory needs. |
| Relevance | **High.** All studies involve isolated, lone, remote, or home-based workers whose WHS risk is directly shaped by lack of supervisory |

| Finding | Staff supervision must address worker isolation as a WHS risk |
|---|---|
| | access. Findings apply directly to disability and community-based support contexts. |
| Coherence | **High.** All studies consistently show that isolation increases WHS risk, that workers lack immediate access to supervisors, and that informal workarounds (e.g., buddy systems) emerge when formal supervisory structures are absent. No contradictory findings. |
| Adequacy of Data | **Moderate.** Multiple studies provide rich, detailed accounts of isolation-related risk, but none directly evaluate supervision models designed to mitigate WHS risk. Evidence is conceptually strong but limited in volume. |
| Overall CERQual Assessment | Moderate confidence |
| Explanation of Confidence | Evidence is consistent, relevant, and coherent across diverse isolated-work contexts, showing that isolation is a WHS risk requiring supervisory mitigation. Confidence is downgraded due to methodological limitations and limited direct evaluation of supervision as a WHS intervention. |

### Finding 1.10 Supervisors must have manageable spans of control to provide effective supervision

Evidence indicates that excessive supervisory spans of control significantly undermine the quality and effectiveness of supervision. Svanström et al. (2025) report that expanded spans of control reduce supervisors' capacity to engage in meaningful oversight, timely feedback, and relational supervision. Deveau and Rickard (2024) similarly report that supervisors responsible for between five and 25 staff lacked the time and availability to provide effective supervision, with competing demands displacing reflective and developmental support. McFadden, Maclochlainn, et al. (2024) further highlight that overwhelmed supervisors were unable to deliver adequate supervision or provide the contextual support required for safe practice. This is particularly critical for isolated support workers, for whom supervision functions as a key safety mechanism in the absence of immediate peer support.

Together, this evidence underscores the need for intentionally limited spans of control to enable supervisors to maintain regular contact, provide timely guidance, and respond effectively to emerging risks in dispersed or lone-working contexts.

| Finding | Supervisors must have manageable spans of control to provide effective supervision |
|---|---|
| Studies Contributing to the Finding | Svanström et al. (2025); Deveau and Rickard (2024); McFadden, Maclochlainn, et al. (2024) |
| Methodological Limitations | **Moderate.** Svanström et al. (2025) uses repeated cross-sectional surveys with low response rates; Deveau and Rickard (2024) is a small qualitative study with selection bias; McFadden, Maclochlainn, et al. (2024) relies on self-report survey data. None directly measure |

| Finding | Supervisors must have manageable spans of control to provide effective supervision |
|---|---|
| | "optimal" span of control, but all provide credible evidence on supervisory capacity. |
| Relevance | **High.** All studies examine supervisory workload, capacity, and the impact of span of control on supervision quality. Findings apply directly to disability and community-based contexts where supervisors oversee dispersed or isolated staff. |
| Coherence | **High.** All studies consistently show that larger spans of control reduce supervisors' ability to observe practice, provide feedback, maintain relationships, and support staff wellbeing. No contradictory findings. |
| Adequacy of Data | **Moderate.** Evidence is rich but limited to three studies; none provide numeric thresholds for isolated work. However, all offer detailed qualitative or quantitative data showing the negative effects of large spans of control. |
| Overall CERQual Assessment | Moderate confidence |
| Explanation of Confidence | Evidence is consistent, relevant, and coherent across multiple settings, showing that supervisors require manageable spans of control to deliver effective supervision. Confidence is downgraded due to methodological limitations and limited volume of studies directly examining span of control in isolated disability support work. |

## Grey literature

The grey literature resources supported the findings from the academic evidence. The following resources were found to conclude that appropriate supervision for isolated support work requires *frequent, planned, relational, and readily accessible supervision*, delivered by supervisors with *manageable spans of control* and should be supported by structured supervision plans 'tailored to the practitioner's context, experience and risk.' (Regional Local Health Network, 2023).

| Resource | Relevant finding |
|---|---|
| Regional Local Health Network Allied Health Professional Supervision Framework | The SA Health Regional LHN Allied Health Professional Supervision Framework (Regional Local Health Network, 2023) provides a practical, organisation-wide approach to ensuring safe, high-quality supervision for allied health professionals. **This resource emphasises that supervision must be planned, documented, and regularly reviewed through formal supervision plans tailored to each practitioner's role, experience, and risk context.**<br><br>It outlines clear goal-oriented expectations for supervisors and supervisees, promotes reflective practice, and requires accessible, timely supervision supported by multiple modalities (face-to-face, phone, telehealth). Noting that supervision should emphasise teaching and learning at the point of care and support. |

| Resource | Relevant finding |
|---|---|
| | The framework positions supervision as a core component of professional governance, mandating that supervisors have the capacity, capability, and workload flexibility to provide effective oversight- an approach that inherently limits span of control and reinforces the need for more frequent, structured supervision for practitioners working in isolated or high-risk environments. |

### AACORD

| Domain | Assessment |
|---|---|
| Authority | **High.** The framework is produced by SA Health, a state government health authority responsible for clinical governance, workforce capability, and service quality across South Australia. It reflects formal organisational policy and aligns with national allied health supervision standards. |
| Accuracy | **Moderate to High.** The framework is consistent with established supervision literature, national allied health professional standards, and recognised models of reflective practice. |
| Coverage | **Moderate.** The framework provides comprehensive guidance on supervision structures, roles, responsibilities, supervision plans, documentation, frequency, and governance. It covers reflective practice, risk-based tailoring, and expectations for both supervisors and supervisees. However, it does not address supervision **ratios** or **span of control** numerically, and it is focused on allied health rather than disability support workers specifically. Coverage is strong for supervision processes but narrower for workforce modelling. |
| Objectivity | **High.** The document is policy-oriented, descriptive, and procedural, with no commercial interests. Its purpose is to standardise safe and effective supervision across a public health workforce. The tone is neutral and governance-focused, with no advocacy or promotional bias. Recommendations are framed around safety, quality, and professional standards. |
| Relevance | **High.** Although written for allied health professionals, the framework is highly relevant:<br>• addresses supervision in rural, remote, and isolated contexts<br>• mandates structured supervision plans<br>• requires supervision intensity to be tailored to risk and practitioner experience |

| Domain | Assessment |
|---|---|
| | • emphasises supervisor **capacity and workload limits**, which directly informs span-of-control considerations<br>The principles described in this framework translate well to isolated disability support work and support the scientific evidence. |
| Date | **Recent (2023).** The framework is current and reflects contemporary supervision expectations within SA Health. It aligns with modern governance and reflective practice standards. No outdated content is evident. |

The 'Supervision and Support for Allied Health Professionals and Therapy assistants working remotely in disability' resource (detailed below) expanded on the findings identified in the scientific literature. This resource supports the inclusion of the following findings:

### Finding 1.11 Flexible and multimodal supervision extends good practice

The resource emphasises a wide range of supervision models:

- direct, indirect, and remote supervision
- peer supervision
- group supervision
- cross-organisation supervision
- co-ops for sole traders.

This expands the evidence base by demonstrating that span of control needs to consider the supervisor's ability to maintain multiple modes of contact and support. *However, it should be noted that this finding is informed only by grey literature resource. The AACORD quality for this resource is moderate to high*.

### Finding 1.12 Clear role boundaries and delegation frameworks are required

The 'Supervision and Support for Allied Health Professionals and Therapy assistants working remotely in disability' resource (detailed below) highlights the need for clear roles and responsibilities, and frameworks established to ensure the difference between supervision, line management and mentoring is clear. Delegation frameworks are recommended to match tasks to competence and scope of practice, tailored to foreseeable changes in staffing and service delivery. The appropriateness of delegations must be considered based on the alignment between degree of expertise and experience relevant to task complexity, level of risk and degree of judgment to be exercised. *However, it should be noted that this finding is informed only by grey literature resource. The AACORD quality for this resource is moderate to high*.

| Resource | Relevant finding |
|---|---|
| Supervision and Support for Allied Health Professionals and Therapy assistants working | This resource (National Disability Services, n.d.-b) provides practical, operational strategies for supervising isolated and remote workers, emphasising that remote supervision requires more intentional structure, flexible models, multiple modalities, trained supervisors, clear delegation frameworks, and organisational support systems. It reinforces that supervision intensity must increase when workers are isolated, and that |

| Resource | Relevant finding |
|---|---|
| remotely in disability | supervisors must have capacity and capability, which inherently limits span of control. |

### AACORD

| Domain | Assessment |
|---|---|
| Authority | **Moderate to High.** Produced by National Disability Services (Piper), the peak body for non government disability service providers. While not a government regulatory document, it is sector credible and widely used in disability workforce development. |
| Accuracy | **Moderate.** The resource is practical and consistent with accepted supervision principles. It does not cite empirical research but aligns with recognised supervision frameworks (e.g., SA Health, HETI, SARRAH). Content is accurate for operational guidance. |
| Coverage | **Moderate.** Provides extensive strategies for remote supervision, including training, technology, flexible models, delegation, mentoring, and communities of practice. However, it does not address governance structures, supervision frequency standards, or span of control modelling. |
| Objectivity | **High.** The document is descriptive, practical, and non commercial. It presents strategies without advocacy bias and does not promote specific products or services. |
| Relevance | **High.** Directly addresses supervision of remote, isolated, and sole practitioner disability workers, making it highly relevant to your review question. It provides concrete strategies that demonstrate why isolated workers require more structured and frequent supervision. |
| Date | **Recent (implied).** Although not dated, the content reflects current supervision practices. No outdated concepts are present. |

| Resource | Relevant finding |
|---|---|
| Mental Health Peer Supervision Framework | This resource (Lived Experience Workforce Program, 2022) emphasises that effective supervision for lived-experience workers must be relational, psychologically safe, reflective, regular, and structured through supervision agreements. It highlights that supervisors must have capacity, training, and time to build trust and maintain reflective practice. These requirements imply that span of control must be small and capacity-based, because relational and reflective supervision cannot be delivered at scale or through large supervisor-to-worker ratios. |

### AACORD

| Domain | Assessment |
|---|---|
| Authority | **High.** Developed by the Lived Experience Workforce Program (LEWP) and Mental Health Coalition of South Australia, representing peak bodies for lived-experience practice. The framework is sector-endorsed and widely referenced in mental health peer workforce development. |
| Accuracy | **High.** The framework aligns with established principles of reflective practice, trauma-informed supervision, and peer-led models. It provides clear definitions, structured processes, and evidence-aligned expectations for safe supervision. While not research-heavy, its content is consistent with accepted best practice. |
| Coverage | **Moderate to High.** Provides comprehensive guidance on supervision purpose, structure, agreements, roles, reflective practice, and psychological safety. It does not address numeric supervision ratios or workforce modelling, but offers strong conceptual coverage of *how* supervision should occur. |
| Objectivity | **High.** The framework is non-commercial, practice-oriented, and grounded in lived-experience values. It presents balanced, principle-based guidance without advocacy bias or promotional content. |
| Relevance | **High.** Highly relevant as workers often operate in isolated, autonomous, emotionally demanding roles, requiring frequent, relational, and reflective supervision. The framework strongly supports the conclusion that supervisors must have small, manageable spans of control to maintain psychological safety and relational depth. |
| Date | **Recent (2022).** Reflects contemporary supervision practice, including trauma-informed and peer-informed approaches. No outdated content. |

| Resource | Relevant finding |
|---|---|
| The Allied Health Disability Workforce Strategy and Action Plan | The resource (National Disability Services, n.d.-a) highlights that isolated allied health and support workers require more structured, frequent, and accessible supervision due to professional isolation, thin markets, and limited onsite support. It emphasises that effective supervision must include regular mentoring, CPD access, telepractice-enabled supervision, and participation in communities of practice. Supervisors need manageable workloads to provide this level of oversight, particularly when supervising AHAs or support workers who rely on AHPs for guidance, escalation, and skill development. Although the document does not specify numeric supervision ratios, it clearly implies that smaller spans of control are necessary in isolated contexts to maintain safety, quality, and professional support. |

### AACORD

| Domain | Assessment |
|---|---|
| Authority | **Moderate to High.** Produced by National Disability Services (Piper), the peak body for non-government disability service providers. Developed through statewide consultation with AHPs, providers, and government stakeholders. Not a regulatory document, but sector-credible and widely used in workforce planning. |
| Accuracy | **Moderate.** The strategy is evidence-informed and based on extensive consultation and workforce data. It aligns with accepted supervision principles (e.g., structured support, mentoring, telepractice). However, it does not cite empirical research or provide detailed supervision standards. |
| Coverage | **Moderate.** Provides substantial discussion of workforce challenges, supervision access, mentoring, CPD, telepractice, and support structures for isolated practitioners. Does **not** provide numeric supervision ratios, span-of-control modelling, or detailed supervision frameworks for disability support workers. |
| Objectivity | **High.** The document is strategic and developmental, not commercial. It presents system-level workforce issues and solutions without advocacy bias or promotion of specific services. |
| Relevance | **High.** Directly addresses supervision challenges for **isolated allied health and support workers** in rural and remote Tasmania. Strongly reinforces that isolation increases the need for **structured, frequent, and supported supervision**, implying smaller spans of control. |
| Date | **2018 (recent).** While several years old, the content remains aligned with current NDIS workforce challenges (thin markets, telepractice, supervision access). No outdated concepts are present. |

### Finding 1.13 Span of control and supervision models must enable workers to meet their obligations under the NDIS Code of Conduct.

