Policy Title	**Supervision**	**Date Implemented** **or Date of Last Review**	**03/20**
Policy Reference	**2 (25)**	**Date of Next Review**	**03/21**

1. Clinical Supervision

1.1 Introduction

i. This policy aims to provide for an achievable system of clinical supervision across Cove Care.

This policy is inclusive of the professionally-registered and care support workforce (i.e. all professional staff with substantive service-user contact) across the company.

Some non-clinical staff who have significant service-user contact may also require degrees of supervision. These individuals/groups of staff will be identified by the Senior Management Team.

ii. Operational definitions.
Clinical supervision is "…. a formal process of professional support and learning which enables individual practitioners to develop knowledge and competence, assume responsibility for their own practice, and enhance a consumer protection and safety of care in complex situations" (Department of Health,1993).

In its broadest sense, effective clinical supervision has the following components:

Management supervision: this is usually between the line manager and employee, and focuses mainly on task allocation and general performance issues.

Practice supervision: this form of supervision aims to bring about direct learning as a result of reflective practice and casework discussion. It also implies a direct accountability for the practice of supervisees.

Professional supervision: this addresses issues such as professional identity, the development of technical skills and competencies, and identifies areas for professional development i.e. training and Continuous Professional Development (CPD).

For the purpose of this policy, clinical supervision is the provision of regular, structured meetings for all staff within the remit of the policy (see section 3 above). In practice, the baseline provision for clinical supervision within the company be delivered usually in a structured, one-to-one format and have each of the above (management, practice and professional) supervision components (outlined further in Appendix VII). These components will be set at a ratio depending on the need of the supervisee and is identified and agreed by the supervisor and supervisee at the outset of the supervision relationship.

However, this policy further acknowledges that effective quality clinical supervision could also be delivered in a range of different formats and settings and that these are also relevant to professionals working within modern health settings. This is outlined in Section 6.

Usually supervision will be delivered by an individual's direct line manager or other senior member within that discipline, although in certain circumstances cross-disciplinary supervision or supervision external to the organisation may be appropriate.

viii. It is the responsibility of the particular Registered Manager to ensure that the allocation of supervision to supervisees reflects factors such as skill mixing, gender, professional background, be professional goal-orientated, reflect the clinical and child and young person needs of the service, be in line with the practical working arrangements and should be made with the consent of both parties wherever practicable.

ix. The Registered Manager should also ensure that all allocated clinical supervisors are fit for purpose, receive adequate support and training, and are able to demonstrate the following core characteristics.

- Expertise (i.e. adequate levels of skill, experience and training).
- Experience (i.e. be recognised as developing breadth and depth of experience at their level of operation)
- Acceptability/credibility (i.e. the supervisor should be acceptable to those they supervise and credible as a skilled practitioner).
- Training (i.e. in receipt of supervision-specific training and can evidence satisfactory levels of professional development educational activities)
- Commitment (i.e. evidence of arranging and attending sessions and demonstrate regard for the supervisee).

x. Other skills that supervisors should have or develop include professional curiosity about new ideas; an openness and flexibility in their clinical and professional outlook and approaches, analytical in their thinking about the supervision content; and facilitative in their method of supporting and promoting learning for the supervisee. Guidance for the development of in-service training programmes are included in Appendix III.

xi. When these structures are put in place by the Registered Manager, it is the shared responsibility of the clinical supervisor and supervisee to ensure that supervision sessions are arranged and are completed.

xii. Other strategies for local implementation of clinical supervision are included in Appendix 1.

xiii. Guidelines for supervisees in their preparation for supervision is included in Appendix III

xiv. Where delays occur in the running of regular sessions between supervisor and supervisee, it is the responsibility of the clinical supervisor to ensure that all satisfactory measures have been taken to facilitate the sessions and that these measures are documented and auditable.

xv. One to one supervision sessions should preferably take place in a safe, comfortable environment which is conducive to open and confidential discussion. This should be away from the main child and young person areas to minimise the potential for disturbances or the content being overheard.

xvi. Multidisciplinary approaches to supervision (i.e. reflective team meetings and staff support systems) can be effective models for supervision, especially where the focus is on clinical MDT interventions, where "management supervision "is seen as secondary to the process (Cutliffe & Hyrkas, 2006). It should be noted that this type of supervision, where utilised, does not replace the structured, one to one format in which the management issues have a clear focus.

xvii. Features of a range of disciplines' systems for clinical supervision are outlined in Appendix VIII.

