

<b>Title:</b> <b>Practice Supervision for Health Professionals in the Mental Health Services</b>	<b>Number:</b> <b>IRM 3.14-1</b>
	<b>Date:</b> JUNE 2004
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## POLICY

**Ongoing supervision is critical to ensure quality assurance in mental health practice, regardless of experience and level of appointment.**

This policy applies as follows to Queensland Health staff in Mental Health Services in relation to their participation in practice supervision:

- Allied health staff—mandatory;
- Medical staff—not mandatory, however districts are encouraged to adopt the policy within existing resources;
- Non-acute and/or non-inpatient based nursing staff (i.e. Community-based Mental Health Nurses)—not mandatory, however Districts are encouraged to adopt the policy within existing resources.

Participation in practice supervision is a shared responsibility of the above mentioned staff and service management. Therefore, it is recommended that a mix of 'bottom-up' and 'top-down' approaches be applied to achieve participation in practice supervision. For example: an existing or new Mental Health practitioner has a responsibility to identify the need for practice supervision with their line manager as a part of the performance and development process (i.e. obtain training and attend regular supervision sessions). Conversely, a line manager has a responsibility to negotiate with a staff member through the performance and development process to encourage the staff member to participate in practice supervision (also refer to the guidelines accompanying this policy, particularly guidelines 6 and 8).

This policy and accompanying guidelines:

- define and formalise the practice supervision process;
- place emphasis on the consideration of all parties in supervision, areas to be covered in supervision, criteria for selection of supervisors and importance of adequate resourcing for practice supervision;
- are designed to ensure minimum standards of access to, and quality of practice supervision across the Mental Health Service; and
- highlight the role of practice supervision in relation to performance and development of staff.

Supervision is a broad term encompassing a range of principles, activities and areas of work practice. **For the purpose of this policy supervision refers to *practice supervision*** as described in the definitions that follow. Note that it is recognised that each of the following supervision areas are closely linked in the effective management and development of staff within the workplace and due consideration

should be given to each area within the management of the core business of Mental Health Services. In addition to the definitions provided for supervision, some additional definitions are provided for contextualisation purposes.

## DEFINITIONS

**Supervision** is broadly defined as a working alliance between two staff members where the primary intention of the interaction is to enhance the knowledge, skills and attitudes of at least one staff member. Supervision is distinguished from therapy or assistance for personal problems or for emotional distress that is unrelated to the workplace.

**Practice Supervision** is supervision about practice as a staff member of the Mental Health Service. That is, it focuses primarily on practice issues, rather than broader supervision, staff development and/or line management issues. It interfaces with these and other issues related to career development and a staff member's work-life, particularly in relation to training and skill acquisition required to better address clinical duties that a person needs to perform. Practice Supervision can be:

- *Intra-Professional*—primarily focuses on discipline or profession-specific practice skills and is conducted by members of the same profession; or
- *Cross-Professional*—primarily focuses on practice skills by a member of another profession.

**Staff development** is a global term encompassing a wide range of activities including courses, conferences, colloquia or workshops, case or program reviews, and work placements. Practice supervision is one component of staff development. As such, further staff development needs may be identified within practice supervision. Where further staff development needs are identified as a part of a practice supervision relationship, the participants are encouraged to share this with relevant line management to facilitate negotiation of inclusion with Performance and Development Plans. However, prior to information being shared with relevant line management, practice supervision participants should negotiate and agree how information will be shared.

**Mentoring** involves a relationship of role modelling, advocacy and support that may be incorporated in supervision relationships but may also occur outside such relationships.

**Formal Supervision** (which includes practice supervision) refers to a supervision relationship that is formalised within an agreed document eg. a supervision (or practice supervision) agreement or similar, and that is conducted in individual or group meetings that are scheduled to take place and usually have an agreed agenda. Formal supervision is contrasted with *Informal* meetings or consultations and is distinguished from team meetings that may incorporate elements of practice review (eg. case reviews), but which are not regulated by a supervision agreement that meets the definition of supervision.

**Administrative and/or Line Management Supervision** is supervision that primarily focuses on administrative or line management issues such as attendance, work allocation and workplace issues.

**Supervision of supervisors** is supervision that focuses on the provision of supervision.

**Peer consultation** involves supportive and problem-solving discussions between staff in which suggestions and information can be exchanged. While peers can be in a formal supervision relationship, peer consultation typically implies bilateral or multilateral relationships for mutual support without formal processes for evaluation of practice skills.

An **Individual Format** for supervision involves a single supervisee meeting with one or more supervisors, at the same or different times. A *Group Format* implies more than one supervisee meeting with their supervisor/s at the same or different times.

**Performance Appraisal and Development Plan** is the model of overall performance appraisal and future development needs used by Queensland Health to help an employee to meet the expectations of the organisation in terms of their work. It includes discussion of strengths and weaknesses, as well as strategies to improve these. This includes the identification of any training and personal development needs the employee may have to help him or her carry out their work effectively.

Participation in Performance Appraisal and Development is mandatory for all Queensland Health employees except temporary employees appointed for periods of less than three months, and casual employees. The *Health Services Act 1991 Directive 1/98 Performance Appraisal and Development* and Industrial Relations Manual Policy Instruction (IRM) 8.2: Performance Appraisal and Development makes such a performance appraisal program mandatory for all Health Service Districts.

