NHS GG&C Mental Health Services

Mental Health Occupational Therapy Services

Supervision Framework, Guidance & Procedures

Important Note:
The Intranet version of this document is the only version that is maintained.
Any printed copies should therefore be viewed as 'Uncontrolled' and as such, may not necessarily contain the latest updates and amendments.

Document Number:	**MHS 50**
Lead Author:	**Julie McKelvie, Occupational Therapy Mental Health Adviser (Adult)**
Approved by:	**MHS Quality & Clinical Governance Group**
Date approved:	
Date for Review:	**March 2026**
Replaces previous version: [if applicable]	**MHS 50 – Occupational Therapy Supervision Framework, Guidance and Procedures Final 2.0**

MHS 50 – Mental Health Occupational Therapy Services Supervision Framework, Guidance and Procedures Statement Guidance

Please record brief details of the changes made alongside the next version number. If the policy or guideline has been reviewed **without change**, this information will still need to be recorded although the version number will remain the same.

Version	Date	Brief Summary of Changes	Author(s)
1.0	Aug 2017	First version approved.	J McKelvie
2.0	April 2021		J McKelvie K Lowson
3.0	April 2024	At a glance summary sheet attached	J McKelvie K Lowson

MHS 50 – Occupational Therapy Supervision Framework, Guidance and Procedures

At A Glance

Supervision Purpose and Aims

The aim of professional supervision across mental health services is to enable a culture of continuous improvement in clinical and professional practice. Supervision is an accountable, formalised process which supports, assures and develops knowledge, skills and practice. It is developmental in nature where the supervisee is supported to reflect on, maintain and improve the quality of their practice primarily for the benefit of the service user. The professional governance associated with the provision of supervision offers reassurance to the wider organisation that the quality of service delivery is being monitored.

Supervision Standard

All staff are required to participate in and engage actively in supervision.
All staff will have a supervision agreement in place and compliance will be reviewed annually by both parties (Form 1).

Supervision will take place 6 weekly as a minimum, and more frequently where required through review (Form 3).

A written record of supervision will be recorded and kept by both parties (Form 2).

The professional Supervisor will be a more senior Occupational Therapist.

The Lead Occupational Therapist will determine the supervision structure within their service with discussion and agreement of the Care Group Lead Occupational Therapist.

The Lead Occupational Therapist will be supervised by the Care Group Lead Occupational Therapist responsible for their area.

Where a supervisor is absent and as a result 2 consecutive supervision sessions have not taken place then an alternative arrangement will be put in place by the Lead Occupational Therapist.

Content of supervision sessions will remain confidential except in the interests of patient safety or when there are professional practice concerns.

All occupational therapy staff will complete TURAS supervision modules.

Role and Responsibilities of Supervisee

Possess knowledge around different models of supervision.
Take an active role in own supervision, bringing issues for discussion and making use of the support and learning offered.

Engage with the reflective process around practice issues and in working towards agreed goals (Form 4).

Discuss freely any difficulties in relation to practice and reflect on same.

Provide feedback to allow the evaluation of the supervision process (Form 5).

Work to the supervision agreement and implement agreed actions from supervision

Have completed the TURAS modules on supervision.

Alternative Supervisory Arrangements

If a supervisor is absent for 2 consecutive supervision sessions of the supervisee, then the Lead Occupational Therapist/Care Group Lead will identify temporary alternative arrangements. This may include providing an alternative 1:1 supervisor, group supervision, review of clinical reports or a combination of these approaches.

In the case where a supervisor is leaving post and will not be immediately replaced then the Lead Occupational Therapist should make alternative arrangements for the supervision of the staff member.

Conflict Resolution

If there is disharmony or conflict in the supervisory relationship it is expected and encouraged that where possible the issues are raised in supervision where both parties have the opportunity to communicate with each other and try to resolve the issues collaboratively. This would be considered to be a win-win situation.

Steps to follow for conflict resolution:

- Identify the problem and any unmet needs
- Arrange to discuss the problem and needs
- Describe the problem and needs from each person's perspective
- Consider the other persons point of view
- Negotiate a solution
- Follow up the solution (Adler & Towne 1996)

If and when efforts have been made to try to resolve issues and matters remain unresolved then this should be raised with the Lead Occupational Therapist/ Care Group Occupational Therapist depending on the band of staff involved. The Lead Occupational Therapist/ Care Group Lead will meet with the staff members separately and where indicated and acceptable to all parties will arrange a 3 way meeting to try to resolve the issues.

There can be a number of outcomes to these discussions including 3 way supervision for a period of time to assist the resumption of a more positive supervisory relationship, temporary change in supervisor with an agreed time scale, permanent change as a last resort.

A final option may be the use of the NHS GGC Mediation Framework utilising an impartial 3rd party. It should be noted that this is a confidential service and there is no formal feedback to the referrer.

'Professional supervision and clinical supervision inevitably cross over in many circumstances and will be supplied by the same person. Both enable the supervisee to underpin and root their practice in a sound understanding of the core values, beliefs, knowledge and skills fundamental to occupational therapy.' RCOT

Contents

Introduction

Occupational Therapy staff working in Mental Health Services and all associated specialist areas in NHS Greater Glasgow & Clyde have had professional supervision embedded in their working practice and culture for many years. This guidance was first developed in 2006, then reviewed and ratified in 2011 and 2017 via mental health clinical governance structures.