1.2 Record Keeping

i. At the outset, all clinical supervision should be discussed and agreed by the supervisee and supervisor, and contracted on the Clinical Supervision Agreement (Supervision Form 1).

ii. The agreement should clearly set out and record basic ground rules for the supervision such as:

- Confidentiality (see blow)
- Frequency/duration (n.b. within minimum criteria set out in section 45.4 (iv) above)
- Areas for future supervision work
- Acknowledgement of the record-keeping process (see below)
- Evaluation process for the supervision.

iii. A record of date and occurrences is to be completed by the supervisor and supervisee in each case on the Supervision Register (Supervision Form 2). This record should be filed in the clinical area and kept for monitoring and audit purposes by the Registered Manager.

iv. The content of the supervision and any outcome/actions should be outlined on the Clinical Supervision Form (Supervision Form 3). This responsibility for the completion of this is that of the supervisors, although either party can complete the form during the session. All records

made should adhere to a professional code of practice for record-keeping (see NMC, 2005; Appendix IV).

v. The format of the supervision should be clearly documented at the top of the form from those examples listed above (i.e. structured/formal, group/informal, etc.) This will enable supervisors and supervisees to design a flexible approach to clinical supervision and to utilise a range of professional opportunities to carry it out.

vi. In addition, both supervisor and supervisee are encouraged to keep any additional personal notations they find useful for further reference purposes, i.e. by reflective diary entries.

vii. The Clinical Supervision Register is kept on the clinical area and can be accessible for monitoring and quality audit purposes. The Clinical Supervision Agreement and Clinical Supervision Forms should be given to the supervisee, with additional hard copies kept confidentially and securely in the unit's Human Resources department, accessible only to the line manager, Registered Manager/designated Senior Management Team member (where different) in the following circumstances:

- Performance Development Review (PDR) cases
- Where there are concerns regarding the safety and/or well-being of a client
- Where there are concerns regarding professional misconduct issues.

In these circumstances, the supervisor will aim to inform the supervisee regarding any third party involvement wherever possible, although this might not be practicable in all instances.

viii. References to service-users should be anonymous at all times within the clinical supervision records. Abbreviations or initials should be used. Further to this, there should be a system in place for advising service-users about the nature of supervision generally and the potential for them to be subjects for supervision.

Senior Management Team. This application should detail why the external provision is necessary, a clear cost-benefit analysis, and the benefits to the practitioner themselves, the child and young person group and the operational needs of the service.

It is of the utmost importance for the implementation of effective supervision, which facilitates best practice and focuses on safe, autonomous professional development, that supervisors recognise and are able to distinguish the separate components to their role as clinical supervisors (Edwards *et al*, 2005). For instance, the provision of quality clinical supervision is not restricted to issues of line management only.

The primary role and function of the clinical supervisor is to support and empower the practitioner and to promote the development of their clinical practice.

The primary role of the clinical supervisee is to be open, objective and motivated about their professional development, be able to contribute respectfully and professionally within supervision sessions, and to respond appropriately to constructive feedback from the supervisor.

1.3 Rationale

i. A robust system for the delivery of clinical supervision is central to the safe and effective management of health services (Draper *et al,* 1999).
ii. Sound clinical supervision systems have been found to improve child and young person care outcomes (Hyrkas & Paunonen-Ilmonen, 2001; Hyrkas *et al* 2006); staff morale (Berg & Hallberg, 1999) and staffing retention (Nicklin, 1997) in specialist health services.
iii. There is also some evidence which indicates that the delivery of clinical supervision may reduce stress and burnout levels amongst staff (Williamson & Dodds, 1997).

1.4 Clinical Supervision Format

There are various formats for the provision of clinical supervision:

- One-to-one formal clinical supervision: structured regular meetings with management, practice and professional development functions.

- One-to-one informal supervision: utilising an ad-hoc arrangement between a staff member and appropriately skilled supervisor when necessary. This may be performed following a serious or significant incident, and its aim is to compliment the one-to-one formal arrangement, not to replace it.

- Preceptorship: the identification of an experienced practitioner to provide transitional role support (Butterworth & Faugier, 1992). This is often done with (but is not restricted to) recently qualified professionals and has both professional and academic perspectives.

- Mentorship: the provision of an enabling relationship which facilitates professional development for the staff member (Butterworth & Faugier, 1992). This is often done with student or training professionals but can also be utilised to promote the lifelong learning process for all staff, and to facilitate in the process of professional and academic formal learning i.e. NVQ and post registration programmes of education.