The Practice Supervision process is an integral part of this larger process in the case of clinicians.

**Unsatisfactory Performance Process** – The specific process that must be followed when a supervisor has serious concerns regarding an employee's overall competence or behaviour. This process is outlined in the Industrial Relations Manual Policy Instruction (IRM) 8.3: Unsatisfactory Performance, pursuant to *Health Services Act 1991 Directive 3/99: Unsatisfactory Performance*. Unsatisfactory performance can be the result of numerous factors, including insufficient competencies, poor job design, indolence, ill health and problems with co-workers. When the normal practice supervision process fails to address clinical competency deficits effectively, the Unsatisfactory Performance Process may be implemented. It would normally include a formal Performance Improvement Plan and a more regimented and detailed supervision plan.

It is recommended that Unsatisfactory Performance Processes, whether identified and/or arising through practice supervision or not, are managed outside of practice supervision (i.e. a separate arrangement). Typically, management of an Unsatisfactory Performance Process would involve staff such as the supervisee, supervisor, relevant service management (eg. Line/Service Manager, Director) and human resource management staff. A practice supervisor would not normally be involved with an Unsatisfactory Performance Process unless specifically required to on a 'negotiated' and/or 'agreed in advance' basis. Examples of when this may occur include legislative/policy requirements such as acts of negligence and/or unlawful behaviour.

The principles and activities contained within supervision include:

1. Definitions (as described above).
2. Adoption of a standard practice supervision policy.
3. Staff will participate in formal supervision of their practice (as per the policy).
4. Recognition of interested parties.
5. Objectives of practice supervision.
6. Practice supervision is a component of staff development.
7. Practice supervision is essential to quality assurance.
8. Participation in practice supervision will be included in Performance and Development Plans.
9. Practice supervision will be included in task allocation and activity reports.
10. Supervisees need to be assured that aspects of their discussions during supervision sessions are confidential.
11. Formal practice supervision will be structured.
12. Negotiation of extent and type of practice supervision.
13. Minimum levels of practice supervision.
14. Delivery of practice supervision.
15. Criteria for selection of supervisors.
16. External supervisors.
17. Choice of supervisor.
18. Wherever possible, practice supervision should be received from a separate person than the line manager.
19. Registration requirements are the joint responsibility of the staff member and Queensland Health.
20. Practice supervision content.
21. Practice supervision will emphasise positive features.
22. Use of technology in supervision.
23. Resources for practice supervision.
24. Supervision of practice supervisors.

**Note: Guidelines providing more detailed explanations of the above principles and activities follow.**

### **1. Definitions**

As per pages 2 to 4 of policy

### **2. Adoption of a Standard Practice Supervision Policy**

This practice supervision policy is to be adopted and implemented across zones and districts. The policy is mandatory for Allied Health staff. It is not mandatory for Medical staff or for Community-based Mental Health Nursing staff (however Districts are encouraged to adopt and apply the policy to these staff within existing resources). This practice supervision policy is subject to all existing Queensland Health corporate policies.

### **3. Staff will participate in formal supervision of their practice (as per the policy).**

The receipt of formal practice supervision is required of:

- full-time;
- part-time; and
- temporary staff appointed for more than 3 months.

For part-time and casual staff who are not new to the service, the amount of supervision should be proportional to full time equivalent (FTE). For staff new to the service, regardless of FTE proportion, minimum levels for supervision apply (refer to Guideline 13).

In recognition of other relevant Queensland Health corporate policy it is not mandatory for casual or temporary staff appointed for less than 3 months to participate in practice supervision. However, for quality assurance purposes, Districts may elect to adopt this policy for these types of staff on a needs basis.

#### **4. Recognition of Interested Parties**

Practice supervision will take account of the needs of all relevant parties (i.e. staff member, organisation and consumer). The amount and content of practice supervision will reflect those needs. A supervision agreement (as in 11 below) will outline the role of interested parties, and the limits of confidentiality and/or information sharing to occur across the interested parties in practice supervision. For Quality Assurance purposes, line managers and clinical directors may be involved in practice supervision (eg. Refer to Guideline 8 and 10). Where line managers and clinical directors are involved with practice supervision it is recommended that issues associated with duality in roles is identified and clearly articulated in supervision agreements (i.e. how management of the dual roles will occur; Guideline 18). Also refer to Guideline 18 for examples of the roles and responsibilities of practice supervisors and line managers/clinical directors. The attached sample supervision agreement includes an area where the management of role duality and associated issues can be agreed.

#### **5. Objectives of Practice Supervision**

The primary aims of practice supervision are to:

- maintain the highest possible standards of mental health practice, mental health service and consumer outcomes;
- maximise staff morale and retention.

It strives to achieve these aims by:

- recognising and promoting good practice;
- fostering development of relevant skills and knowledge;
- assisting staff to solve problems in fulfilling their duties.

#### **6. Practice Supervision is a Component of Staff Development**

Practice supervision arrangements will be seen in the context of overall staff development, but will not be the sole focus of staff development.