The NDIS Code of Conduct details the behavioural expectations to support these findings. The Code of Conduct sets clear practice expectations for disability support workers, highlighting values-based expectations are developed and sustained through relational supervision.

| Resource | Relevant finding |
|---|---|
| NDIS Code of Conduct | The NDIS Code of Conduct (National Disability Insurance Scheme, n.d.) requires workers to act with respect for rights, uphold dignity, support self-determination, communicate in ways that enable people to express their will and preferences, act with integrity, and prevent harm. These expectations are inherently values-based and require ongoing supervisory reinforcement to translate into everyday practice. |

#### AACORD

| Domain | Assessment |
|---|---|
| Authority | **High.** The Code is established under the *NDIS Act 2013* and regulated by the NDIS Quality and Safeguards Commission. It is a mandatory, legislated instrument governing all NDIS workers and providers, giving it the highest level of regulatory authority. |
| Accuracy | **High.** The Code is grounded in human rights principles (including CRPD) and provides clear, normative behavioural expectations. While not empirical evidence, its statements are accurate for their purpose: defining safe, ethical, rights-aligned conduct. |
| Coverage | **Moderate.** The Code outlines essential values and behavioural expectations but does not provide operational detail on supervision, span of control, or organisational systems. It is foundational but not comprehensive for workforce design. |
| Objectivity | **High.** Developed through statutory processes, the Code is neutral, regulatory, and not advocacy-driven. Its purpose is safeguarding, compliance, and rights protection. |
| Relevance | **High.** The Code sets the minimum behavioural and ethical expectations for all disability support workers, including those working alone. It directly informs supervision requirements because relational supervision is a key mechanism for embedding the Code's values in day-to-day practice. |
| Date | **2018.** Introduced in 2018 and remains current. Reinforced through ongoing Commission guidance and capability frameworks. |

The National Disability Services co-design program for foundations for a 1:1 line-of-sight supervision tool for support workers was conducted in parallel with this evidence review. Findings from this co-design practice project emphasise that effective line-of-sight oversight and support is 'supported by a combination of environmental awareness, clear worker prompts, good communication, practical documentation and strong supervisory oversight rather than any single mechanism alone' (National Disability Services, 2026).

| Resource | Relevant finding |
|---|---|
| NDS Foundations for 1:1 Line-of-Sight Supervision Tool [in press] | 1:1 line-of-sight supervision (National Disability Services, 2026) is a complex and context-dependent practice that requires more than proximity alone. No single tool is sufficient and that the most effective approach combines practical prompts, environmental awareness, documentation and strong organisational support. Tools should be understood as support to good practice, not substitutes for worker judgement, training, supervision or provider responsibility. |

### AACORD

| Domain | Assessment |
|---|---|
| Authority | **Moderate to High.** Produced by National Disability Services (Piper), the peak body for non-government disability service providers. Developed through consultation with providers, and government stakeholders. Not a regulatory document, but sector-credible and widely used in workforce planning. |
| Accuracy | **Moderate.** The report provides clear, normative behavioural expectations. While not empirical evidence, its statements are accurate for their purpose: defining practical guidance for improving process and policy. No empirical evidence is cited to support recommendations. |
| Coverage | **Moderate.** Provides discussion of workforce challenges, supervision access, mentoring, CPD, telepractice, and support structures for isolated practitioners. Does **not** provide numeric supervision ratios, span-of-control modelling, or detailed supervision frameworks for disability support workers. |
| Objectivity | **High.** The document is focused on identifying practical tools to progress safety in isolated support work contexts. It presents operational-level workforce issues and solutions without promotion of specific services. |
| Relevance | **High.** Directly addresses supervision challenges for **isolated disability support workers** in South Australia. Strongly reinforces that tools cannot be a solution alone and need to be implemented as part of a suite of measures, implying smaller spans of control. |
| Date | 2026 – publication concurrent with this report |

## Consultation feedback

Stakeholders were presented with the draft findings 1.1 to 1.13 and a summary of the supporting evidence. Overall, the evidence suggested that supervision of isolated support workers should be more frequent, skilled, relational and explicitly designed to counteract isolation-related risk.

Stakeholders were supportive of the findings and insights for practice encouraging planned, regular, relational and safe environments to allow support workers to raise uncertainty, mistakes and practice concerns without fear of punishment. This was seen as an opportunity to upskill support workers and improve the support they provide.

Stakeholders viewed the finding around peer group supervision (1.1) as a promising and useful approach particularly for dispersed workers. However, they noted that these models take time, resourcing and careful design to ensure they are effective and operate with quality.

The need for support workers to access rapid decision-making supports (Finding 1.3) was discussed in depth. Organisations reported different setups and needs depending on their size and services. They reported having clear escalation frameworks to support rapid access to support, one provider described 24-hour hotline available to provide such supports. The term ‘escalation’ (Finding 1.9) was viewed by the group as jargon and needed clarification. In-response, escalation has been clearly defined in the glossary of this report.

Discussion around supervisory relationships (Finding 1.8) indicated that continuity of such relationships was important but difficult to sustain in practice. Stakeholders noted that workforce movement, changing funding, casual staffing and multiple service locations make continuity challenging. A distinction was raised between line management and practice supervision, suggesting that these functions may need to be considered separately.

Stakeholders considered cultural responsiveness as a core requirement of effective supervision. Supervisory relationships were reported to be influenced by cultural norms around authority, hierarchy, feedback, and help-seeking, and these dynamics can affect whether workers feel able to speak openly. Supervision models should therefore recognise and respond to cultural expectations, ensuring that all workers can raise concerns safely, confidently, and without fear of negative consequences.

Stakeholders provided feedback that flexible and multimodal supervision (Finding 1.11) required clearer explanation. Stakeholders sought clarification about whether face-to-face supervision is considered best practice. The discussion suggested that face-to-face remains valuable, but phone, online and other modes may improve access and make supervision more achievable for isolated workers. In response the term multimodal supervision has been clearly defined in the glossary of this report.

While stakeholders strongly supported the recommended approaches to strengthen safety and practice quality, they expressed concerns about feasibility within current levels of funded time available for both supervisors and workers. Current funding models and workforce structures—such as part-time shift patterns, 24-hour rosters, casualised workforces, and staff working across multiple services—make it difficult for organisations to maintain consistent supervisory relationships and reliably meet supervision expectations.

## Summary

These findings and practice insights are informed by a synthesis of direct evidence, indirect evidence, relevant grey literature and stakeholder consultation. While the quality and depth of available evidence vary, the overall body of findings provides sufficient support to outline key principles for determining an appropriate span of control for disability support workers operating in isolation.

### Key findings summary: Appropriate span of control and supervision for isolated support work

| Number | Finding |
|---|---|
| Source: Published scientific evidence | |
| 1.1 | Organisations should implement structured peer group supervision for isolated workers and ensure that it is delivered within a psychologically safe, trusting environment |
| 1.2 | More frequent supervision is needed for isolated workers than team-based staff<br>- Isolated workers require frequent and accessible supervision |
| 1.3 | Support workers should have access to rapid decision-making support |
| 1.4 | Supervision must be regular, planned, proactive, and provide timely feedback. |
| 1.5 | Supervision must be protected and prioritised |
| 1.6 | Supervision must be disability-specific and be delivered by supervisors with relevant expertise |
| 1.7 | Supervisors should be trained, skilled, and supported to deliver effective supervision |
| 1.8 | Relational, trust-based, and psychologically safe supervision is high priority, underpinned by continuity of supervisory relationships (especially for isolated workers). |
| 1.9 | Staff supervision must address worker isolation as a WHS risk, including structured check-ins, escalation pathways, and proactive monitoring. |
| 1.10 | Supervisors must have manageable spans of control to provide effective supervision |
| Source: Grey literature | |
| 1.11 | Flexible and multimodal supervision extends good practice |
| 1.12 | Clear role boundaries and delegation frameworks are required |
| 1.13 | Span of control and supervision models must enable workers to meet their obligations under the NDIS Code of Conduct. |
| Source: Consultation feedback | |
| Considerations for practice and implementation | Stakeholders agreed that supervision for isolated workers must be *more frequent, skilled, relational,* and explicitly designed to counteract isolation-related risk.<br>Strong support for planned, regular supervision delivered in psychologically safe environments where workers can raise uncertainty, mistakes, and practice concerns without fear of punishment. Seen as an opportunity to upskill workers and improve care quality. |

| Number | Finding |
| --- | --- |
| | Peer group supervision was viewed as promising, especially for dispersed workforces. Stakeholders emphasised that peer models require time, resourcing, and careful design and support to be effective and operate with quality.<br><br>Stakeholders agreed continuity of supervisory relationships is important but difficult to maintain due to workforce movement, funding changes, casual staffing, and multiple service locations. They highlighted the need to distinguish line management from practice supervision.<br><br>Stakeholders considered cultural responsiveness as essential to supervision models to ensure culturally safe communication.<br><br>Stakeholders noted face-to-face supervision remains valuable, but phone, online, telehealth, and video modes improve access for isolated workers. |

## 4.2 What are the best practice supervision ratios to ensure staff and client safety in isolated support work?

### Direct evidence

The evidence supports the need for supervisors' spans of control to be manageable enough to provide frequent, proactive, relational contact and rapid support (as per Finding 1.10.) In addition, Jepsen et al. (2025) suggest that worker isolation should be treated as a core WHS risk rather than an individual problem to be managed.

Jepsen et al. (2025) report that isolated home-care and disability support workers face significant WHS risks, including aggression, boundary violations, unpredictable environments, and lack of information- while working alone. These findings support the notion that isolated workers require *more intensive, lower supervision ratios* than standard staffing models, because safety depends on rapid access to supervisors, proactive oversight, and reduced lone-work burden.

#### Finding 2.1 Supervision ratios for isolated support workers must be lower than standard ratios to ensure adequate oversight, timely decision support and safe practice

| **Finding** | **Supervision ratios for isolated support workers must be lower than standard ratios to ensure adequate oversight, timely decision support and safe practice.** |
|---|---|
| Studies Contributing to the Finding | Ekstedt et al. (2022); Jepsen et al. (2025); Holen-Rabbersvik et al. (2018); Farrelly et al. (2019); Lenthall et al. (2018) |
| Methodological Limitations | **Moderate.** All included studies use qualitative or mixed-methods designs. They are appropriate for exploring worker experience but have small samples, self-report bias, and limited reflexivity reporting. |
| Relevance | **Minor–moderate.** The studies span aged care, disability, rural nursing, and inter-municipal services across Sweden, Australia, Ireland, and Norway. All involve isolated, community-based, lone-worker models, directly relevant to isolated disability support work, though not identical. |
| Coherence | **Minor.** Findings across all studies converge strongly: isolation increases risk, and team-based or closely supervised structures reduce it. |
| Adequacy of Data | **Moderate.** There is rich qualitative evidence describing the risks of isolation and the protective effect of closer supervision. However, no study provides numeric supervision ratios. Standard ratios are not numerically defined. |
| Overall CERQual Assessment | **Low–moderate.** Evidence is consistent across multiple countries and service models, directly relevant to isolated support work but does not provide explicit ratios |
| Explanation of Confidence | Evidence is consistent across multiple countries and service models and directly relevant to isolated support work. However, the absence |

| Finding | **Supervision ratios for isolated support workers must be lower than standard ratios to ensure adequate oversight, timely decision support and safe practice.** |
|---|---|
| | of quantitative ratio data and reliance on qualitative studies limits precision. |

### Limitations

The scientific evidence from isolated-work studies demonstrate supervision ratios should be lower for isolated workers. However, the evidence is qualitative in nature, context specific and does not support recommendations for numerical supervision ratios. Standard supervision ratios are not defined.