- Coaching/Role modelling: the provision of "supervision in-action" by a suitably qualified staff member. This format effectively utilises specific learning opportunities from general ward-based activities.

- Group formal supervision (Begat *et al,* 1997): structured regular sessions between groups of staff, most often multidisciplinary and facilitated by senior suitably qualified and skilled staff.

- Group informal supervision utilising ad-hoc meetings between staff when needed. This might take the form of care planning meetings, or held following a critical incident.

- Individual reflective practice: staff member maintains a reflective journal or log, which is supported and reviewed regularly by the supervisor. The reflective material can be used thematically as learning and development opportunities (for later reflection in -and on- action, see Schon, 1983)

- Group Reflective Practice: organised formal sessions facilitated by skilled and experienced staff, utilising a structured model of reflection (i.e. Olofsson, B, 2005; Palmer *et al* 1994).

- Peer/"buddy" supervision: informal or formal support between colleagues of equal grade.

- Post-Incident De-Briefs: the structured individual or group meeting to review the impressions and reactions that staff experience during or following critical and/or serious incidents (Dyregrov, 1989).

- Team meetings: regular, discipline-specific meetings, often with a focus on day-to-day professional operations, which can incorporate supportive and educational components to compliment other forms of supervision.

1.5 Clinical Supervision: Delivery

i. This policy acknowledges the validity of each of the above supervision formats listed under 45.3.

ii. It is the responsibility of the particular Registered Manager to ensure that adequate arrangements for a framework for clinical supervision, utilising the above mechanisms, are in place on a continuous and ongoing basis for all their staff. Some suggestions for local implementation are found in Appendix 1.

iii. These arrangements will be informed by a comprehensive service-level training needs risk assessment.

iv. While any combination of a number of the above formats is acknowledged as the most effective method of delivering clinical supervision to individual practitioners and to groups of professionals, this policy directs that all staff within its remit receives as an absolute minimum 1 hour of one to one formal supervision per month. This is the minimum required to ensure satisfactory levels of support.

v. This one to one formal supervision should include aspects of management, practice development and professional development supervision as identified by the supervisee and supervisor on an ongoing basis. Examples of issues that may be covered within each aspect are outlined in Appendix.

vi. Further to this, it is the responsibility of the Registered Manager to ensure that individual members of staff receive any *ad hoc* support.

vii. This supplementary support is of particular importance in acute or dynamic services with high levels of clinical incidents. Here, structured group reflective practice (see Gibbs, 1994 *inter alia:* see appendix II) led by skilled and experienced staff, might be particularly effective in facilitating safe and effective thinking around difficult clinical situations, reducing stress and minimising the effects of trauma, and generating proactive action plans (Palmer *et al,* 1994).

ix. Records should be stored as above. Where supervision is recorded electronically, this should be agreed at the outset by the supervisor and supervisee, but the storage of records should remain by hard copy in the Registered Manager's safe and secure area.

1.6 Audit

i. It is the responsibility of the Registered Manager to ensure that the system of clinical supervision is quality audited. As a minimum, this audit should monitor:

- Each individual has a clinical supervisor in place.
- Supervision sessions occur as a minimum 1 hour each month for all staff
- All Clinical Supervision Records are completed and signed.

ii. Further more in-depth, evaluative audits should take place according to the need of the service and/or department. Guidelines for these audits are found in Appendix V.

References

Begat, I.B.E.; Severinsson, E.I.; & Bergen, I.A. (1997): Implementation of clinical supervision in a medical department: nurses' views of its effects. *Journal of Clinical Nursing* 6, 389-394.

Berg, A. & Hallberg, I.R. (1999): Effects of systematic clinical supervision on psychiatric nurses' sense of coherence, creativity, work-related strain, job satisfaction and view of the effects from clinical supervision: a pre-post test design. *Journal of Psychiatric and Mental Health Nursing* 6, 371-381.

British Psychological Society (BPS) (2003): *Policy Guidelines on Supervision in the Practice of Clinical Psychology.* London: BPS.

Butterworth, T, & Faugier, J. (1992):*Clinical Supervision and Mentorship in Nursing.* London: Chapman & Hall.