## **7. Practice Supervision is Essential to Quality Assurance**

The provision of appropriately targeted, cost-effective practice supervision is regarded as an essential component of quality assurance procedures in Mental Health Services.

## **8. Participation in Practice Supervision will be Included in the Performance and Development Process**

Performance and Development Plans for staff will include their participation (delivery and receipt) in practice supervision (based on self-reports and reports from all supervisors). Conversely, where education and training needs are identified as part of participation in supervision, subject to Guideline 10, these should be included in an individual's Performance and Development Plan.

## **9. Practice Supervision will be Included in Task Allocation and Activity Reports**

Task allocation within the service (including administrative, provision of practice supervision and direct service delivery) is to be equitably allocated in overall balancing of duties and tasks to be undertaken by staff.

The provision of practice supervision and indicators of practice supervision quality and outcomes will be considered for inclusion in reports of staff activity and in quality assurance reviews of Mental Health Services.

Arrangements regarding practice supervision will be identified in district Mental Health Service operational plans.

## **10. Supervisees Need to be Assured that Agreed Aspects of their Discussions During Supervision Sessions are Confidential**

Development of an effective practice supervision relationship requires the formation of mutual trust and an atmosphere of safety. Conversely, line managers/team leaders need appropriate and timely access to information about matters that affect their administration, including information that is relevant to staff performance, staff development and service management.

To maintain service quality and develop rational professional development plans, it is important that exchanges of information between supervisees and managers about their professional development and performance should be as free as possible. However except as detailed below (e.g. in relation to competence or performance), supervisees should be able to elect to keep agreed aspects relating to the content of matters raised in supervision session confidential to the supervision relationship.

An understanding of how information will be used and/or shared is required to develop an effective practice supervision relationship. Practice supervision agreements will stipulate areas of confidentiality and the limits to it, for example:

- what is to occur if impaired or inappropriate practice is alleged or identified;

- discussion of the practice supervision with the supervisor's own supervisor and/or the line manager of the supervisee;
- if and how information within a practice supervision relationship may impact upon future recruitment and selection exercises.

Issues related to confidentiality and documentation of supervision will routinely be included in supervision agreements.

A clear agreement on confidentiality is especially important where practice supervision is delivered by the person who also undertakes the Performance and Development process and/or administrative supervision/line management. An example of a standard supervision agreement is provided in the attachments.

### **Resolution of Practice Supervision Problems**

Wherever possible practice supervision problems should be prevented or dealt with rapidly and through the following process:-

- **Supervisor/supervisee issues:** In the first instance, problems that arise in the course of practice supervision should be addressed between the supervisee/s and supervisor/s. If there is a remaining problem, the issue should first be raised with the professional senior and/or line manager, then with human resource management. If, after this process has been applied and an employee is/or remains aggrieved, then Industrial Relations Manual Policy Instruction (IRM) 3.5 'Grievance Resolution and EB5 Grievance Settling; and Industrial Disputes' may be accessed.
- **Competence and/or other performance issues:** Where a supervisor or supervisee has concerns regarding the other party's overall competence or behaviour as defined in the *Health Services Act 1991, Directive of the Governor in Council, No. 2/99: Unsatisfactory Performance*, then these issues should be raised with the Director/Manager of the relevant Mental Health Service for appropriate action.

A Flow chart for managing unsatisfactory performance is attached as Attachment 6 and should be read in conjunction with IRM 8.3.

## **11. Formal Practice Supervision Will Be Structured**

### **11.1 Agreement**

Formal practice supervision relationships will have a written agreement (See Attachment).

Practice supervision will typically occur in work time. The frequency, duration of practice supervision sessions and the general nature of supervision outcomes will be reported to the supervisee's line manager at least every 12 months.

#### **(a) Features**

This agreement will specify:

- the goals of practice supervision,
- expected outcomes,
- the mutual obligations,
- structure of supervision,
- evaluation processes,
- limits of confidentiality,
- ethical issues,
- content of supervision.

Supervision agreements will not be formal contracts between the parties, but will be statements of mutual understanding regarding the nature of practice supervision that each party will attempt to provide or obtain. Agreements will be subject to unforeseen circumstances (eg. changes in workload, duties or workplace location) and subject to regular review and renegotiation. This review and renegotiation is recommended to occur at least annually, however, alterations to a written agreement may be negotiated by the parties at any time.

When staff are short-term, the limited nature of the agreement needs to be considered.

## **11.2 Agenda**

It is recommended that practice supervision have a written agenda that is negotiated between the parties prior to a session. A sample agenda form is provided in the attachments.

## **11.3 Records**

Participants in practice supervision relationships are encouraged to maintain records of practice supervision sessions for their own benefit. These types of records should not be onerous. The attachments provide a sample of a typical session record.

## **11.4 Evaluation**

Evaluations of the practice supervision and related goal attainment will be made **by both parties** at least every 12 months.