## Grey literature

The grey literature provides numeric guidelines and commentary to support rationales behind appropriate supervision ratios in relation to current practice:

| Resource | Relevant finding |
|---|---|
| Span of Control: What factors should determine how many direct reports a manager has?<br><br>No single ideal number of direct reports exists | The article (Society for Human Resource Management, 2013) published by the Society for Human Resource Management, reports that no single ideal number of direct reports exists. Instead, organisations should determine span of control by assessing task complexity, workforce capability, organisational size and culture, and the manager's actual responsibilities.<br><br>Narrow spans support closer supervision; wide spans support autonomy but risk overload.<br><br>*NB- refers to theories of span of control for management rather than specific findings related to disability support. |

### AACORD

| Domain | Assessment |
|---|---|
| Authority | **Moderate to High.** The Society for Human Resource Management SHRM is a long standing, internationally recognised professional body for HR practice. Content is produced or reviewed by HR experts and practitioners. The archived page is part of SHRM's HR Q&A knowledge base, which is considered sector credible. |
| Accuracy | **Moderate.** The resource accurately summarises accepted management theory (e.g., span-of-control principles, classic organisational design concepts). It is conceptually sound but not empirically referenced. Assertions are consistent with mainstream organisational behaviour literature but lack citations to primary research. |
| Coverage | **Moderate.** Provides a concise overview of key determinants of span of control (task complexity, workforce capability, organisational size, culture, managerial responsibilities). Does not provide quantitative |

| Domain | Assessment |
|---|---|
| | guidance, sector-specific considerations, or detailed operational models. Useful but not comprehensive. |
| Objectivity | **High.** The content is descriptive, neutral, and non-commercial. It does not promote specific products, consulting services, or organisational models. Tone is informational rather than advocacy-driven. |
| Relevance | **Moderate to High.** Directly relevant to inform supervision and span of control in isolated disability support work. Reinforces that span of control must be context-driven, shaped by complexity, risk, and supervisory load—not fixed ratios. However, is not disability context specific. |
| Date | **2013.** An older resource. However, span-of-control principles are relatively stable over time. Still, the age limits applicability for contemporary policy settings and modern workforce structures. |

| Resource | Relevant finding |
|---|---|
| Frontline Leader Organisational Designs and Span of Control (Ability First/DSS)<br><br>Recommends 7:1 for disability frontline leaders | Notes that there is no correct, one size fits all span of control, discusses reports from Society for Human Resource Management (2013) Span of Control: What factors should determine how many direct reports a manager has? (resource reported above) Appropriate ratios depend on factors such as the nature of the work, worker skills, service complexity and geographic distribution.<br><br>The current NDIS model embeds a supervision allowance based on a 15:1 ratio (15 Disability Support workers per Frontline Leader).<br><br>This resource (Department of Social Services, 2020) identified large variations across providers (4:1 to 90:1) driven by workforce casualisation, service models and organisational design (noting that casual and part time workers increase headcount for supervisors).<br><br>Providers are reporting that 11:1, 15:1 ratios are too high. Best practice models from public sector organisations are much narrower (7:1 to 10:1).<br><br>The report concludes that 7:1 is likely to be a suitable best-practice ratio for disability service Frontline Leaders. |

### AACORD

| Domain | Assessment |
|---|---|
| Authority | **High.** Produced by Ability First/DSS, with direct access to provider data and sector expertise. Authored/commissioned by organisations with legitimate authority over disability service design. |

| Domain | Assessment |
|---|---|
| Accuracy | **Moderate–high.** Draws on reported provider ratios (4:1 to 90:1) and compares them with public sector benchmarks (7:1–10:1). Internal logic is consistent and grounded in real-world operational data. |
| Coverage | **Moderate.** Focused specifically on frontline leader span of control in disability services. Provides useful detail on variation (4:1–90:1) and NDIS assumptions (15:1), but does not present formal outcome data (e.g. safety incidents) linked to specific ratios. |
| Objectivity | **Moderate.** The document has a clear normative stance (15:1 is too high; 7:1 is best practice), but this is justified with sector feedback and comparison to public sector models. |
| Relevance | **High.** Directly addresses span of control for disability frontline leaders |
| Date | **Recent 2020 (Moderate–high).** Context refers to current NDIS pricing model and contemporary provider experience. Assuming publication within the last few years, temporal relevance is high for current policy settings. |

| Resource | Relevant finding |
|---|---|
| Health Services Union Submission: 2023-24 NDIS Annual Price Review to NDIS Workforce Inquiry<br><br>Recommends lower spans of control than 1:11 to 1:15 | This resource (Health Services Union, 2024) reports that ***'the expansion of spans of control from 1:11 to 1:15 has had destructive impacts on participants and the NDIS workforce.'***<br><br>HSU national recommend that assumed spans of control for supervisors need to remain low.<br><br>HSU Recommendation: Immediate increases to supervisor spans of control that ensure workers can be feasibly observed and participants better supported with in depth consultation with the NDIS Quality and Safeguards Commission. |

### AACORD

| Domain | Assessment |
|---|---|
| Authority | **High.** Produced by a major union representing disability and health workers. Strong legitimacy as a voice on workforce conditions and supervision impacts. |
| Accuracy | **Moderate.** Claims are based on member experience and internal evidence, but methods and data are not detailed. Statements are plausible and consistent with other evidence, but should be treated as **advocacy-oriented** rather than neutral empirical reporting. |

| Domain | Assessment |
|---|---|
| Coverage | **Moderate.** Focused on spans of control (1:11 to 1:15) and their impacts on participants and workforce. Provides clear recommendations (keep spans low; ensure workers can be feasibly observed), but does not quantify outcomes or provide detailed analytic methods. |
| Objectivity | **Low–moderate.** This is an advocacy submission with a clear agenda (improved conditions, lower ratios). The tone and framing are explicitly normative. It should be balanced with other sources. |
| Relevance | **High.** Directly addresses supervision spans of control in NDIS, explicitly linking higher ratios (1:15) to negative impacts on participants and workers. |
| Date | **High.** Submission to the **2023–24** NDIS Annual Price Review |

| Resource | Relevant finding |
|---|---|
| Supervision and Support for Allied Health Professionals and Therapy assistants working remotely in disability | This resource (National Disability Services, n.d.-b) provides practical, operational strategies for supervising isolated and remote workers, emphasising that remote supervision requires more intentional structure, flexible models, multiple modalities, trained supervisors, clear delegation frameworks, and organisational support systems. It reinforces that supervision intensity must increase when workers are isolated, and that supervisors must have capacity and capability, which inherently limits span of control. |

### AACORD

| Domain | Assessment |
|---|---|
| Authority | **Moderate to High.** Produced by National Disability Services (Piper), the peak body for non-government disability service providers. While not a government regulatory document, it is sector-credible and widely used in disability workforce development. |
| Accuracy | **Moderate.** The resource is practical and consistent with accepted supervision principles. It does not cite empirical research but aligns with recognised supervision frameworks (e.g., SA Health, HETI, SARRAH). Content is accurate for operational guidance. |
| Coverage | **Moderate.** Provides extensive strategies for remote supervision, including training, technology, flexible models, delegation, mentoring, and communities of practice. However, it does not address governance structures, supervision frequency standards, or span-of-control modelling. |
| Objectivity | **High.** The document is descriptive, practical, and non-commercial. It presents strategies without advocacy bias and does not promote specific products or services. |

| Domain | Assessment |
|---|---|
| Relevance | **High.** Directly addresses supervision of remote, isolated, and sole-practitioner disability workers, making it highly relevant to your review question. It provides concrete strategies that demonstrate why isolated workers require more structured and frequent supervision. |
| Date | **Recent** (implied). Although not dated, the content reflects current supervision practices. No outdated concepts are present. |

These resources suggest that supervision ratios of 1:11 to 1:15 negatively impact the quality of support provided to people with disability. The Health Service Union submission recommends lower spans of control that ensure that workers can be observed and supported to deliver care. The Frontline Leader Organisational Designs and Span of Control resource agrees that supervision ratios of 1:11 is too high, and that best practice models from public sector organisations are much narrower ranging from 1:7 to 1:10.

The Supervision and Support of Allied Health Professionals and Therapy Assistants working remotely in Disability resource reinforces that supervision intensity must increase when workers are isolated, and that supervisors must have capacity and capability, which inherently limits span of control.

On a practical level, SHRM demonstrate that specific ratios for supervision for disability support workers are not suitable. To ensure safe practice, providers should determine span of control by assessing task complexity, workforce capability, organisational size and culture, along with the managers usual role and responsibilities.

### Finding 2.2 Supervision ratios in isolated disability support work should be capability-based and risk-responsive, not cost-driven or numerically fixed.

To determine appropriate supervision ratios organisations should consider:

- Task complexity - Higher-risk, variable or non-routine work requires smaller spans of control.
- Workforce capability - Less experienced or less autonomous staff require closer supervision and therefore smaller supervision ratios are required.
- Managerial responsibilities - Supervisors with significant administrative, strategic or compliance duties require fewer direct reports to maintain effectiveness.
- Organisational culture and structure - Cultures emphasising autonomy may support wider spans; cultures emphasising oversight, development and safety require narrower spans.
- Organisational size and resources – Smaller organisations may widen spans for cost reasons, but this must not compromise safety or supervisory quality.

## Indirect evidence

None of the scientific evidence reports a numeric supervision ratio for isolated disability support workers.

However, the evidence demonstrates that large spans of control were reported to reduce supervisory effectiveness, increase risk and reduce job satisfaction:

- Svanström et al. (2025) reported that as the span of control increases, supervisors cannot maintain relationships, provide feedback, or support staff wellbeing.

    - However, this article does not define what a ‘large’ span of control ratio is. The authors use the Ottawa Hospital Span of Control (TOH-SOC) which provides a weighted complexity ratio, rather than a headcount.
- Deveau and Rickard (2024) reported that managers lacked time to observe practice or supervise due to workload and administrative burden. An expanded span of control demonstrated a negative impact with job satisfaction. In this article the number of staff managed ranged from five to 25 staff (average 12.5).
- McFadden, Maclochlainn, et al. (2024) reported that overwhelmed supervisors cannot provide adequate supervision. Lack of supervision predicts burnout and intention to leave (high staff turnover results in lack of continuity of care).

## Consultation feedback

Stakeholders were presented with draft findings 2.1 and 2.2 and a summary of the supporting evidence. Overall, the evidence suggested that supervision could not be reduced to a single ratio and should instead be guided by risk, worker capability, supervisor capability, participant support needs and service context.

Stakeholders were supportive of a capability-based and risk-responsive approach rather than a single fixed ratio as presented in finding 2.2. Stakeholders noted that high-risk and complex settings require lower spans of control and stronger real-time support**.** Settings involving behaviours of concern, restrictive practices, frequent incidents, emergency service involvement or rapidly changing needs were described as requiring greater supervisory availability and more responsive escalation pathways. In addition, Stakeholders suggested that supervisors required both capacity and capability to provide supervision to support workers.

Stakeholders described the need for a framework approach within which to consider the most appropriate span of control. This was considered more appropriate to allow considerations for relevant factors including: complexity of the support setting, worker experience, agency or casual staff use, responding to patterns of incidents or complaints, restrictive practices, supervisor workload and availability of rapid decision support. They felt strongly that the diversity and complexity of contexts within which support work was performed needed to be considered before allocating an appropriate number of staff that supervisors could competently and safely supervise.

Examples provided included several ways organisations provided a higher level of support to staff on commencement and then dropped intensity of supervision, such as a ‘flipped’ model: rather than increasing the span of control for isolated workers, new starters received more frequent supervision and support, which was reduced in frequency for workers who demonstrated they needed less supervision after an initial period. This enabled the continuation of higher intensity supervision where needed.

Participants in consultation consistently agreed that supervision models should be flexible, capability-based, risk-responsive and not driven primarily by cost or generic numbers. In addition, stakeholders valued supervisors who understand the people, services and practical realities of support work. They noted that supervisors do not necessarily need to work every shift, but should have credible sector experience, local knowledge and disability-specific expertise.

Consultation discussions identified several considerations for an appropriate framework that are critical in determining an appropriate span of control, considering provider structures, service settings, and the realities of isolated working contexts. These included:

### Person

- The support needs of the person, inherent to them (such as complex medical or disability related conditions)
- Currently unmet needs of the person which may give rise to increased risk or need for more support (for example, increased support required at certain times of the day such as meal times)

### Staff member receiving supervision

- Depth of experience
- Level of training
- Time in the job
- Familiarity with the people, co-workers and supervisor

### Supervisor

- Level of knowledge of the people with disability, staff members,
- Time in organisation, level of knowledge of the organisation's systems and policies/relevant broader policy
- Depth of knowledge and experience in supervision practice

### Support context

- Level of risk in the support structure (e.g. restrictive practices)
- Root cause of worker isolation
- Supporting strategies in place to mitigate worker isolation (e.g. multiple pathways to get real-time advice and support if an incident occurs; on-call systems)

### Organisational context

- Number of workers working in isolation
- Strategies to mitigate effects of isolated work

### Funding context

- Capacity for increasing span of control within available funding
- Creative approaches to using available resources (e.g. peer, group supervision)

## Summary

These findings are informed by a synthesis of direct evidence, indirect evidence, relevant grey literature and stakeholder consultation. While the quality and depth of available evidence vary, the overall body of findings provides guidance that supervision for isolated support workers should be lower than standard ratios, and that supervision ratios should be determined through consideration of multiple factors in a framework approach.

### Key findings summary: Best practice supervision ratios

| Number | Finding |
|---|---|
| Source: Published scientific evidence | |
| 2.1 | Supervision ratios for isolated support workers should be lower than standard ratios to ensure adequate oversight, timely decision support and safe practice |
| Source: Grey literature | |

| Number | Finding |
|---|---|
| 2.2 | Supervision ratios in isolated disability support work should be capability-based and risk-responsive, not cost-driven or numerically fixed.<br>The evidence suggested that 'risk responsive' span of control framework should consider;<br>• Task complexity<br>• Workforce capability<br>• Managerial responsibilities<br>• Organisational culture and structure<br>Organisational size and resources |
| Source: Consultation feedback | |
| Considerations for practice and implementation | Stakeholders suggested that supervisors required both capacity and capability to provide supervision to support workers. They valued supervisors with relevant practice knowledge, who understood the people, services and practical realities of support work.<br>Stakeholders were supportive of a 'risk-responsive approach' where the complexity of each situation is considered to determine an appropriate span of control. This flexibility in this approach was considered necessary for organisations to consider changing needs and contexts.<br>A framework, rather than a fixed ratio would allow for supervision ratios to be calibrated to consider risks, skills and strengths across domains, including:<br>• The profile of the person/people with disability being supported<br>• Staff member receiving supervision (experience in field, time in job, etc)<br>• The supervisor (expertise, experience in supervising, etc)<br>• Support context (kind of isolated context; risk)<br>• Organisation (other supporting strategies to reduce risk e.g. on-call systems, senior manager accessibility)<br>• Funding context (capacity to increase span of control; strategies to supervise differently within funding envelope) |

## 4.3 What are the implications of this evidence for supervision?

### Direct evidence

The evidence identified suggests that when isolated support workers are supervised appropriately and have access to quick support to make decisions and use reflective practice, use of restrictive practices decreases.