College of Occupational Therapy (1997): *Standards, Policies and Procedures: Statement on Supervision in Occupational Therapy.* London: College of Occupational Therapy

Cutliffe, J.R. & Hyrkas, K. (2006): Multidisciplinary attitudinal positions regarding clinical supervision: a cross-sectional study. *Journal of Nursing Management* 14, 617-627.

Department of Health (1993): *A Vision for the Future.* London: HMSO/NHS Management Executive

Draper. B.; Koukos, C.; Fletcher, P.; Whitehead, A.; Reynolds, F.; Coleman, M.; & Rafferty, M. (1999): Evaluating an initiative: clinical supervision in a community health trust *British Journal of Community Nursing* 4, 525-530

Dyregrov,A (1989): Caring for helpers in disaster situations: psychological debriefing. *Disaster Management* 2 (1), 25-30

Edwards, D; Cooper, L; Burnard, P, Hanningan, B; Adams, J; Fothergill, A: & Coyle, D. (2005): Factors influencing the effectiveness of clinical supervision. *Journal of Psychiatric and Mental Health Nursing* 12, 405-414.

General Social Care Council (GSCC) (2002): Code of Practice for Social Care Workers and Code of Practice for Employers of Social Care Workers. London: GSCC

Gibbs, G. (1994): The Reflective Cycle In: Palmer, A.M; Burns, S & Bulman, C. (1994): *reflective practice in Nursing: The Growth of the Reflective Practitioner.* Oxford: Blackwell Science.

Hyrkas, K; Appelqvist-Schmidlechner, K.A; & Haataja, R. (2006): Efficiency of clinical supervision: influence on job satisfaction, burnout and quality of care. *Journal of Advanced Nursing 55 (4), 521-535.*

Hyrkas, K & Paunonen-Ilmonen,M.2001): The effects of clinical supervision on the quality of care: examining the results of team supervision. *Journal of Advanced Nursing 33, 492-502*

Nicklin, P. (1997) *Clinical Supervision – Efficient and Effective?* Final Report to Research Steering Group. York: Hexham Genera Home.

Nursing and Midwifery Council (NMC) (2001a) *Clinical Supervision.* London: NMC A-Z Advice Sheet.

Nursing and Midwifery Council (NMC) (2001b) *Supporting Nurses and Midwives Through Lifelong Learning.* London NMC.

Nursing and Midwifery Council (NMC) (2005) *Guidelines for Records and Record Keeping.* London: NMC.

Olofsson, B. (2005): Opening up: psychiatric nurses' experience of participating in reflection groups focussing on the use of coercion. *Journal of Psychiatric and Mental Health Nursing 12, 259-267.*

Palmer, A.M.; Burns, S. & Bulman,C. (1994): *Reflective Practice in Nursing the Growth of the Reflective Practitioner.* Oxford: Blackwell Science.

Royal College of Psychiatrists (RCP) (2001): *Curriculum for Basic Specialist Training and the MRCPsych Examination.* Council Report CR95. London : RCP.

Schon, D.A. (1983): *The reflective Practitioner.* New York: Jossey-Bass

Williamson, G.R.; & Dodds, S. (1997): The effectiveness of a group approach to clinical supervision in reducing stress: a review of the literature. *Journal of Clinical Nursing 8, 338-344.*

APPENDIX I: LOCAL IMPLEMENTATION STRATEGIES

Block out sessions (i.e. ½ day sessions as required) in the unit diary each week to accommodate the facilitation of clinical supervision.

Ensure that whole team and the unit administrators know that no other meetings or sessions are to be double-booked with these supervision sessions.

The Unit Manager should liaise with other heads of departments to aim to recruit different members of the multidisciplinary team to undertake unit tasks during these periods to free up staff to attend supervision sessions.

The Unit Manager should look to deploy flexible off duty/rota allocation around the times that clinical supervision sessions are booked.

Strategic parts of the working clinical day (i.e. child and young person leave periods, school or therapy) might also be utilised creatively in order to facilitate supervision sessions.

Any additional strategies (i.e. provision of overtime or time owing arrangements) for the facilitation of clinical supervision must be agreed in advance in agreement with the supervisee, the supervisor, and the Head of the particular department in accordance with the local services budgetary allowances.