## **11.5 Multiple Supervisors**

It is recognised that a supervisee may have more than one practice supervisor at any given time to maximise access to specific practice/clinical expertise and/or competencies across the full spectrum of mental health service provision. In these instances, it may not be reasonable to develop a separate written agreement with each practice supervisor. To this end, staff should consider having a primary supervisor and negotiate the use of additional practice supervisors on an 'as needs' basis. The goals of the sessions provided by any additional practice supervisors could be added to the existing written agreement between the supervisee and primary supervisor. The intent of this type of arrangement would be to minimise inefficiencies with administrative

work-loads associated with the use of multiple written agreements. Additionally, this type of arrangement facilitates an integrated and coordinated approach to a supervisee's practice needs.

## 12. Negotiation of Extent and Type of Practice Supervision

The extent and type of formal practice supervision that is needed and the required competencies of the supervisor will vary according to the supervisee's competencies, the extent of current task demands and the rate of new developments in relevant practice. Practice supervision needs will be assessed by the supervisee, their line manager and their practice supervisor/s, and negotiated between these parties. A review and renegotiation of practice supervision arrangements will occur as a part of the Performance and Development process and at other times on the request of any of the parties.

## 13. Minimum Levels of Practice Supervision

Minimum levels for formal practice supervision are outlined below. These minimum levels will be reviewed as needs, resources and staffing profiles change. The minimum level does not include peer consultation or other methods of informal supervision or consultation.

**The minimum level should not be interpreted as a maximum or routine level.** Greater amounts of practice supervision may be required to meet the objectives of professional development and the maintenance of high quality services. For example, greater amounts may be required in some cases where the supervisee is a sole rural practitioner. However, supervision contact above the minimum levels will be subject to the availability of resources.

Practice supervision frequency will vary according to the level of relevant competencies and experience. A minimum level of monthly access to practice supervision for all staff is recommended.

### HIGH FREQUENCY

- **Recent Graduates:** Recent graduates, that is, staff in the first 2 years (full-time equivalent) of mental health practice since graduation of entry level qualification, generally have greater needs for practice supervision and generally require consolidation of core competencies and basic professional skills.
- **Staff with limited practice experience in mental health.** Other staff may require significant development of practice-related competencies to meet requirements for satisfactory performance of allocated tasks and to function effectively to contribute to the outcomes philosophy of the Mental Health Service.
- **Staff having significant change in role.** Other staff with significant change in work role, such as from CYMHS to Adult MHS or from acute to community based work.

*Total practice supervision:*

- a frequency of at least weekly and duration of at least 4 hours per month.

*Component of supervision from the same profession:*

- at least 2 hours per month.

*Component of individual supervision:*

- at least 2 hours per month.

**LOW FREQUENCY**

- **Staff with more than 5 years experience.** Staff who demonstrate advanced skills in all areas relevant to their current duties (including practice supervision) and have at least 5 years (full-time equivalent) experience in mental health practice will obtain practice supervision that meets standards of low frequency supervision or better.

*Total practice supervision:*

- duration of at least 1 hour per month.

*Component of supervision from the same profession:*

- equivalent of at least 1 hour each 3 months, which may be from a peer.

- **Part-time staff.** The above high and low frequency rates are attributed to full time staff. The amount of practice supervision for part-time staff should be at least proportionate to the full time equivalent and should occur at least monthly.

**14. Delivery of Practice Supervision**

Subject to the criteria for supervisor selection (Guideline 15 below). The following staff will normally be expected to deliver practice supervision:

- Professional Officer Stream Level 3 and above;
- Nursing Officer Stream Level 2 and above;
- Medical staff.

**(Subject to criteria for selection, Guideline 15).**

Delivery of practice supervision will be subject to other duties and to the fulfilment of requirements to be a practice supervisor. However, in recognition of distinctive needs and/or varying levels of clinical expertise in all types of Mental Health practice, Districts may elect to develop local level guidelines and/or processes for the selection and/or recognition of supervisors who are staff (or have been staff) of the Mental Health Service. The intent of this would be to facilitate quality and effectiveness of practice supervision outcomes.

Practice supervisors who are not Queensland Health staff (eg. private practitioners) must meet minimum credentialing requirements as detailed in Guideline 16 of this policy.

## **15. Criteria for Selection of Supervisors**

### **15.1 Competence in Clinical Practice**

The above mentioned minimum levels of practice supervision contact will be obtained from a supervisor with:

- at least 2 years of FTE mental health practice experience (with a preference of 5 or more years of experience);
- demonstrated advanced skills in core competencies in mental health or the development of expert/advanced competencies, either way the practice supervisor's competencies should be relevant to the supervisee's current practice supervision needs.

The supervisor will have at least the same or higher level of practice skills than the supervisee, in the majority of specific competencies that are the primary focus of the supervision.

It is preferred that supervision contact be face-to-face, although supervision via electronic means is encouraged when this is not possible (See Guideline 22).

Wherever possible, at least 50% of the minimum contact levels will be obtained from a supervisor with at least 5 years of experience in mental health practice and advanced relevant practice skills.

### **15.2 Competence in the Core Supervision-Related Skills**

All practice supervisors are expected to be able to demonstrate that they have appropriate competence levels in skill areas required for effective practice supervision. The Queensland Health Mental Health Service recognises an obligation to provide access to appropriate training and evaluation of competence in supervision skills.