Conversely, when supervision is insufficient the risk increases that people with disability will receive unsafe care, increased restrictive practices or violations of dignity. If spans of control are too wide, workers are isolated without support, staffing may be insufficient, relationships inconsistent and debriefing is not resourced sufficiently. Support workers are more likely to skip de-escalation practices and use restrictive practices such as chemical restraint. The impact to positive working relationships and the potential for other kinds of harm is significant.

To improve safety and minimise restrictive practices:

### Finding 3.1 Supervision should be treated as a core safety mechanism — not simply 'another administrative task'

The evidence demonstrates that when isolated support workers don't have regular, protected time with a supervisor, key safety practices such as de-escalation, reflective discussion, and post-incident learning do not occur regularly. This increases the likelihood of harm and critical incidents and the use of restrictive practices which may otherwise be avoided.

Resourcing supervision properly means giving supervisors enough time, authority, and manageable workloads to check in frequently, provide real-time guidance, and support workers after difficult events. In practice, it reframes supervision as essential infrastructure for safe, rights-based support. This finding suggests that supervision should be treated as a *core safety function*, not merely an administrative task.

| **Finding** | **Supervision should be treated as a core safety mechanism - not simply 'another administrative task'** |
|---|---|
| Studies Contributing to the Finding | McKeown et al. (2019); Averill et al. (2024); Stevens et al. (2022) |
| Methodological Limitations | **Moderate.** All qualitative evidence; some small samples; context-specific settings. |
| Relevance | **High.** directly applicable to isolated disability support where workers make autonomous decisions. |
| Coherence | **High.** All studies consistently link inadequate supervision to unsafe care, increased restraint, or dignity violations. |
| Adequacy of Data | **Moderate.** Rich qualitative data across three settings (mental health, community mental health, district nursing). |
| Overall CERQual Assessment | Moderate-High confidence |
| Explanation of Confidence | Strong convergence that supervision is essential for safety and restraint reduction; limitations relate to qualitative design, not inconsistency of findings. |

### Finding 3.2 Span of control should enable responsive oversight

The evidence suggests that when supervisors are stretched thin, isolated workers can be left to make high-risk decisions alone, policies are bypassed under pressure, and early warning signs of distress or unsafe practice can go unnoticed. Reducing spans of control ensures supervisors have the capacity to check in frequently, respond quickly when workers need help, and maintain meaningful knowledge of each worker and client.

This finding means that supervisors should not be responsible for too many workers, because wide spans of control make it extremely difficult to provide the timely, hands-on oversight that recognises and prevents potential harm, interrupts escalation and avoids inappropriate use of restrictive practices.

| Finding | Span of control should enable responsive oversight |
|---|---|
| Studies Contributing to the Finding | McKeown et al. (2019); Averill et al. (2024); (Stevens et al., 2022) |
| Methodological Limitations | **Moderate.** All studies are qualitative; some have small or context-specific samples; however, methods are appropriate for exploring supervisory capability and lone-worker decision-making. |
| Relevance | **High.** Findings directly apply to isolated disability support work, where workers operate alone, face high-risk situations, and rely heavily on supervisory responsiveness. |
| Coherence | **High.** All studies consistently show that when supervisors are responsible for too many staff, oversight collapses, unsafe decisions increase, and early signs of escalation are missed. The mechanism is stable across mental health, community care, and district nursing. |
| Adequacy of Data | **Moderate.** Multiple studies provide rich, detailed accounts of supervisory overload and its consequences, but no study provides quantitative ratio data. |
| Overall CERQual Assessment | Moderate confidence |
| Explanation of Confidence | Evidence strongly supports the causal pathway: **wide spans of control result in reduced supervisory capacity and increased risk of restraint and unsafe practice**. Confidence is moderate due to qualitative designs and lack of ratio data, but the consistency and relevance of findings are strong. |

### Finding 3.3 Supervision and staffing models should support consistent, relationship-based care

The evidence shows that when staff are consistent and know a person well, they can anticipate triggers, support autonomy, and respond early before situations escalate. In contrast, high turnover, casualisation, and fragmented rosters increase the likelihood that workers will rely on restrictive practices because they lack the relational knowledge needed for safe, personalised support. In practice, this finding positions relationship continuity as a core harm-prevention strategy, not a “nice to have.” This finding means that organisations should design supervision, staffing and rostering systems that allow workers to build stable, ongoing relationships with the people they support, because these relationships directly reduce distress, behaviours of concern, and the need for restrictive practices.

| Finding | Staffing models should support consistent, relationship-based care |
|---|---|
| Studies Contributing to the Finding | Watson et al. (2025); Van der Meulen Anne Pier et al. (2018) |

| Finding | Staffing models should support consistent, relationship-based care |
|---|---|
| Methodological Limitations | **Moderate.** Both studies are qualitative with small samples and single-site contexts. However, methods are appropriate for exploring relational care and restraint-related decision-making. |
| Relevance | **High.** Findings directly apply to disability support, where relationship-based practice is central to preventing escalation and supporting autonomy, especially in isolated work |
| Coherence | **High.** Both studies consistently show that stable, ongoing relationships between workers and clients reduce behaviours of concern and reliance on restrictive practices. Watson demonstrates an 80% reduction in PRN use with consistent staffing; Van der Meulen shows that long-term relational knowledge reduces the need for restraint. |
| Adequacy of Data | **Moderate.** Two studies contribute, each with rich, detailed accounts of how relationship continuity affects autonomy, distress, and restraint. More studies would strengthen adequacy, but existing data is strong. |
| Overall CERQual Assessment | Moderate-High confidence |
| Explanation of Confidence | Strong, consistent evidence that continuity of staff–client relationships reduces behaviours of concern and restrictive practices. Confidence is slightly reduced due to limited number of studies, but the mechanism is clear, well-supported, and highly relevant to disability |

### Finding 3.4 Staffing models should strengthen immediate decision-making support for lone workers

The evidence shows that when staff are isolated and under pressure, they often have to make complex safety decisions without guidance, which increases the likelihood of unsafe practice, violations of dignity, and the use of restrictive practices. Strengthening decision-making support includes ensuring workers can quickly reach a supervisor, building structured team-level safety processes (like virtual huddles or zoning), and requiring proactive check-ins during high-risk shifts. In practice, this finding recognises that lone workers need *more* supervisory support to prevent escalation and maintain safe, rights-based care. This finding means that organisations must provide stronger, more immediate decision-making support for workers who operate alone, because lone workers face high-risk situations without the benefit of peer oversight.

| Finding | Staffing models should strengthen immediate decision-making support for lone workers |
|---|---|
| Studies Contributing to the Finding | Averill et al. (2024); Stevens et al. (2022) |

| Finding | Staffing models should strengthen immediate decision-making support for lone workers |
|---|---|
| Methodological Limitations | **Moderate.** Both studies are qualitative with limited geographic scope and small samples. However, methods are appropriate for examining lone-worker contexts, safety risks, and supervisory gaps. |
| Relevance | **High.** Lone working is a core feature of disability support, especially in individualised living arrangements. The mechanisms identified directly apply to restraint prevention in isolated work. |
| Coherence | **High.** Both studies consistently show that lone workers face increased safety risks and make high-stakes decisions without adequate oversight. They also demonstrate that workload pressures lead to bypassing safety protocols, reinforcing the need for stronger supervisory support. |
| Adequacy of Data | **Moderate.** Two studies provide detailed, context-rich accounts of lone-worker decision-making challenges. More studies would strengthen adequacy, but existing evidence is sufficiently robust to support the finding. |
| Overall CERQual Assessment | Moderate-High confidence |
| Explanation of Confidence | Evidence clearly demonstrates that lone workers require more supervisory support to prevent unsafe decisions and reduce reliance on restraint. Confidence is slightly limited by the small number of studies, but the consistency, richness, and direct relevance of the findings are strong. |

### Finding 3.5 Supervisors should embed structured debriefing and reflection into daily practices

The evidence shows that when workers don't have structured opportunities to reflect on incidents, understand triggers, and learn from what happened, the same situations recur and quality and safety problems become more likely. Embedding debriefing into routine practice, supported by supervisors with the time and skill to guide it, helps workers process stress, improve decision-making, and strengthen relational approaches that prevent harm from occurring and recurring. In practice, this finding positions reflective practice as a core mechanism for reducing future risk and harm, not a paperwork exercise. This finding means that organisations must treat debriefing and reflective practice as essential safety activities.

| Finding | Supervisors should embed structured debriefing and reflection into daily practices |
|---|---|
| Studies Contributing to the Finding | McKeown et al. (2019) |
| Methodological Limitations | **Moderate.** Single qualitative study; participant views only; limited generalisability. However, methodology is appropriate for exploring how staffing and supervision affect debriefing and restraint. |

| Finding | Supervisors should embed structured debriefing and reflection into daily practices |
|---|---|
| Relevance | **High.** Debriefing and reflective practice are central to restrictive practice frameworks and directly applicable to disability support, especially in isolated work where workers lack informal peer reflection. |
| Coherence | **High.** The study provides a clear, internally consistent explanation of how lack of time, staffing, and supervisory capability leads to the abandonment of debriefing and reflective practice, which in turn increases restraint. |
| Adequacy of Data | **Low-Moderate.** Only one study directly addresses debriefing as a restraint-prevention mechanism. The data is rich but limited in breadth |
| Overall CERQual Assessment | Moderate |
| Explanation of Confidence | Evidence strongly supports the mechanism: without protected time and supervisory support, debriefing does not occur, and restraint is more likely to recur. Confidence is limited by the single-study evidence base but strengthened by the clarity and relevance of the findings. |

### Finding 3.6 Organisations and providers should embed human-rights principles into supervision and decision making

The evidence shows that when staffing is tight or organisational culture is risk-averse, workers can default to restrictive or confinement-based practices that limit people's rights. Strengthening human-rights-based practice ensures supervisors actively check whether restrictions are being used because of genuine risk or simply because systems, staffing, or routines make rights-respecting support harder to deliver. In practice, this finding reframes restrictive practices responsibilities as a human-rights obligation, not just a clinical or behavioural issue. This finding means that organisations should embed human-rights principles, including autonomy, freedom of movement, dignity, and least-restrictive practice, into everyday supervision and decision-making.

| Finding | Organisations and providers should embed human-rights principles into supervision and decision making |
|---|---|
| Studies Contributing to the Finding | Steele et al. (2020); Watson et al. (2025) |
| Methodological Limitations | **Moderate.** Both studies are qualitative with small samples; some key perspectives (e.g., people with disability) are under-represented. However, methods are appropriate for exploring human-rights impacts in care setting |
| Relevance | **High.** Findings directly apply to disability support, where restrictive practices are regulated and human-rights obligations are central to service delivery. |

| Finding | Organisations and providers should embed human-rights principles into supervision and decision making |
|---|---|
| Coherence | **High.** Both studies show that organisational culture, staffing constraints, and risk-averse practices lead to unnecessary restrictions on autonomy and freedom of movement. They consistently link human-rights-based practice with reduced reliance on restrictive measures. |
| Adequacy of Data | **Moderate.** Two studies provide rich, detailed accounts of how rights are compromised in practice and how relational, well-supported care reduces restrictive practices. More studies would strengthen adequacy, but existing data is strong. |
| Overall CERQual Assessment | Moderate-High |
| Explanation of Confidence | Evidence clearly demonstrates that rights-restricting practices often arise from organisational constraints rather than genuine risk. Strengthening human-rights-based practice provides a direct pathway to reducing restraint. Confidence is slightly limited by the small number of studies, but the mechanism is consistent and highly relevant. |

## Grey literature

### Finding 3.7 Supervision should actively promote individualised, trauma-informed, person-centred support

| Resource | Relevant finding |
|---|---|
| Best practice in the reduction and elimination of seclusion and restraint seclusion: time for change | This report (O'Hagan M, 2008) reviewed international literature to find best practices for reducing and eliminating seclusion and restraint in mental health inpatient settings and assessed their relevance to the New Zealand context. The report concludes that seclusion and restraint can be significantly reduced when services adopt a coordinated, rights-based, trauma-informed, recovery-oriented approach supported by strong leadership, workforce development, service-user involvement, and practical prevention tools. |