APPENDIX II: REFLECTIVE CYCLE

1. Description of facts: What happened?"

2. THOUGHTS: "What were you thinking about during ....."

3. FEELINGS: "How did this make you feel?"

4. ANALYSIS: "Why did it happen?"

5. EVALUATION: “What was good and bad about the experience?”

---

7. ACTION PLAN: “How can your practices be changed as a result of the experience?”

From Gibbs, 1994

APPENDIX III: GUIDELINES FOR SAMPLE CONTENT OF IN-SERVICE TRAINING PROGRAMMES FOR CLINICAL SUPERVISORS

Area	Content
Definitions	Theoretical models of supervision
Process of supervision	Reflective Practice
The Clinical Supervisory Relationship	Setting ground rules Confidentiality Boundary setting Responsibility Preparing to supervise Preparing to be supervised
Delivery	Methods of effective communication Management/Practice/Professional components Listening Non-verbal communication Reflecting Paraphrasing Focussed interviewing (cognitive model)
Group delivery	Managing Group Dynamics Post-Incident Supervision Reflective Practice Post-Incident De-Brief Mediation

APPENDIX IV: GUIDELINES FOR SUPERVISEES

You can analyse and value what you are learning by:

- Identifying the clinical, managerial or organised issues that you bring to the clinical supervision sessions.
- Reflecting on what you have explored in each session.
- Examining your current practice in relation to the areas/situations covered.
- Identifying and sharing any further learning needs
- Making decisions about how and where the new learning can be used.

You can devise a plan for putting learning into practice by:

- Planning what you want to achieve
- Identifying the areas of practice you want to develop
- Setting realistic aims and time for completion

- Identifying relevant resources and further learning support.
- Reviewing and evaluating your progress with your clinical supervisor.

You can record what you have achieved by:

Reporting your reflections to these activities and recording other learning opportunities that happen.
- Maintaining a personal record of the progress that you are making.
- Writing a critical review showing how you have changed or adapted your practice.

Source: Palmer *et al,* 1994)

GUIDELINES FOR SUPERVISEES

Phase 1
Preparing for Clinical Supervision
- Why am I engaging in clinical supervision:
- What do I want from the relationship
- What areas of my practice do I want to develop?
- How can I successfully become involved?
- How will I know what I have gained or learnt from the experience?

How will I know what I have gained or learnt from the experience?

Phase 2
Choosing a Clinical Supervisor
- What do I want from a clinical supervisor?
- Who has the skills to help me assess my limitations and build on my strengths?
- Who can help me challenge my assumptions?
- Who can I work effectively with?

Phase 3
Working with My Clinical Supervisor
- What are our mutual expectations of roles?
- What will be our commitment?
- How are we building trust and confidence in each other's abilities?
- Who sets the agenda?
- How does the relationship offer scope for my personal and professional development?

Phase 4
Reflecting on the Relationship
- How do I feel about working with my clinical supervisor?
- How do I demonstrate that I remain committed to the clinical supervision process?
- What are the benefits and outcomes for child or young person/client care?
- Is ours an effective relationship and what criteria for effectiveness do we use?

- How will we know when these criteria have been met?
- How am I documenting what is happening and what am I learning?

It is suggested that these reflective activities will help you identify, and then work with further, the issues that arise – issues and challenges that will be particular to your own specific context and personal circumstances. It is important that the dialogue that you begin to have with these questions is recorded in your portfolio, and may even be shared with your clinical supervisor if you should so wish.

APPENDIX V: GUIDELINES FOR RECORD-KEEPING (FROM NMC, 2005)

Records should:

- Be factual, consistent and accurate
- Be written as soon as possible after an event
- Be written clearly and in such a manner that text cannot be erased
- Be written in such a manner that alterations are dated, timed and signed in such a way that the individual making the alteration is easily identifiable and that the original text can still be read
- Be accurately dated, timed and signed, with the signature printed alongside the first entry
- Not include abbreviations, jargon, meaningless phrases, irrelevant speculation and offensive subjective statements
- Be readable on photocopies

In addition, where supervision records make reference to a client or service user, individuals should be referred to by way of initials only.

APPENDIX VI. GUIDELINES FOR QUALITY AUDIT

Audit Standard	Audit Procedure
1. All staff have a clinical supervisor allocated.	Check records
2. All staff receive 1 hour of clinical supervision per month.	Check records
3. All supervision is documented as per policy	Check records
4. All documentation meet the NMC's guidelines documents	Scrutinise
5. All staff are satisfied with their supervision	Ask supervisees
6. Direct changes to clinical practice/child and young person care have occurred related to clinical supervision	Ask supervisees
7. All staff have read the clinical supervision policy	Ask staff
8. Direct impact on staff support has occurred since the implementation of clinical supervision.	Ask supervisees
9. Direct improvements to staff morale has occurred since the implementation of clinical supervision.	Ask supervisees


COVE CARE
RESIDENTIAL

APPENDIX VII: EXAMPLES OF ISSUES TO BE COVERED IN FORMAL ONE TO ONE CLINICAL SUPERVISION SESSIONS.