### **15.3 Intra-Professional Component**

The interchange that occurs during multidisciplinary case review and a good understanding of team members' skills are seen as critical to the smooth working of the multidisciplinary team. The functioning of such a team is maximised when it takes full advantage of specialist skills that individual staff have acquired and development of these skills through appropriate targeted practice supervision.

Practice supervision by members of other professions is seen as especially useful when there are needs to develop core competencies, and where the practice supervisor has expertise in a specific skill area that is needed in the specific work setting, consumer group or procedure. The primary criterion for selection of supervisors or consultants from outside the profession will be the level of relevant knowledge and skills rather than their profession.

The receipt of some supervision from members of the same profession is required for all health staff. The amount and proportion of practice supervision

that is obtained will depend on service requirements, and the employee's role and will be negotiated between the staff member, managers and supervisors and routinely discussed in the context of the Performance and Development Plan process.

It is recommended that at least 50% of practice supervision contact is obtained from an appropriate supervisor from the same profession. In cases where there is legislation or professional accreditation requirements related to regulating supervision within that profession, this requirement should be given priority and aligned to employment related practice duties wherever possible.

## **16. External Supervisors**

Wherever possible, practice supervision is to be obtained from within the local Mental Health Service, where this is not possible or practical, practice supervision should be sought from within another Health Service District.

Queensland Health recognises that in some limited circumstances (eg. where there is an insufficient number of supervisors to meet the demand for supervision) supervision may need to be obtained through engagement of an external supervision provider.

Prior to the engagement of an external supervisor, a credentialing process is to be undertaken and the appropriate delegated service management authority must sign off on the approval of the credentials. Appropriate credentials should include:

- evidence of relevant professional registration or equivalent;
- evidence of recent practice relevant to the proposed supervision;
- evidence of adequate professional indemnity insurance.

Names of appropriate referees should be given. It is the engaging District's responsibility to verify the accuracy of the information.

In addition to providing the above information, a proposed external supervisor is required to:

- provide evidence of supervision competence that is recognised by Queensland Health, through participation in Queensland Health's practice supervision training program (or an equivalent training program ) within an agreed period (e.g. 6 months);
- sign a confidentiality agreement (a sample format is included in the attachments);
- participate in the Mental Health Service's quality management activities.

It is recommended that credentialing information or evidence that is obtained from an external practice supervisor is retained in accordance with corporate and/or local record keeping policy.

External supervisors will maintain communications with the delegated service authority and other relevant interested parties, as identified in the supervision agreement.

## 17. Choice of Supervisor

Subject to the preceding requirements, the advisability of allowing some choice of supervisor or supervisee for practice supervision (wherever possible) is recognised. The selection of a supervisor will be negotiated between the supervisor, supervisee and line manager and will be subject to factors such as supervisor availability, resources required, duties of each party, relevance of the supervisor's knowledge and skills, organisational needs and supervisor and supervisee preferences.

## 18. Roles and Responsibilities

*Wherever possible, practice supervision should be received from a separate person than the line manager, to avoid conflicts of role and engender openness. However, it is recognised that this may not always be possible. The following examples of typical line management versus practice supervisor roles and responsibilities are provided as a guide to assist with developing supervision arrangements to minimise unnecessary conflict when a line manager may also be a practice supervisor:*

<b>TYPICAL ROLES AND RESPONSIBILITIES</b>	
Line Management	Practice Supervisor
Human Resource Management (eg. Time/attendance, leave, disputes, performance)	Facilitate skills acquisition associated with clinical practice with a focus on enhancing client outcomes
Budget/Resource issues	Educating (teaching, facilitating, conceptualising about issues related to clinical practice, evidence-based interventions/best practice)
Change management	Mentoring (eg. monitoring, evaluating, promoting enhanced organisational skill)
Work allocation	Supporting (listening, understanding, reflecting)
Approving Practice Supervision Agreements	Ethical issues
Code of Conduct Issues	Code of Conduct Issues
Caseload management	Negotiate content of supervision agreement with supervisee

Although not preferred, it is recognised that in some instances a staff member's line manager may also be their practice supervisor. In these cases, it is recommended that line manager –vs- practice supervisor roles be clearly separated and documented in the practice supervision agreement. The intent of this type of approach is to minimise undesirable conflict and develop a relationship of mutual trust and respect.

**19. Registration Requirements are the Joint Responsibility of the Staff Member and Queensland Health.**

Where a health profession is regulated by a Queensland registration act, the Mental Health Service will facilitate the attainment of supervision requirements for initial or continued registration by that staff member, while stipulating that fulfilment of these supervision requirements (together with costs that are associated with additional supervision) will remain the primary responsibility of the staff member.

**20. Practice Supervision Content**

Formal supervision should allow direct assessment of practice strengths and areas needing further development, rather than relying solely on self-assessments or self-selection of material for discussion. Such assessment will normally involve observation (live or by audio or video recording) of clinical work or other practice, review of files, reports or letters, use of role-plays in supervision sessions, and/or a detailed description of proposed actions. Supervisees and supervisors will develop procedures to ensure that identified problems with practice (including, but not restricted to negative consumer feedback) are immediately addressed.

They will also ensure that a balance is maintained between issues that relate to the interests of each relevant party. Other aspects of specific content of practice supervision sessions will conform with current standards for evidence-based supervision practice.