**AACORD**

| Domain | Assessment |
|---|---|
| Authority | **High.** Produced by recognised leaders in restraint-reduction and trauma-informed practice (O'Hagan M, 2008). Widely cited internationally. |
| Accuracy | **Moderate–High.** Evidence-informed, grounded in trauma-informed and recovery-oriented frameworks. Not a systematic review, but synthesises high-quality practice evidence. |

| Domain | Assessment |
|---|---|
| Coverage | **High.** Addresses organisational culture, trauma-informed care, person-centred practice, and alternatives to restraint. Broad scope across mental health and disability contexts. |
| Objectivity | **Moderate.** Strong advocacy stance toward eliminating restraint. Values-driven but transparent about its position. |
| Relevance | **High.** Directly applicable to supervision that promotes person-centred, trauma-informed practice and reduces restrictive practices. Context specific but not specific to isolated support workers. |
| Date | **2008.** Not recent, but still foundational and widely referenced. |

| Resource | Relevant finding |
|---|---|
| Practice Guide: Organisational approaches to reducing restrictive practices | The resource (Dowse, 2022) outlines how NDIS provider organisations can reduce and eliminate restrictive practices by strengthening governance, improving staff capability, redesigning environments, and embedding human-rights-based, person-centred practice. It draws on research and a case study showing that when organisations invest in leadership, staff training, reflective practice, high-quality behaviour support planning, and meaningful data use, restrictive practices decline because risks are better understood, behaviours are interpreted as communication and supports become more proactive and aligned. |

### AACORD

| Domain | Assessment |
|---|---|
| Authority | **High.** Produced by the NDIS Commission- the national regulator for restrictive practices. |
| Accuracy | **High.** Aligns with NDIS legislative requirements, positive behaviour support principles, and contemporary rights-based practice. |
| Coverage | **High.** Addresses organisational systems, supervision, monitoring, person-centred strategies, and least-restrictive practice. |
| Objectivity | **High.** Regulatory guidance with no commercial or advocacy bias. |
| Relevance | **High.** Directly relevant to supervision, oversight, and embedding person-centred, least-restrictive practice. |
| Date | **2022.** Reflecting current regulatory expectations. |

| Resource | Relevant finding |
|---|---|
| Regulated Restricted Practices Guide | Supervision, as described in the Regulated Restrictive Practices Guide, functions as a rights-protection and quality-assurance mechanism that ensures support is genuinely person-centred. The Guide (NDIS Quality and Safeguards Commission, 2020) requires providers to uphold dignity, autonomy and the *least restrictive* option, meaning supervisors must actively check that staff tailor responses to the individual rather than relying on routines, staffing constraints or organisational convenience. Because restrictive practices must be justified, documented and used only as a last resort, supervision plays a critical role in helping staff understand the person's needs, preferences and communication, and in coaching them to use positive, individualised alternatives. |

**AACORD**

| Domain | Assessment |
|---|---|
| Authority | **High.** Produced by the NDIS Commission- the authoritative source for restrictive-practice regulation. |
| Accuracy | **High.** Legally aligned, precise definitions, and clear regulatory requirements. |
| Coverage | **Moderate–High.** Focuses on regulated restrictive practices, rights, dignity, and least-restrictive alternatives. Less detail on supervision specifically. |
| Objectivity | **High.** Regulatory, compliance-focused, non-commercial. |
| Relevance | **High.** Strong relevance to supervision that ensures rights, autonomy, and least-restrictive decision making. |
| Date | **2020** Moderately current and aligned with contemporary NDIS practice. |

## Consultation feedback

Stakeholders were presented with draft findings 3.1 to 3.7 and a summary of the supporting evidence. Overall, the evidence suggested that effective supervision is a safety, quality, and rights-protection mechanism - and for isolated support workers it must be responsive, relational, reflective and grounded in human-rights and trauma informed practice.

Stakeholders agreed with the evidence and supported finding 3.1 that supervision should be framed as support for better practice and not be considered as an extra administrative burden. They noted that for some the term 'supervision' can be experienced or interpreted as critique or monitoring. They suggested that asking workers, "What do you need to provide better support?" changes the tone and aligns supervision with continuous improvement, confidence building and quality support. This aligns with previous findings relating to psychologically safe environments (finding 1.1).

Consultation stakeholders highlighted that supervisors need to be supportive, approachable, communicative and respectful. They described experiences where supervisors were reactive, unfriendly or poorly suited to a supervisory role, even if they had technical skills. Members also noted that supervisors need cultural awareness and the ability to build trust with workers from diverse

cultural and language backgrounds, including workers who may be hesitant to question authority or raise concerns. Gender and other intersectional issues are also important to consider.

Stakeholders emphasised that supervision alone cannot guarantee quality or safety. They stressed that supervision must operate alongside other foundational safeguards—including strong recruitment, thorough induction, ongoing training, person-specific preparation, consistent staffing, effective handover processes, and stable support relationships. Without these broader workforce and organisational conditions in place, supervision cannot fully achieve its intended impact.

## Summary

These findings are informed by a synthesis of direct evidence, indirect evidence, relevant grey literature and stakeholder consultation. While the quality and depth of available evidence vary, the overall body of findings reflects that supervision should also embed structured debriefing and reflective practice to strengthen learning and reduce future incidents. Across all supervision processes, human-rights principles must guide decisions, and supervisors should actively promote individualised, trauma-informed, person-centred approaches that reduce the need for restrictive practices.

## Key findings summary: Implications of the evidence for supervision

| Number | Finding |
|---|---|
| Source: Published scientific literature | |
| 3.1 | Supervision should be treated as a core safety mechanism - not simply ‘another administrative task’ |
| 3.2 | Span of control should enable responsive oversight |
| 3.3 | Supervision and staffing models should support consistent, relationship-based care |
| 3.4 | Staffing models should strengthen immediate decision-making support for lone workers |
| 3.5 | Supervisors should embed structured debriefing and reflection into daily practices |
| 3.6 | Organisations and providers should embed human-rights principles into supervision and decision making |
| Source: Grey literature | |
| 3.7 | Supervision should actively promote individualised, trauma-informed, person-centred support |
| Source: Consultation feedback | |

| Number | Finding |
|---|---|
| Considerations for practice and implementation | Stakeholders agreed that supervision should be framed as a core safety, quality, and rights-protection mechanism, not an additional administrative burden.<br><br>Stakeholders endorsed reframing supervision around the question *"What do you need to provide better support?"* to promote continuous improvement, confidence building, and psychological safety.<br><br>Stakeholders emphasised that supervisors must be supportive, approachable, communicative, respectful, and culturally aware. Technical skill alone is insufficient if relational qualities are lacking.<br><br>Stakeholders stressed that supervision alone cannot ensure quality or safety. It must sit alongside strong recruitment, thorough induction, ongoing training, person-specific preparation, consistent staffing, effective handover, and stable support relationships. |

## 4.4 Limitations

The current evidence base does not address all components required to determine an appropriate span of control for disability support workers.

While the available scientific evidence provides guidance on supervision structures and organisational enablers, it does not fully capture the practical complexities of support work or the lived experience of people with disability.

These draft findings and practice insights were taken to consultation to ensure they were grounded in real-world practice, reflected the realities of frontline support work, and meaningfully contribute to high-quality, rights-aligned support for people with disability. However, we acknowledge that some of the issues raised in consultation were out of scope or not reported in the available evidence. Identified gaps included:

### Sole operators and private workers

Members raised the issue of support workers operating privately or as sole providers, who may not have organisational supervision structures. Sole operators are outside the current scope for this project. However, the team agreed this should be identified as an important area for future research and policy attention.

### Reporting practice needs more sophistication

Concerns were raised about inconsistent reporting practice. Some providers may over-report incidents because workers are unsure what to do, while others may under-report or avoid reporting. Workers and organisations may need clearer understanding of incident reporting, restrictive practices and escalation requirements. The group linked this to the need for better supervision, support and decision-making guidance when workers are uncertain.

## 4.5 Next steps

Stakeholders identified a range of practical implementation strategies to amplify the impact of the research, including:

- Practical tools and examples to strengthen the implementation of findings and practice insights.

- Development of case studies, scenarios, decision frameworks, colour-coded risk indicators, examples of urgent support situations and guidance for new workers to help translate findings and practice insights into practice.
- An overview of what good supervision looks like, what makes a good supervisor, and how supervisory conversations can be structured.
- Evaluation built into implementation to determine whether new supervision approaches are working (using measurable outcomes and indicators).

## 4.6 Overview of key findings

### Key findings summary: Appropriate span of control and supervision for isolated support work

| Number | Finding |
|---|---|
| Source: Published scientific evidence | |
| 1.1 | Organisations should implement structured peer group supervision for isolated workers and ensure that it is delivered within a psychologically safe, trusting environment |
| 1.2 | More frequent supervision is needed for isolated workers than team-based staff<br>- Isolated workers require frequent and accessible supervision |
| 1.3 | Support workers should have access to rapid decision-making support |
| 1.4 | Supervision must be regular, planned, proactive, and provide timely feedback. |
| 1.5 | Supervision must be protected and prioritised |
| 1.6 | Supervision must be disability-specific and be delivered by supervisors with relevant expertise |
| 1.7 | Supervisors should be trained, skilled, and supported to deliver effective supervision |
| 1.8 | Relational, trust-based, and psychologically safe supervision is high priority, underpinned by continuity of supervisory relationships (especially for isolated workers). |
| 1.9 | Staff supervision must address worker isolation as a WHS risk, including structured check-ins, escalation pathways, and proactive monitoring. |
| 1.10 | Supervisors must have manageable spans of control to provide effective supervision |
| Source: Grey literature | |
| 1.11 | Flexible and multimodal supervision extends good practice |
| 1.12 | Clear role boundaries and delegation frameworks are required |

| Number | Finding |
|---|---|
| 1.13 | Span of control and supervision models must enable workers to meet their obligations under the NDIS Code of Conduct. |
| Source: Consultation feedback | |
| Considerations for practice and implementation | Stakeholders agreed that supervision for isolated workers must be *more frequent, skilled, relational,* and explicitly designed to counteract isolation-related risk.<br><br>Strong support for planned, regular supervision delivered in psychologically safe environments where workers can raise uncertainty, mistakes, and practice concerns without fear of punishment. Seen as an opportunity to upskill workers and improve care quality.<br><br>Peer group supervision was viewed as promising, especially for dispersed workforces. Stakeholders emphasised that peer models require time, resourcing, and careful design to be effective.<br><br>Stakeholders agreed continuity of supervisory relationships is important but difficult to maintain due to workforce movement, funding changes, casual staffing, and multiple service locations. They highlighted the need to distinguish line management from practice supervision.<br><br>Stakeholders considered cultural responsiveness as essential to supervision models to ensure culturally safe communication.<br><br>Stakeholders noted face-to-face supervision remains valuable, but phone, online, telehealth, and video modes improve access for isolated workers. |

## Key findings summary: Best practice supervision ratios

| Number | Finding |
|---|---|
| Source: Published scientific evidence | |
| 2.1 | Supervision ratios for isolated support workers should be lower than standard ratios to ensure adequate oversight, timely decision support and safe practice |
| Source: Grey literature | |
| 2.2 | Supervision ratios in isolated disability support work should be capability-based and risk-responsive, not cost-driven or numerically fixed.<br><br>The evidence suggested that 'risk responsive' span of control framework should consider;<br>• Task complexity<br>• Workforce capability<br>• Managerial responsibilities<br>• Organisational culture and structure<br><br>Organisational size and resources |
| Source: Consultation feedback | |

| Number | Finding |
|---|---|
| Considerations for practice and implementation | Stakeholders suggested that supervisors required both capacity and capability to provide supervision to support workers. They valued supervisors with relevant practice knowledge, who understood the people, services and practical realities of support work.<br><br>Stakeholders were supportive of a 'risk-responsive approach' where the complexity of each situation is considered to determine an appropriate span of control. This flexibility in this approach was considered necessary for organisations to consider changing needs and contexts.<br><br>A framework, rather than a fixed ratio would allow for supervision ratios to be calibrated to consider risks, skills and strengths across domains, including:<br>• The profile of the person/people with disability being supported<br>• Staff member receiving supervision (experience in field, time in job, etc)<br>• The supervisor (expertise, experience in supervising, etc)<br>• Support context (kind of isolated context; risk)<br>• Organisation (other supporting strategies to reduce risk e.g. on-call systems, senior manager accessibility)<br>• Funding context (capacity to increase span of control; strategies to supervise differently within funding envelope) |

## Key findings summary: Implications of the evidence for supervision

| Number | Finding |
|---|---|
| Source: Published scientific literature | |
| 3.1 | Supervision should be treated as a core safety mechanism - not simply 'another administrative task' |
| 3.2 | Span of control should enable responsive oversight |
| 3.3 | Supervision and staffing models should support consistent, relationship-based care |
| 3.4 | Staffing models should strengthen immediate decision-making support for lone workers |
| 3.5 | Supervisors should embed structured debriefing and reflection into daily practices |
| 3.6 | Organisations and providers should embed human-rights principles into supervision and decision making |
| Source: Grey literature | |
| 3.7 | Supervision should actively promote individualised, trauma-informed, person-centred support |
| Source: Consultation feedback | |

| Number | Finding |
|---|---|
| Considerations for practice and implementation | Stakeholders agreed that supervision should be framed as a core safety, quality, and rights-protection mechanism, not an additional administrative burden.<br><br>Stakeholders endorsed reframing supervision around the question *"What do you need to provide better support?"* to promote continuous improvement, confidence building, and psychological safety.<br><br>Stakeholders emphasised that supervisors must be supportive, approachable, communicative, respectful, and culturally aware. Technical skill alone is insufficient if relational qualities are lacking.<br><br>Stakeholders stressed that supervision alone cannot ensure quality or safety. It must sit alongside strong recruitment, thorough induction, ongoing training, person-specific preparation, consistent staffing, effective handover, and stable support relationships. |

# 5. Applying the findings to priority contexts

This section of the report applies the findings from the evidence review to four priority practice areas, identified through consultation with the Department and stakeholders.