Management

- Monitor case load/work load
- Monitor standards of professionalism
- Monitor timekeeping, attendance and sick-leave
- Plan targets and performance indicators
- Plan learning and development opportunities
- Plan for and implement additional supervisory/supportive resources
- Monitor participation in professional activities, i.e. staff meetings, audit
- Discuss supervisees own supervision of junior staff where appropriate
- Establish links to PDR/appraisal

Practice Development

- Recognition of achievements and good practice areas
- Identification of areas for further development
- Relevant information of service development relevant and appropriate to role
- Support and reflection on clinical work with service users
- Exploration of emotional investment/involvement with service-users, especially regarding issues such as transference and counter-transference
- Promote evidence-based practice and interventions
- Monitoring of practice development work with colleagues i.e. contributions to education/staff
- development
- Advice, theoretical knowledge and clinical expertise
- Monitoring general competency of practice
- Referral to multidisciplinary colleagues/other resources for consultation for issues outside of the supervisors remit/expertise
- Provide ongoing constructive feedback
- Assess training and development needs and liaise with line manager/appraisal links

Professional Development

- Monitoring of professional standards, relevant codes of practice and conduct, professional competency and ethical decision-making
- Monitoring of professional registration
- Ensuring that supervisee meets minimum CPD criteria set by professional registration body
- Monitoring and supporting the continuing development of expertise in profession-specific interventions to ensure high standards of clinical excellence
- Ensuring that supervisees practice is in line with up to date evidence-based practice
- Ensuring supervisee practice is in line with anti-discriminatory practice

APPENDIX VIII: SUMMARY OF GUIDELINES FROM PROFESSIONAL PERSPECTIVES

1. Nursing

Guidelines Published: Nursing and Midwifery Council (NMC)

Key Papers:
NMC "A-Z" Advice Sheet on Clinical Supervision (2001a)
NMC Supporting nurses and midwives through lifelong learning (2001b)

2. Psychology

Guidelines Published: British Psychological Society

Key Paper:
Policy Guidelines on Supervision in the Practice of Clinical Psychology (BPS, 2003)

Key Positions
"The Division of Clinical Psychology has held for a long time that time and space to allow for reflection, discussion and feedback on all elements of practice is a valuable way of enhancing practice and improving service quality, whilst being uncertain about the detailed nature of what supervision and its parameters might be"

Clinical Psychologists should engage in clinical supervision at a level of 60-90 minutes for every 20 clinical sessions worked.

Medicine

Guidelines Published: Royal College of Psychiatrists

Key Paper:
Curriculum for Basic Specialist Training and the MRCPsych Examination (2001)

Key Positions:
Expectation that trainees receive one hour per week face to face supervision by the consultant. Medical professionals utilise the format of case review and case presentations to share examples of good practice for educational and development purposes.

Occupational Therapy

Guidelines Published: College of Occupational Therapists.

Key Paper:
Standards, Policies and Procedures: Statement on Supervision in Occupational Therapy (1997)

Key Position:
“Supervision should be interactive, and used as a means for ensuring that supervisees are able to do their job effectively, and are assisted in their own professional and personal development”.

Social Work

Guidelines Published: General Social Care Council (GSCC)

Key Paper:
Code of Practice for Social Care Workers and Code of Practice for Employers of Social Care

Key Position:
Section 2: Employers of social workers must ensure that systems are in place to ensure safe practice. This includes:

2.2. Effectively managing and supervising staff to support effective practice and good conduct and supporting staff to address deficiencies in their performance.

Section 6. Social Workers are accountable for the quality of their work and take responsibility for maintaining and improving knowledge and skills. This includes:

6.2. Seeking assistance from the employer or the appropriate authority if you do not feel able or adequately prepared to carry out any aspect of your work, or you are not sure how to proceed in a work matter.

Signed by Cove Care
Lee Smith

Director
March 2020

Supervision Agreement

THIS AGREEMENT IS MADE BETWEEN:

	and	
SUPERVISEE		SUPERVISOR

WE AGREE TO THE FOLLOWING:

1. The aims of supervision are to enable the supervisee to reflect in depth on issues affecting practice in order to develop professionally and personally towards achieving, sustaining and developing a high quality and safe service.