**21. Practice Supervision will Emphasise Positive Features**

While areas of practice that require further development are addressed in supervision sessions, practice supervision will highlight successes and achievements in practice, and seek to maintain or increase their frequency.

**22. Use of Technology in Supervision**

Face-to-face practice supervision is the preferred method of delivery wherever possible and a component of supervision should remain face-to-face. However the geographical dispersion of staff throughout the state implies that supervision by e-mail, videoconferencing or teleconferencing has an important place in ensuring access to supervisors, especially in providing urgent access in crises. Effective use of both electronic technology and audiovisual aids will be a factor in the evaluation of practice supervision in the service.

**23. Resources for Practice Supervision**

In considering resources the following is provided as a general, but not prescriptive guide for items to be considered for provision of effective, confidential and flexible practice supervision:

- Private facilities in which to meet;

- access to information technology (eg. e-mail, teleconference, videoconference);
- support for travel to participate in face-to-face practice supervision meetings;
- inter-service access to external supervision where a need is identified and the person is unable to access within the service. Note: prior to engaging external supervision, cross-district/zonal arrangements should be explored and accessed where possible.

## 24. Supervision of Practice Supervisors

Just as practice supervision provides quality assurance and staff development for mental health practice, supervision of practice supervisors provides a similar function for the delivery of practice supervision. All supervisors will receive supervision of their own provision of practice supervision with a consultant who has a high level of demonstrated competence in the provision of practice supervision. Such supervision will be incorporated in the time allocated for practice-related supervision and may be provided by the same person in the same sessions.

As in other areas of practice supervision, the frequency of this supervision should be negotiated according to level of relevant competencies and task difficulties. Minimum levels are described below. These levels will be reviewed as needs, resources and staffing profiles change.

### HIGH FREQUENCY

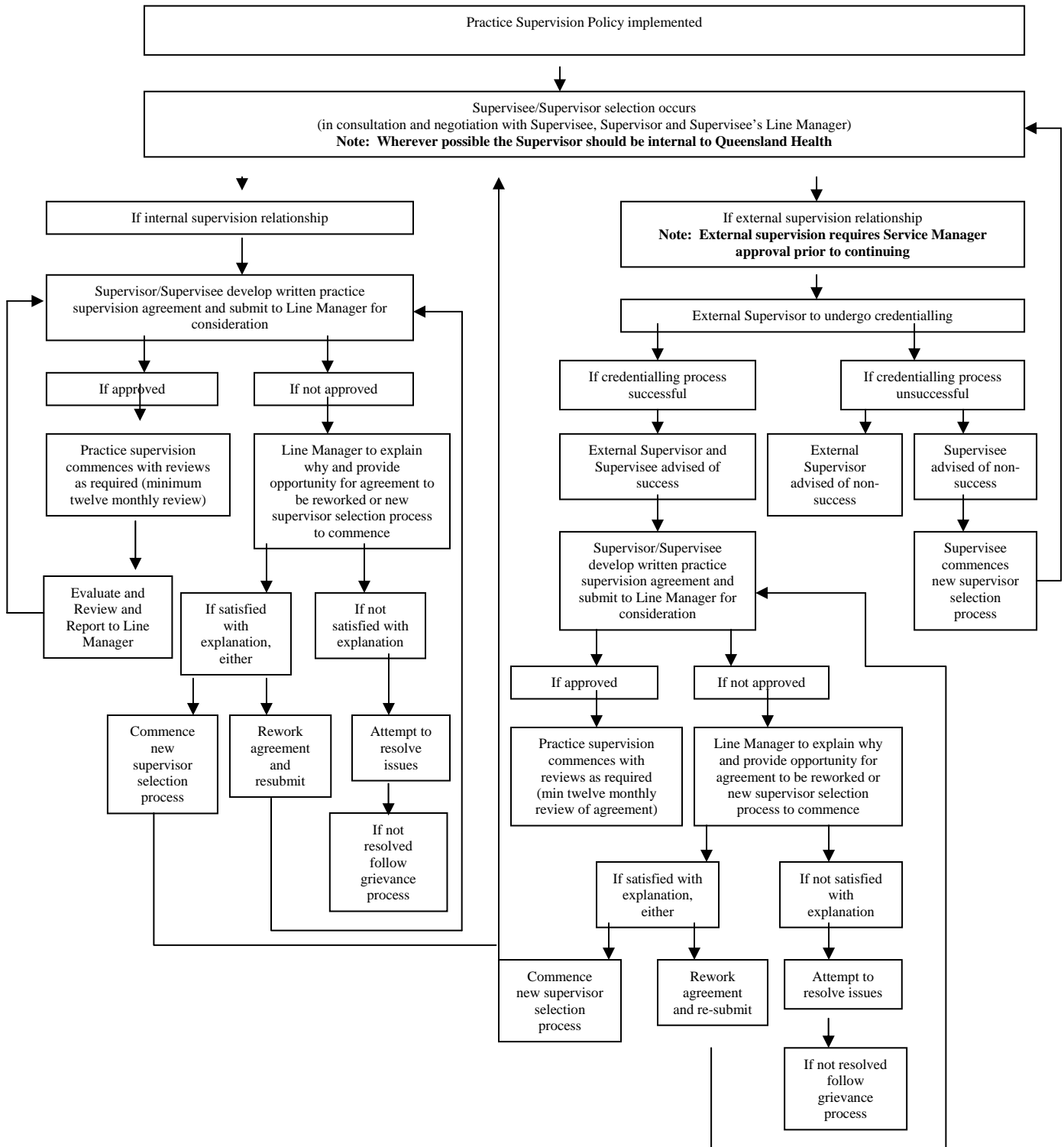
- **Staff in the first 2 years of supervision delivery.** High frequency supervision is recommended.
- **Staff requiring significant development of supervision-related competencies.** High frequency supervision is recommended.