The four contexts are:

1. Support workers providing 1:1 line of sight oversight and support for a person with a medical/disability need which requires direct supervision as a clinical requirement, and where the worker's line manager/supervisor would ultimately be responsible for ensuring continuity of care.
2. Supervision and support of support workers providing 1:1 support to people with disability where workers undertake their role alone (at least in part), but there is no medical/disability requirement for line-of-sight oversight and support or continuity of care.
3. Supervision and support of support workers who may be working interchangeably to provide 1:1 support to multiple participants in a shared setting, where workers may perform some of their work isolated from others.
4. Supervision and support of support workers where their work includes 1:1 'intensive supervision' as an authorised restrictive practice, where supervision is applied to monitor behaviours of concern that create a risk of harm to the person or others.

The practice examples follow in turn.

## PRACTICE EXAMPLE 1

Supervision and support of workers when a person with disability requires 1:1 line of sight oversight and support from a support worker due to a medical/disability need; and where the worker's line manager or supervisor is responsible for ensuring continuity of care to the person.

Jacob is a 24-year-old man with complex epilepsy and high and complex support needs. He lives in Specialist Disability Accommodation and receives 24-hour support. Because Jacob's seizures are unpredictable and can result in serious injury, medical deterioration or death, he requires continuous 1:1 line-of-sight oversight and support.

This practice example illustrates the findings that supervision for isolated workers should be treated as a core safety mechanism (finding 3.1), be more frequent and accessible than for team-based staff (finding 1.2), provide rapid decision-making support (finding 1.3), and be regular, protected (finding 1.5), disability-specific (finding 1.6), responsive to risk (finding 3.1) and relational (finding 1.8).

### Key supervision requirements

- continuous line-of-sight support by a dedicated worker
- rapid access to clinical and supervisory advice when escalation or judgement is required
- clear disability-specific procedures, role boundaries and escalation pathways
- planned supervision, debriefing and risk review to monitor fluctuating needs.

Jacob's support is guided by individualised plans covering medical needs, risks, escalation pathways and role boundaries. These plans need regular review, and supervision must be scheduled and protected so reflective discussion and feedback are not displaced by day-to-day operational pressures.

The line manager must have a manageable span of control to provide responsive oversight, timely feedback and rapid support (finding 1.10). Continuity depends on stable staffing, planning for staff turnover, active rostering and backup arrangements so Jacob is supported by workers who know him well, including his seizure patterns and preferred supports.

### Isolated work risks

Much of Jacob's support is delivered by a lone worker. This is both a work health and safety risk and a structural risk in service design, because one worker is solely responsible for detecting seizures, responding immediately and escalating when needed. Supervision therefore needs to address isolation directly through structured check-ins, proactive monitoring and flexible contact with supervisors.

### Key risks include:

- the worker is the only person immediately available to detect and respond to seizures
- there is no on-site backup if the worker is occupied, fatigued or managing competing demands
- critical escalation decisions are made independently and in real time.

### Systemic risks include:

- Single point of failure: safety depends on one worker's vigilance and judgement
- Reduced margin for error: delays or misjudgements can have immediate serious consequences
- Escalation limits: assistance may not be immediately available in time-critical situations
- Fatigue and cognitive load: prolonged lone oversight and support can reduce responsiveness

- Practice variability: outcomes depend heavily on individual worker capability unless systems are strong

These risks are inherent in using lone worker models for high-intensity, clinically complex support.

## Safeguards and supervision responses

Safeguards include clear clinical procedures, defined escalation pathways, 24/7 on-call support, structured communication, regular reflective supervision, structured debriefing after significant events, and psychologically safe peer discussion (findings 1.12, 3.7). Supervisors need disability-specific expertise, training and enough capacity to provide responsive oversight.

## Possible responses include:

- Jacob and his worker Ali know each other well. Ali makes sure he stays in eyesight of Jacob throughout his shift.
- When it's time for Ali's break, he waits for the floating staff member to relieve him. Today, they are held up at another house. Ali uses the escalation strategy to call the on-call manager for advice.
- Ali's supervisor is informed, and detours to the house. He provides support to Jacob while Ali has his break. Afterwards, they use the opportunity to problem-solve about a concern he has about Jacob's support.

These controls reduce risk but do not remove the hazards created by lone work. Their effectiveness depends on frequent, accessible supervision and supervisors having a manageable span of control (finding 1.10). Developing and sustaining trust in working relationship between supervisors and staff is important in enabling staff to feel able to implement key practices (finding 3.7).

The case highlights a policy tension: complex, high-risk support is often expected to be delivered safely by a single worker with remote oversight. It reinforces the finding that supervision ratios and span of control should be capability-based and risk-responsive, not set only by cost or standard staffing assumptions.

With strong organisational oversight and experienced staff, Jacob can live safely in the community and participate in meaningful daily life. Support should remain individualised, rights-based and person-centred, not simply compliance-focused.

Overall, Jacob's case shows the need for supervision in isolated support work to be regular, proactive, disability-specific, relational and psychologically safe, with structured debriefing, clear escalation arrangements and supervisors who have the capacity to respond.

## PRACTICE EXAMPLE 2

Supervision and support of workers when support is provided by a worker to a person with disability and there are no other people present, but there is no disability/medical requirement for continuity of care (e.g. when the person is funded to receive SIL in a single person setting).

Lana is a 50-year-old woman with intellectual disability who is supported through Supported Independent Living (SIL). She lives in her own home and receives NDIS-funded support to assist with daily living, safety, and community participation.

Lana values her independence and prefers living alone. To enable this, her supports are delivered in an isolated (lone worker) context, where a single support worker assists Lana during each shift without immediate access to on-site colleagues.

Lana's support is guided by current, individualised and accessible plans that describe her daily routines, preferences, communication style, and identified risks. These documents set out clear expectations for how support is delivered, how changes in Lana's wellbeing are recognised, and when escalation is required. Workers are expected to demonstrate that they understand and follow these plans in practice.

### In this isolated work setting, during each shift, each support worker is solely responsible for:

- Observing and evaluating Lana's wellbeing during the shift
- Making initial decisions in response to emerging risks
- Interpreting and actioning support plans in response to Lana's needs
- Responding to incidents which may occur overnight during a passive overnight shift.

Although a small team of support workers are involved in providing Lana's support program, its structure relies on a single support worker each shift, which impacts the structure of how support is delivered. Inherently, the process of providing support involves protecting the health, safety and wellbeing of the participant and worker.

In a living-alone context, lone work is a workplace hazard. The worker must maintain attention, judgement and consistent performance across a wide range of tasks, often without immediate access to colleagues. Isolation becomes especially significant in urgent or uncertain situations, where a delayed response may affect both Lana's safety and the worker's wellbeing. This practice example shows why supervision for staff working alone must be more frequent and accessible than for team-based staff and directly address the risks of isolation to person and worker. Effective supervision is fundamental to meeting the service provider's duty of care to both worker and participant. Specifically, supervision is a work health and safety legislative requirement (finding 1.9) to protect workers from risks (fatigue, stress, manual tasks, client abuse) and must be prioritised as part of a core quality and safety process (finding 3.1).

For isolated workers, more frequent and accessible supervision is required, and should be based on capability and capacity of both the worker and supervisor (including skill level, availability). Supervision must be responsive to risk, rather than constrained by costs and allocated based on numerical formulas and targets. Supervision must be structured to ensure quality support for the participant and health, safety and wellbeing for the support worker.

## In Lana's case, supervision that addresses risks from isolated support work (finding 1.2) should involve:

- regular contact, using flexible formats (phone, texts, planned visits onsite) to ensure effective and timely communication on evolving events and concerns (finding 1.4)
- clear distinctions between situations for independent decision making and those requiring escalation (finding 1.12)
- ensuring worker familiarity with responsive real-time escalation procedures (on-call supervisors who can respond immediately)
- ensuring documented and individualised plans are known and in place for foreseeable risks (emergencies, changes in physical and psychosocial wellbeing, monitoring for risks of abuse)
- ensuring incidents and near-miss events are reported and reviewed to understand and improve the quality of systems and supervision in practice
- peer group supervision to ensure consistency of practice and support standards between support workers working with Lana and social support from peers (finding 1.1).

Supervision is essential for monitoring and maintaining continuity and quality of support. It should be scheduled and prioritised while remaining responsive to changes in support service factors affecting the person, the worker(s) or the service delivery. Effective supervision in Lana's support context requires that supervisors have adequate time, skills, and experience to provide reflective practice supervision, facilitated by disability-specific training and expertise, and can draw on strong interpersonal and problem-solving skills.

Supervision in Lana's support context must promote competent and safe support practice that upholds the rights and responsibilities of both the person and their support workers (finding 3.6). Providing and receiving support is a relational process and so is supervision (finding 3.3). Supervisors should aim to establish a positive relationship, with open communication based on trust and psychological safety. The aim is to build staff skills and confidence to share concerns, identify skill and resource gaps, and monitor worker wellbeing (finding 3.7). Effective supervisory relationships develop over time, so continuity should be prioritised, particularly for isolated workers. Consistent, high-quality care is reinforced when practice expectations are structured, shared and documented for everyone involved.

Timely and responsive decision making is critical in situations where workers are working alone. In Lana's context, the supervisor's role in strengthening immediate decision-making support for the support worker means:

- Establishing clear expectations of the extent and contexts of support worker decision making, and when to seek assistance
- Having timely and regular access to supervisors and knowing procedures for escalating issues through plans that are tailored to the support context and are reviewed regularly
- Providing a clear and documented system of work for support staff that includes:
    - Structured handover practices — highlighting key information in procedures, documented records and progress notes
    - Regularly updating support plans and procedures as Lana's needs change, when organisational/policy contexts change or at least 6-monthly
    - Conducting regular risk assessments to understand likely decision-making situations and developing procedures for responding

    - Developing support workers' skills in basic risk assessment and problem solving for identified situations, including access to necessary skill-based training.
- Individual supervision involving facilitated reflective practice and problem solving
- Supervisor visits to Lana's home to observe the environment and support worker interaction (showing active and engaged oversight).

## PRACTICE EXAMPLE 3

Supervision and support of workers when there are multiple support workers supporting multiple people with disability in the same setting.

How is 1:1 supervision and support maintained to ensure staff are available for participants when they need support?

Four people with intellectual disability live in separate units on the same cluster housing site. People receive Supported Independent Living (SIL) funding through NDIS, which is pooled to maximise coverage of support workers. Each person has complex support needs, including assistance with communication, behaviour support, and health monitoring. At times, one or more residents may require 1:1 line-of-sight support by workers to ensure safety, enable early identification of escalation, and support timely, skilled responses to risk.

Support is delivered by a team of three support workers on each shift. Workers are rostered across the site and are expected to move between people depending on need. This requires clear identification of which residents require 1:1 support at any given time, based on current risk and support plans. While this model provides flexibility, it also means that 1:1 support must be actively allocated and protected in practice, rather than assumed based on staffing levels.

The central challenge in this model is how responsibility for 1:1 support is identified, allocated, maintained, and supervised when multiple workers support multiple residents at the same time. Unlike lone-worker models, where risks arise primarily from physical isolation, risk in this setting emerges from shared responsibility, competing demands, and unclear allocation of accountability.

Maintaining effective support in this environment depends on clear task allocation, role clarity, and accountability within each shift (finding 1.12, 3.4). This includes ensuring that the worker assigned to 1:1 support is both physically and functionally available to that person and is not routinely diverted to respond to other demands. In practice, however, 1:1 support may be present in plans but compromised in delivery when workers are redirected to assist other residents.

Much of the work in this setting occurs in what can be described as an operationally constrained context, where workers must make real-time decisions without consistent supervisory input.

### During busy periods, when several residents require support at the same time, workers must:

- maintain awareness of the needs and risks of more than one resident
- interpret early warning signs of distress or deterioration across different residents
- make independent decisions about how to prioritise competing demands
- determine when and how to escalate concerns, often without immediate access to a supervisor (finding 2.1).

Risk is amplified where more than one resident requires 1:1 support at the same time (finding 3.2), creating situations where workers cannot safely meet all needs without clear prioritisation, coordination, and guidance. Without explicit role allocation, responsibility can become diffused across the team, and decisions about prioritisation are made in real time without consistent structure.

In this environment, supervision is not simply “being present”. It is an active, high-risk task that relies on clear allocation of responsibility, strong communication, and ensuring workers have access to timely decision-making support (finding 1.3, 3.4). Where responsibility is shared but not explicitly

assigned, there is a risk that 1:1 support becomes diluted in practice, even when it is funded and planned.

For workers in these settings, supervision needs to be more frequent, more accessible, and more responsive to risk than in standard team-based models (finding 2.1, 2.2). In this model, standard supervision ratios do not reflect the level of coordination and decision-making required and may leave workers without timely guidance when it is most needed (finding 3.1). Supervision ratios should therefore be lower to ensure that supervisors have the capacity to provide timely input and actively oversee how support is prioritised and delivered across the setting (finding 1.10, 2.1).