2. We will read, discuss and adopt the agreed departmental policy on supervision. The content of sessions will include clinical, managerial, training and personal issues when required, but will maintain a supervisory approach as described in the policy.

3. The time and place for supervision meetings will be protected by ensuring privacy, time boundaries, punctuality and no interruptions. Sessions will only be cancelled with good cause and an alternative date will be planned as soon as possible.

4. We shall aim to meet regularly as follows (note minimum setting of 1 hour per month):

   Frequency – FORTNIGHTLY/MONTHLY
   Length of session – 1.5 HOURS (approximately)

5. Sessions will be guided by an agenda agreed by both supervisor and supervisee.

6. The content of supervision will not be discussed outside the session unless expressly agreed by both parties, with the exception of unsafe, unethical or illegal practice being revealed.

7. A record of supervision will be kept confidentially by supervisor and supervisee as required. Only information relating to dates and times of supervision will be collected for audit purposes.

AS A SUPERVISEE I AGREE TO:

Take responsibility for making effective use of the time made available for supervision by preparing for it and acting upon decisions made within it.

Be willing to learn and change, and to receive support and challenges to help my professional and personal development, and to ensure service provision to agreed standards.

Be willing to acknowledge my weaknesses and be prepared to discuss difficulties with my supervisor within the supportive and constructive environment of the supervision session.

To recognise that my supervisor needs me to be open about my practice to gain maximum benefit.

AS A SUPERVISOR I AGREE TO:

Respect the openness and honesty of my supervisee and offer support, constructive feedback and information and advice to enable you to reflect in depth on issues affecting your practice and to develop professionally and personally.

Ensure that you have the appropriate skills to do your job effectively and that you are able to contribute to the provision of high quality service.

Keep all personal information revealed in supervision confidential. The explicit exception to this being where you reveal any unsafe, unethical or illegal practice and you yourself are willing to go through the appropriate organisational procedures to deal with it.

In the event of this arising, I will:

- Attempt to persuade and support you to deal with the issue directly through the appropriate channels
- Check that this has been done
- If not, only reveal the information to appropriate personnel after informing you that I am going to do so
- Continue to ensure that you are supported through a disciplinary or other process

Signed (Supervisee)		Date	
Signed (Supervisor)		Date	

Supervision – Record of Meeting

Name of Supervisee (staff member)			
Name of Supervisor (manager)		Start Time	
Duration		Finish Time	

Frequency	Monthly		Fortnightly		Weekly	

List Supervision Checklist Issues Discussed (i.e. Fire Checks, YP Files, Accident Reporting etc)

Supervision Date	Supervisee Signature	Supervisor Signature

Supervision Summary

Name of Supervisee (staff member)			
Name of Supervisor (manager)		Start Time	
Placement		Finish Time	
Date of Supervision		Duration	

	Summary of Discussion
Check-in - general wellbeing (physical and emotional), how will any issues be monitored/addressed?	
Information Update – placement changes, communications, risk assessments, etc. Any information for the supervisee/supervisor to update?	
Team Issues – personal issues, queries, consistency, efficiency, ideas, concerns	
Young People – general care, health and hygiene, safety and protection, relationships, assessment and planning, care plan updates, record keeping, rules and boundaries, home visits and family issues	
Health & Safety – day-to-day issues, near misses, fire prevention, Bibby forms to sign in folder, COSHH,	

manual handling, training - inform Head Office of any issues.	
Keyworking – current issues, care planning, keywork sessions, record keeping, communications with Social Worker, family and others	
General – paperwork, cash, issues, annual leave to be taken	
Professional Relationships – young people, other staff, agencies, Social Workers, Police, YOS, families etc	
Evidence of Progress – positive developments from issues or incidents, progress since last supervision i.e. example of a job well done, training/development progress	
Progress Development Plans – Personal skills and competency, strengths, weaknesses, appraisals, training, plan for improvements	
Supervision Issues and Feedback – Efficiency/skill of line management in addressing problems, issues and actions	
Additional comments by supervisee	
Additional comments by supervisor	
Check-out – (refer back to check-in, how is the supervisee feeling now, any issues)	

Action Plan

Staff Member's Signature	
Supervisor's Signature	

book next supervision and note it in your diaries

DATE OF NEXT SUPERVISION	