Supervision at a high level of frequency will incorporate regular reviews of the supervision process including the negotiation of supervision arrangements, agreements, strategies used in supervision sessions, assessment and evaluation strategies, procedures used to deal with supervision problems and other documentation. At least 1 hour per month.

### LOW FREQUENCY

**Staff who demonstrate advanced supervision skills** will obtain practice supervision that meets standards of low frequency supervision or better. At least 1 hour each 3 months.

**FLOW CHART FOR IMPLEMENTATING PRACTICE SUPERVISION IN MENTAL HEALTH SERVICES**  
 (TO BE READ IN CONJUNCTION WITH POLICY AND GUIDELINES)



## Sample Agreement for Practice Supervision between

\_\_\_\_\_ and \_\_\_\_\_.

From \_\_\_\_\_ to \_\_\_\_\_

### 1. **Goals of Supervision** (See Guideline 11)

To include a detailed list of the knowledge and skills that the supervisee and supervisor would like the supervisee to develop in supervision sessions. This will require regular review and renegotiation as the needs and skills of the supervisee change over time.

a) Supervisor \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

b) Supervisee \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

### 2. **Expected Outcomes (Specific Objectives)** (Guidelines 5, 11, 17)

a) Supervisor \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

b) Supervisee \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

c) Shared Objectives \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

### 3. **Mutual Obligations (Responsibilities)** (Guideline 11)

a) Obligations of supervisor \_\_\_\_\_

\_\_\_\_\_

b) Obligations of supervisee \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

c) How will dual roles (eg. line manager and practice supervisor) will be managed (eg. line management issues will not be discussed in practice supervision sessions without mutual consent by way of inclusion in a pre-agreed session agenda) \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

**4. Structure of Supervision** (Guideline 3, 9, 11, 12, 14, 20, 22)

a) Frequency \_\_\_\_\_

b) Duration \_\_\_\_\_

c) Location \_\_\_\_\_

d) What resources do we require for effective supervision (eg., time, space, absence of interruptions) \_\_\_\_\_

\_\_\_\_\_

e) What preparation will be required prior to each session? \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

f) How will agendas for each session be set? \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

g) Availability between sessions: \_\_\_\_\_

h) Is supervisee currently receiving other supervision? \_\_\_\_\_

\_\_\_\_\_

i) If yes, how will different forms of supervision be integrated? \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**4. Evaluating Supervision** (Guideline 11)

a) What is the preferred process for evaluating supervision? \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

b) When will the supervision agreement be reviewed? \_\_\_\_\_

**5. Limits to Confidentiality** (Guidelines 10, 11)

a) How will difficulties in supervision be dealt with? \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

b) What if the supervision relationship completely breaks down? \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**6. Supervision Records (Guidelines 10, 11)**

a) What form will supervision records take? (Eg agendas) \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

b) How will these supervision records be used? \_\_\_\_\_

\_\_\_\_\_

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c) Who will have access to them and in what circumstances (note: if a supervisor has concerns about, or identifies any performance issues regarding ongoing clinical competence it should be referred to the appropriate service manager who has responsibility for managing the unsatisfactory performance process)?

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d) Where will be records be stored: \_\_\_\_\_

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e) Duration of storage: \_\_\_\_\_

f) What records will be used/provided for performance purposes (eg. that practice supervision has occurred)? \_\_\_\_\_

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**7. Ethical Issues**

a) What do your professional code and organisational policies outline as ethical conduct for supervision?

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b) In general, which issues raised in supervision will be kept confidential to this relationship?

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c) Which aspects may be discussed and with whom? \_\_\_\_\_

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**8. Content of Supervision**

To be negotiated in confidence between supervisee and supervisor and should include a list of the knowledge and skills that the supervisee would like to develop in supervision sessions and should be regularly reviewed and renegotiated between the supervisor and supervisee. Also refer to supervision policy and accompanying guidelines for guidance when developing supervision objectives.