Reliance on standard supervision arrangements or broad spans of control can limit the supervisor's ability to respond effectively in real time. A reduced and manageable span of control (finding 3.2) is required so supervisors can provide responsive, real-time oversight and ensure that responsibility for 1:1 support is clearly allocated and maintained during each shift. This includes ensuring that support plans are translated into practice, with clear expectations about how and when 1:1 support must be delivered. This may include during planned times of higher demand, such as for meals or personal care, or responsively, such as to health or behaviour incidents.

In this context, supervision functions not only as support for individual workers, but as a system-level mechanism for coordination, accountability, and oversight of 1:1 support delivery (finding 2.1, 3.2).

## Effective models include:

- clear allocation of responsibility for residents requiring 1:1 support during each shift, with defined expectations that these roles are not routinely interrupted
- identification of a lead worker responsible for coordinating responses when multiple demands arise
- real-time escalation pathways, including access to an on-call supervisor or practice leader who can be reached immediately
- reduced supervision ratios and span of control to enable responsive and timely oversight
- active monitoring of how 1:1 support is delivered in practice, including review of incidents and near misses
- structured handover processes to ensure continuity of critical information about each resident's needs, risks, and support strategies
- stable team arrangements to limit the number of workers involved in each person's support and support relationship-based care.

Supervision in this setting must be disability-specific and grounded in an understanding of individual communication, behaviour, and health needs (finding 1.6). Generic or administrative supervision is insufficient in environments where workers must make real-time decisions about complex and changing risks across multiple individuals. Supervisors require relevant experience, training, and organisational support to deliver effective supervision, including reflective practice and real-time decision guidance (finding 1.7).

## Maintaining continuity of care is critical in an interchangeable workforce model. Where workers frequently rotate across residents, there is a risk that:

- knowledge of individual needs becomes fragmented or incomplete
- early signs of change in behaviour or health are missed
- consistency and predictability of support are reduced
- key support or tasks are missed, assumed to have been addressed by another worker

- trust and relationship-building are undermined.

Inconsistent staffing not only affects quality of care but increases risk, as workers are less able to recognise subtle changes and respond early. Ensuring that staffing arrangements support consistent, relationship-based care requires deliberate workforce design, including stable team allocation, effective communication systems, and sufficient staffing to prevent workers being routinely diverted from their primary responsibilities (finding 3.3).

System-level guidance emphasises that supervision should be treated as a core safety mechanism, embedded within workforce design, risk management, and organisational governance. In settings like this, safe delivery of 1:1 support depends not only on individual worker capability, but on supervision structures, clear allocation of responsibility, and the organisation's capacity to coordinate and oversee support in real time.

## PRACTICE EXAMPLE 4

How do supervisors establish and monitor support worker practice when 1:1 support for restrictive practices is put in place? How are restrictive practices documented, monitored? How is quality in support worker practice developed, monitored? How do supervisors work on environments to reduce the need for restrictive practices?

Harry is a man with intellectual disability who lives in supported independent living and sometimes shows sudden, high-risk aggression when distressed (shouting, throwing objects, self-injurious behaviour, and attempting to hit others). These situations can escalate quickly from early warning signs such as pacing, raised voice, and withdrawing from interaction, and have previously led to injuries and property damage. As part of an authorised behaviour support plan, Harry receives 1:1 intensive supervision from support workers, which is a restrictive practice of 'constantly monitoring a person (environmental scanning, looking for triggers, use of prompts and redirections to prevent behaviours of concern) to prevent their access to items, areas or activities.' (DHS, 2023). The aim of this practice is to monitor early escalation and enable timely, skilled responses that reduce the risk of harm (finding 3.6).

Much of Harry's support Is delivered in isolated contexts. During evening and passive night shifts, one worker is alone in the house with Harry, and is solely responsible for providing continuous support to him. In these shifts, the worker must:

- maintain real-time awareness of Harry's behaviour
- interpret early warning signs without immediate peer input
- make independent decisions about when to escalate for help.

In this environment, supervision to the lone support worker is an active, sometimes high-risk task to resource them to be able to rely on their judgement, emotional regulation, and confidence in clear escalation pathways. Guidance and support through supervision should promote trauma-informed, and person-centred support and aim to build trust between Harry and his worker and in the supervisory relationship (finding 3.7). This example shows why supervision for isolated workers must be more frequent and accessible than for team-based staff, why it needs to directly address worker isolation as a risk factor, and why it should be treated as a core safety mechanism and not an administrative task (findings 1.3, 1.9, 3.1).

For isolated workers, supervision needs to be more frequent, more accessible, and more tightly aligned with the specific risks of restrictive 1:1 monitoring than for staff working in team-based settings. Supervision ratios should be based on the level of risk and the ability of workers and supervisors to respond, rather than on fixed numerical targets or cost considerations (finding 2.2). Guidance on lone workers in supported accommodation settings emphasises regular contact, structured monitoring, and clear limits on what can be done alone, particularly where there is potential for behaviours that present a risk of harm (findings 1.3, 1.9, 3.1, 3.2).

In Harry's context, supervision structures that address worker isolation as a risk might include:

- scheduled brief check-ins during each shift (for example, SMS or phone contact at agreed times) (findings 1.3, 1.9)
- real-time escalation channels (for example, an on-call supervisor or practice leader who can be reached immediately) (findings 1.9, 3.1)
- proactive review of incidents and near misses to understand how 1:1 intensive supervision is actually being delivered by workers in line with behaviour support plans (findings 1.9, 3.5)

- regular debriefing and reflective supervision, so workers can process incidents, examine decision-making, and identify opportunities to safely reduce restrictive practices over time (findings 3.5, 3.6)
- contingency plans for responding to physical or psychological impacts on support workers which may result in them being unable to carry out their role for a short or longer period (findings 1.8, 3.1).

System-level guidance on restrictive practices and supervision emphasises the need for regular, practice-focused supervision that monitors how restrictions are implemented in practice. Treating supervision as a safety control means embedding it into risk assessment and governance processes for lone work, rather than relying solely on individual workers' capability and documentation and ensuring that decisions about supervision are continually considered against human-rights principles such as least restrictive practice, dignity, and safety (findings 3.1, 3.5, 3.6).

# 6. Discussion

The analysis in this report points to a coherent but still underdeveloped evidence base for supervision in isolated disability support work. The academic and practice-based literature agrees around the need for **frequent, structured, relational and risk-responsive supervision, supported by manageable spans of control and rapid access to decision-making support.** However, the evidence does not identify one fixed ratio for supervision that will work in all situations. Consultation with stakeholders supported these findings and provided advice for practical implementation.

For these reasons, the report supports guidance based on principles rather than fixed numbers. The intensity of supervision needed should depend on the level of risk and complexity in each setting. Important factors include the needs of the person with disability, the experience and skills of the worker, how isolated the work is, whether restrictive practices are used, the need for continuity of care, the availability of escalation pathways, and the supervisor's own skills and capacity.

## Practice and policy insights from the findings

A central implication is that **supervision should be understood as core safety infrastructure** rather than only administrative or a way to develop the workforce. In isolated work, supervision can be a key mechanism for managing work health and safety risks, supporting timely decisions, reducing professional isolation, enabling reflective practice and safeguarding the rights and wellbeing of people with disability. This means responsibility should not sit solely with individual workers. **Organisations and systems need to design supervision arrangements that support safe, rights-based and person-centred practice.**

**Span of control should be treated as a question of supervisor capability *and* capacity**, not just the number of workers they are responsible for. Supervisors bring different levels of experience and expertise to their role, and this affects the support they can provide. Alongside this, a supervisor's capacity is shaped by the number of workers they support, but also by travel, dispersed locations, documentation, rostering, incident follow-up, mentoring, debriefing, liaison and communication, and the relational work required to build trust and psychological safety. The same number of workers may therefore be manageable in a stable, team-based setting but unsafe in an isolated, high-risk or clinically complex context. **For this reason, supervision ratios should be risk-adjusted and reviewed regularly** rather than applied as generic organisational targets.

**The complexity of a person's support needs should strongly influence the level of supervision required**. Workers supporting people with changing health needs, behavioural complexity, communication difficulties, cognitive impairment, trauma histories or authorised restrictive practices need closer and more responsive supervision than workers in lower-risk or more stable situations. **The worker's experience is also a very important consideration**. New workers, casual or agency staff, workers who do not know the person well, and workers in high-risk situations need more frequent check-ins, clearer escalation pathways and stronger opportunities for debriefing and reflective practice.

**Supervision needs to be connected to wider safeguarding systems**, including incident reporting, behaviour support, restrictive practice authorisation, WHS processes, training, handover, documentation, quality assurance and escalation. If supervision sits outside these systems, it risks becoming a private conversation rather than a way to support organisational learning, risk prevention and accountability. When supervision is part of governance and safeguarding systems, it can help identify emerging risks, strengthen continuity of care and support consistent practice across teams and shifts. It also supports continuity of care by ensuring key information about health, behaviour, communication, preferences, risks and support strategies is shared and used consistently across rosters, shifts and settings.

Consultation feedback showed that **organisations need practical guidance for implementation,** including a clear decision-making framework, practical examples, and stronger links between supervision, safeguarding, workforce sustainability and outcomes for people with disability. This means the findings should be used to explain not only what good supervision looks like, but also how organisations can decide how much supervision is needed, how it should be delivered, and how escalation and debriefing should occur when workers are alone or facing uncertainty. This will also help with confusion about what constitutes supervision, when sometimes the term is applied to support workers in their practice (such as in the case of restrictive practices).

The evidence also shows that **rights and safety should not be treated as opposing goals**. Good supervision can help workers support a person's autonomy and dignity of risk while also managing risks to worker safety and wellbeing. Without adequate supervision, workers may be left to manage these tensions alone. This can lead to risk-averse decisions, inconsistent practice or greater reliance on restrictive responses. Rights-based, person-centred and trauma-informed supervision can help workers think through these issues, consider less restrictive options and make decisions that uphold both safety and autonomy.

Implementation is also affected by funding and workforce conditions. NDIS pricing, funding limits, casual and part-time work, 24-hour rosters, workforce shortages and staff working across several services can all make it harder to provide consistent supervision. These constraints need to be recognised, because supervision cannot be treated as optional or unfunded if it is needed for safety, quality and safeguarding. **System-level reform may be needed** to make sure supervision time, supervisor capability and rapid decision-making support are properly resourced.

## Gaps, limitations and future research

The limitations of the evidence base (detailed above) mean that the findings should be implemented with careful monitoring, contextual judgement and ongoing review. **Future research** should consider design and evaluation of supervision models, test risk-adjusted approaches to span of control, examine links with worker safety, participant outcomes and restrictive practices, and access to rapid-response or technology-enabled supervision systems. It should include people with disability, families, workers and supervisors to define safe, rights-aligned and effective supervision in practice.

# 7. References


Averill, P., Bowness, B., Henderson, C., & Sevdalis, N. (2024). What does 'safe care' mean in the context of community-based mental health services? A qualitative exploration of the perspectives of service users, carers, and healthcare providers in England. *BMC Health Services Research*, *24*(1), 1053. https://doi.org/https://doi.org/10.1186/s12913-024-11473-3

Bacchi, C. (2016). Problematizations in Health Policy:Questioning How "Problems" Are Constituted in Policies. *Sage Open*, *6*(2), 2158244016653986. https://doi.org/10.1177/2158244016653986

Clibbens, N., Close, A., Poxton, J., Davies, C., Geary, L., & Dickens, G. (2024). Psychosocial Care Delivery in Intensive Home Treatment During a Mental Health Crisis: A Qualitative Thematic Analysis. *International Journal of Mental Health Nursing*, *33*(6), 2257-2266. https://doi.org/https://doi.org/10.1111/inm.13394

Cortis, N., & Van Toorn, G. (2022). Safeguarding in Australia's new disability markets: Frontline workers' perspectives. *Critical Social Policy*, *42*(2), 197-219. https://doi.org/10.1177/02610183211020693

Cvetanovska, N., Said, S., & Jessup, R. L. (2025). Exploring the role of peer health navigators in the Australian health system: A qualitative interview study. *Health Expectations*, *28*(5), e70453.

Department of Social Services. (2020). *Frontline Leader Organisational Designs and Span of Control*. Retrieved 17 July 2026 from https://abilityfirstaustralia.org.au/wp-content/uploads/2020/12/2020_AFA_S2_Control_Analysis_v2.pdf

Deveau, R., & Rickard, G. (2024). Contextual and individual barriers to providing practice leadership by frontline managers in community services for adults with intellectual disabilities: A qualitative study. *British Journal of Learning Disabilities*, *52*(1), 11-22. https://doi.org/10.1111/bld.12542

Dowse, L. (2022). Practice Guide: Organisational approaches to reducing restrictive practices. *NDIS Quality and Safeguards Commission*.

Edmondson, A. (1999). Psychological safety and learning behavior in work teams. *Administrative science quarterly*, *44*(2), 350-383.

Ekstedt, M., Schildmeijer, K., Backåberg, S., Ljungholm, L., & Fagerström, C. (2022). 'We just have to make it work': a qualitative study on assistant nurses' experiences of patient safety performance in home care services using forum play scenarios. *BMJ Open*, *12*(5). https://doi.org/https://doi.org/10.1136/bmjopen-2021-057261

Farrelly, T., Flaherty, S., & Healy, H. (2019). The challenges to public health nurse practice in rural Ireland. *Public Health Nursing*, *36*(3), 341-347. https://doi.org/10.1111/phn.12595

Field, L., Nagy, L., Knaggs, T., & Collett, J. (2024). Positive risk-taking within social care for adults with physical disabilities: A review of guidelines in practice in England. *Br J Occup Ther*, *87*(8), 466-476. https://doi.org/10.1177/03080226241246511

Gould, J. (2025). They Deserve More: Social Justice and the Disability Support Workforce Crisis. Pac Rim: The Premier Global Gathering on Disability, Honolulu, Hawaii, USA.