Supervisee name: \_\_\_\_\_ Supervisor Name: \_\_\_\_\_

Signature: \_\_\_\_\_ Signature: \_\_\_\_\_

Date: \_\_\_\_\_ Date: \_\_\_\_\_

**Line Manager Agreement:**

Line Manager Name: \_\_\_\_\_

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

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# SETTING AGENDAS SAMPLE

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## NOTES ON SUPERVISION SESSION

Between: \_\_\_\_\_ And: \_\_\_\_\_

Date: \_\_\_\_\_

Topic	Discussion	Agreed action

Agenda items for next session	Preparation required

Signed \_\_\_\_\_

Signed \_\_\_\_\_

Date \_\_\_\_\_

Date \_\_\_\_\_

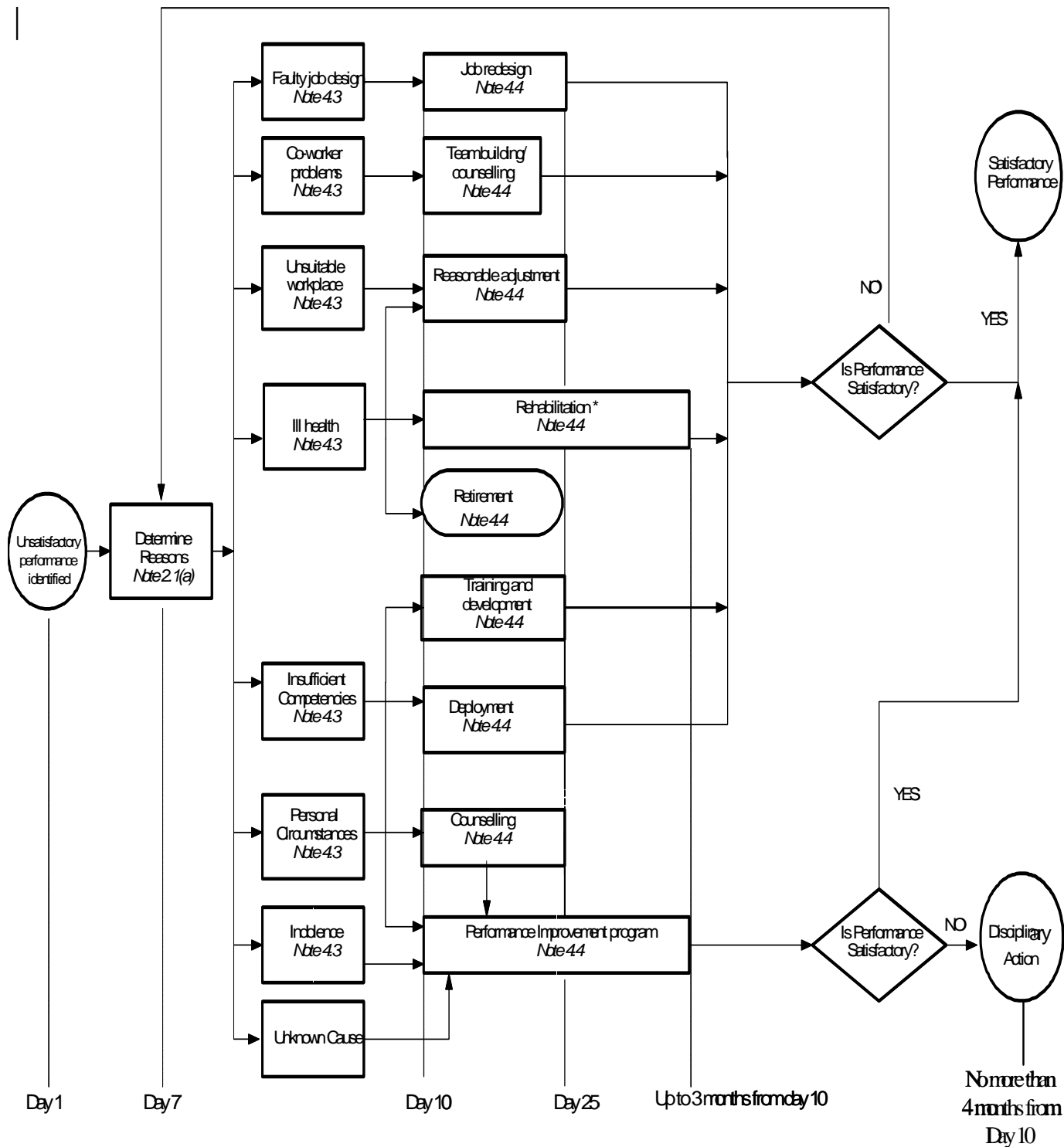
## Sample Record of Supervision Meetings

Supervisee's Name:..... Supervisor's Name.....

- |   |   |   |  |
|---|---|---|--|
| 1. Review of clinical notes/reports.        | 3. Problem solving about practice issues.         | 5. Demonstration of skills or strategies by supervisor. | 7. Discussion of secondary practice issues (e.g. team relationships, responses to work demands). |
| 2. Reflection about practice by supervisee. | 4. Discussion of additional skills or strategies. | 6. Demonstration/rehearsal by supervisee.               | 8. Personal or career development.   |

Date of meeting	Time spent	Material covered <small>(Please write numbers from above list)</small>	Comments	<i>Initials</i>	
				Sup/ee	Sup/or
<i>2/7/02</i>	<i>1 hour</i>	<i>1, 3, 4, 6</i>	<i>(Supervisor observed clinical practice)</i>		
<i>8/8/02</i>	<i>1.5 hours</i>	<i>2, 4, 6, 8</i>			





Management of Unsatisfactory Performance of Health Service Employees