Government of South Australia. (2012). *Work Health and Safety Regulations 2012*. Retrieved 20 July 2026 from https://www.legislation.sa.gov.au/_legislation-documents/lz/c/r/work-health-and-safety-regulations-2012/current/2012.268.auth.pdf

Gray, J. A., & Muramatsu, N. (2013). When the job has lost its appeal: Intentions to quit among direct care workers. *Journal of Intellectual and Developmental Disability*, *38*(2), 124-133.

Gur, A., & Klein, M. (2025). Social work supervision in the disability field: a systematic literature review. *Social Work Education*, *44*(3), 409-430. https://doi.org/10.1080/02615479.2024.2319251

Hallinan, P., & McMahon, A. (2024). Supporting relational, trauma-informed social care work with autistic adults: Evaluation of a reflective supervision group pilot. *The British Journal of Social Work*, *54*(1), 3-21.

Hawkins, R., Redley, M., & Holland, A. J. (2011). Duty of care and autonomy: how support workers managed the tension between protecting service users from risk and promoting their independence in a specialist group home. *Journal of Intellectual Disability Research*, *55*(9), 873-884. https://doi.org/https://doi.org/10.1111/j.1365-2788.2011.01445.x

Health Services Union. (2024). *2023-24 NDIS Annual Price Review*. Retrieved 17 July 2026 from https://hsu.net.au/wp-content/uploads/2024/11/2024.02-HSU-response-to-NDIS-APR.pdf

Holen-Rabbersvik, E., Eikebrokk, T. R., Fensli, R. W., Thygesen, E., & Slettebø, Å. (2018). Critical issues for employees in inter-municipal health care services: a multiple case study. *BMC Health Services Research*, *18*(1), N.PAG-N.PAG. https://doi.org/10.1186/s12913-018-3586-8

Iacono, T., Bould, E., Beadle-Brown, J., & Bigby, C. (2019). An exploration of communication within active support for adults with high and low support needs. *J Appl Res Intellect Disabil*, *32*(1), 61-70. https://doi.org/10.1111/jar.12502

Janlöv, A.-C., Granskär, M., & Berg, A. (2015). Challenges highlighted during peer supervision by mental health nurses and social workers recently trained as case managers in Sweden. *Issues in Mental Health Nursing*, *36*(10), 809-816.

Jepsen, D. M., Du Toit, S. H. J., Barker, T. R., Wodak, S., Lawn, E., Freeburn, T., Rhee, J., Laragy, C., & Convery, E. (2025). Caring for home care workers: Health and safety hazards, harms and risk factors. *PLoS One*, *20*(8). https://doi.org/https://doi.org/10.1371/journal.pone.0329959

Koelewijn, A., Lemain, C., Honingh, A. K., & Sterkenburg, P. S. (2023). View of relatives on quality of care: narratives on the care for people with visual and intellectual disabilities. *Disability & Society*, *38*(3), 483-502. https://doi.org/10.1080/09687599.2021.1947192

Lenthall, S., Wakerman, J., Dollard, M. F., Dunn, S., Knight, S., Opie, T., Rickard, G., & MacLeod, M. (2018). Reducing occupational stress among registered nurses in very remote Australia: A participatory action research approach. *Collegian*, *25*(2), 181-191. https://doi.org/10.1016/j.colegn.2017.04.007

Lived Experience Workforce Program. (2022). *Mental Health Peer Supervision Framework*. Retrieved 17 July 2026 from https://mhcsa.org.au/wp-content/uploads/2022/02/LEWP-Peer-Supervision-Framework-140222.pdf

Lokman, S., Bal, R., Didden, R., & Embregts, P. J. C. M. (2025). The role of relational work in promoting safe community participation by people with mild intellectual disabilities and severe challenging behaviour living in residential facilities. *Research in Developmental Disabilities*, *158*, 104946. https://doi.org/https://doi.org/10.1016/j.ridd.2025.104946

MacLochlainn, J., McFadden, P., McColgan, M., Naylor, R., Schroder, H., McGrory, S., Nicholl, P., Currie, D., Kirby, K., & Mallett, J. (2025). Children's Social Work Safe Staffing Supply and Workforce Demands Analysis: A Case Study from Northern Ireland. *British Journal of Social Work*, *55*(3), 993-1014. https://doi.org/10.1093/bjsw/bcae163

Marsh, P., & Kelly, L. (2018). Dignity of risk in the community: A review of and reflections on the literature. *Health, Risk & Society*, *20*(5-6), 297-311.

McFadden, P., Davies, H., Manthorpe, J., MacLochlainn, J., McGrory, S., Naylor, R., Mallett, J., Kirby, K., Currie, D., Schroder, H., Nicholl, P., Mullineux, J., & McColgan, M. (2024). Safe Staffing and Workload Management in Social Work: A Scoping Review of Legislation, Policy and Practice. *British Journal of Social Work*, *54*(5), 2006-2026. https://doi.org/10.1093/bjsw/bcae017

McFadden, P., Maclochlainn, J., Manthorpe, J., Naylor, R., Schroder, H., McGrory, S., Ravalier, J., Nicholl, P., Currie, D., Kirby, K., Davies, H., Mullineux, J., McColgan, M., & Mallett, J. (2024). Perceptions of Safe Staffing, Self-Reported Mental Well-being and Intentions to Leave the Profession among UK Social Workers: A Mixed Methods Study. *British Journal of Social Work*, *54*(5), 1965-1987. https://doi.org/10.1093/bjsw/bcae014

McKeown, M., Thomson, G., Scholes, A., Jones, F., Baker, J., Downe, S., Price, O., Greenwood, P., Whittington, R., & Duxbury, J. (2019). "Catching your tail and firefighting": The impact of staffing levels on restraint minimization efforts. *Journal of Psychiatric and Mental Health Nursing*, *26*(5-6), 131-141. https://doi.org/https://doi.org/10.1111/jpm.12532

National Disability Insurance Scheme. (n.d.). *NDIS Code of Conduct*. Retrieved 17 July 2026 from https://www.ndiscommission.gov.au/rules-and-standards/ndis-code-conduct#paragraph-id-10878

National Disability Services. (2026). Foundations for 1:1 Line-of-Sight Supervision Tool: Co-design program under EU Term 3.3.1 of the Enforceable Undertaking by Department of Human Services (in press).

National Disability Services. (n.d.-a). *Full Strategy and Action Plan*. Retrieved 30 June 2026 from https://nds.org.au/images/resources/tas-allied-health/Full-Strategy-and-Action-Plan_final.pdf

National Disability Services. (n.d.-b). *Workforce Hub*. Retrieved 17 July 2026 from https://nds.org.au/policy-and-advocacy/workforce/

NDIS Quality and Safeguards Commission. (2019). *Incident Management Systems Detailed Guidance for Registered NDIS Providers* Retrieved 20 July 2026 from https://www.ndiscommission.gov.au/sites/default/files/2024-09/detailed-guidance-incident-management-systems-detailed-guidance-regi-20240926.pdf

NDIS Quality and Safeguards Commission. (2020). Regulated Restrictive Practices Guide. *NDIS Quality and Safeguards Commission*(20 July 2026).

NDIS Quality and Safeguards Commission. (2023). *Supervising for Capability* Retrieved 20 July 2026 from https://www.ndiscommission.gov.au/sites/default/files/2025-12/WCF-Super-Overview-Resources-Workers-PDF.pdf

Nickson, A., Gair, S., & Miles, D. (2016). Supporting Isolated Workers in their Work with Families in Rural and Remote Australia: Exploring Peer Group Supervision. *Children australia*, *41*(4), 265-274. https://doi.org/10.1017/cha.2016.41

O'Hagan M, D. M., Long J,. (2008). Best practice in the reduction and elimination of seclusion and restraint; Seclusion: time for change. *Auckland: Te Pou Te Whakaaro Nui: the National Centre of Mental Health Research, Information and Workforce Development*.

Pack, M. (2015). 'Unsticking the Stuckness': A Qualitative Study of the Clinical Supervisory Needs of Early-Career Health Social Workers. *The British journal of social work*, *45*(6), 1821-1836. https://doi.org/10.1093/bjsw/bcu069

Patynowska, K. A., McConnell, T., McAtamney, C., & Hasson, F. (2023). 'That just doesn't feel right at times' – lone working practices, support and educational needs of newly employed Healthcare Assistants providing 24/7 palliative care in the community: A qualitative interview study. *Palliative Medicine*, *37*(8), 1183-1192. https://doi.org/10.1177/02692163231175990

Piper, L. (2025). Risk as a Right: Supporting Dignity of Risk in Disability Services Pac Rim: The Premier Global Gathering on Disability, Honolulu, Hawaii, USA.

Regional Local Health Network. (2023). *Allied Health Professional Supervision Framework*. Retrieved 17 July 2026 from https://www.sahealth.sa.gov.au/wps/wcm/connect/a0d70888-9276-4d79-bafd-

487b04a5671c/Regional+LHN+Allied+Health+Professional+Supervision+Framework_2024+06.pdf?MOD=AJPERES&CACHEID=ROOTWORKSPACE-a0d70888-9276-4d79-bafd-487b04a5671c-pZu8XDw

Rothwell, C., Kehoe, A., Farook, S. F., & Illing, J. (2021). Enablers and barriers to effective clinical supervision in the workplace: a rapid evidence review. *BMJ Open*, *11*(9), e052929. https://doi.org/10.1136/bmjopen-2021-052929

SafeWork Australia. (n.d.-a). *Managing WHS risks Review controls*. Retrieved 20 July 2026 from https://www.safeworkaustralia.gov.au/book/health-care-and-social-assistance/managing-whs-risks/review-controls

SafeWork Australia. (n.d.-b). *Psychosocial hazards*. Retrieved 20 July 2026 from https://www.safeworkaustralia.gov.au/book/health-care-and-social-assistance/hazards-risks-and-controls/psychosocial-hazards

SafeWork SA. (2026). *Enforceable Undertaking Application Guidelines*. Retrieved 17 July 2026 from https://safework.sa.gov.au/__data/assets/pdf_file/0004/136624/Enforceable-Undertaking-Application-Guidelines-Amended-A3833150.pdf

SafeWork SA. (n.d.-a). *Emergency response*. Retrieved 20 July 2026 from https://safework.sa.gov.au/workplaces/emergency-response

SafeWork SA. (n.d.-b). *Remote and isolated work*. Retrieved 20 July 2026 from https://safework.sa.gov.au/workplaces/psychosocial-hazards/remote-and-isolated-work

Society for Human Resource Management. (2013). *Span of Control: What factors should determine how many direct reports a manager has?* . Retrieved 17 July 2026 from https://web.archive.org/web/20130719121159/http:/www.shrm.org/TemplatesTools/hrqa/Pages/Whatfactorsshoulddeterminehowmanydirectreportsamanagerhas.aspx

Steele, L., Carr, R., Swaffer, K., Phillipson, L., & Fleming, R. (2020). Human Rights and the Confinement of People Living with Dementia in Care Homes. *Health Hum Rights*, *22*(1), 7-19.

Stevens, E., Price, L., & Walker, L. (2022). "Just because people are old, just because they're ill..." dignity matters in district nursing. *The Journal of Adult Protection*, *24*(1), 3-14. https://doi.org/https://doi.org/10.1108/JAP-07-2021-0024

Svanström, J., Skytt, B., Lindberg, M., & Lindberg, M. (2025). Expanded span of control, leadership and management performance, work-related stress, and job satisfaction among first-line managers: A repeated cross-sectional study. *WORK*, *81*(3), 2952-2963. https://doi.org/10.1177/10519815251326470

Terras, M. M., Hendry, G., & Jarret, D. (2019). The challenges of safety and community integration for vulnerable individuals. *Safety*, *5*(4), 85.

Van der Meulen Anne Pier, S., Hermsen, M. A., & Embregts Petri, J. C. M. (2018). Restraints in daily care for people with moderate intellectual disabilities. *Nursing Ethics*, *25*(1), 54-68. https://doi.org/https://doi.org/10.1177/0969733016638141

Watson, J., Jenkin, E., Anderson, K., O'Shea, A., Murfitt, K., David, J., Taylor, S., Ge, G., Frawley, P., & Dew, A. (2025). A human rights framing of the experiences of supporting people with intellectual disability in congregate care: Post-pandemic reflections. *Journal of Intellectual & Developmental Disability*, 1-11. https://doi.org/https://doi.org/10.3109/13668250.2025.2513336

Weaver, N., Coffey, M., & Hewitt, J. (2017). Concepts, models and measurement of continuity of care in mental health services: A systematic appraisal of the literature. *Journal of psychiatric and mental health nursing*, *24*(6), 431-450. https://doi.org/10.1111/jpm.12387

West, R., Yates, S., & Dickinson, H. (2025). Training and supervision of disability support workers: Perspectives of NDIS participants using unregistered providers. *Australian Journal of Social Issues*, *60*(1), 270-286.

Flinders University

CRICOS No. 00114A