In 2017 the AHP Clinical Supervision Policy was developed in NHS GGC for use by all AHPs, and sets out the commitment of the board to clinical supervision as a vital aspect of the governance framework that enables and supports staff to deliver high quality healthcare. In developing the policy the working group recognised that professional supervision within mental health services was already embedded within working practice and represented the gold standard.

The 2021 review of the mental health Occupational Therapy Services Supervision Framework, Guidance and Procedures takes cognisance of the AHP Clinical Supervision Policy (2017), fully embracing it as the foundation from which clinical supervision within the board should be built whilst working to the principle that the mental health guidance is an enhanced framework developed specifically for the mental health care group and the particular needs of staff working with the complexities of the patient group.

Whilst the AHP policy deals specifically with clinical supervision, the mental health framework is more eclectic, encompassing clinical and professional aspects which fits with the Occupational Therapy Services professional leadership, structure and governance arrangements across a wide range of teams which form the mental health family.

Supervision Purpose and Aims

The aim of professional supervision across mental health services is to enable a culture of continuous improvement in clinical and professional practice. Supervision is an accountable, formalised process which supports, assures and develops knowledge, skills and practice. It is developmental in nature where the supervisee is supported to reflect on, maintain and improve the quality of their practice primarily for the benefit of the service user. The professional governance associated with the provision of supervision offers reassurance to the wider organisation that the quality of service delivery is being monitored.

Supervision in mental health was aptly described in 2014 by the Forensic Occupational Therapy Service Appreciative Inquiry which stated that ‘when supervision is at its best, it happens regularly and consistently within a supported and trusted relationship. It is a shared responsibility that is prioritised, with the commitment of time, space and energy. Supervision inspires our creativity and development of self and services. It is structured and focused to provide opportunities to reflect, review & plan. Supervision makes us feel valued and empowers us to make positive change.’

The Health and Care Professions Council (HCPC) is the regulatory body for Occupational Therapists. The HCPC Standards of Conduct, performance and ethics (2016) includes a number of standards relating to supervision, identified as an integral component of professional practice as does the Standards of Continuing Professional Development (2012).

The occupational therapy professional body, The Royal College of Occupational Therapists (RCOT) published 'Supervision, Guidance for Occupational Therapists and their Managers' in 2015. It states that *'the content of supervision changes according to its context and the working relationship of those involved. Supervision enables the supervisee to develop professional, organisational and personal capabilities which promote and maintain the quality and effectiveness of their work. The end purpose almost always remains the same, being the promotion of the well-being and best interests of the service user*.'

Professional and Clinical Supervision

In Section1.2 of the RCOT guidance it makes clear that the boundary of professional and clinical supervision blurs and is often supplied by the same person.

'Professional supervision and clinical supervision inevitably cross over in many circumstances and will be supplied by the same person. Both enable the supervisee to underpin and root their practice in a sound understanding of the core values, beliefs, knowledge and skills fundamental to occupational therapy.'

RCOT Supervision Guidance.pdf

Within mental health occupational therapy structures the established and proven model is that both professional and clinical supervision are delivered by the one occupational therapy supervisor.
However in the case where an occupational therapist is delivering a service/therapy that is not core to their occupational therapy role e.g. CBT, in addition to their professional supervision as covered by this framework, they will also receive separate and specialist supervision from a practitioner who is trained with the suitable competencies to deliver the supervision.

Line Management Supervision

In the case of the Lead Occupational Therapists and some Occupational Therapists in specialist services, they may be line managed via the general/operational management structure and as such will receive line management supervision via their line manager who is unlikely to be an occupational therapist or if they are an occupational therapist, they will not be employed in that role. There may be a cross over with professional and clinical supervision due to the nature of the work e.g. in relation to operational performance issues such as caseload management, waiting lists, service delivery. This is to be expected and is reflective of the complexities of our structures, managerially and professionally.

In the case of Care Group Lead Occupational Therapists they will be supervised by one of the 2 Occupational Therapy Professional Advisors in the mental health structure who in turn will be supervised by the Occupational Therapy Professional Lead for Partnerships. All of these post holders will be line managed by a line manager who is not an Occupational Therapist. Again the content of the supervision may be similar in nature but fulfils the function of performance reporting and accountability to the general management structure.

Structure of Supervision

In recognising that supervision is a dynamic process it follows that it can be delivered in a variety of ways. Within Mental Health Occupational Therapy service in NHS GGC one to one supervision is custom and practice and will continue to be the norm for most staff but this may be delivered in a combination of ways:

- a face to face meeting or via MS Teams, or another platform that is approved via board governance
- supervisor and supervisee working together
- supervisee being observed in practice

In some services, where an occupational therapist works single handed in a service, supervision should include face to face meetings but should also involve phone and email contact as required, and is provided in addition to on site line management supervision.

Professional Supervision Standard for Occupational Therapy staff in NHS GGC Mental Health Services

- All staff are required to participate in and engage actively in supervision.
- All staff will have a supervision agreement in place and compliance will be reviewed annually by both parties.
- Supervision will take place 6 weekly as a minimum, and more frequently where required through review.
- A written record of supervision will be recorded and kept by both parties.
- The professional Supervisor will be a more senior Occupational Therapist.
- The Lead Occupational Therapist will determine the supervision structure within their service with discussion and agreement of the Care Group Lead Occupational Therapist. The allocation of supervisors will be determined by the clinical area in which they work in order to ensure robust governance, accountability and accessibility. It is custom and practice that the supervisor will be from the same service/department as the supervisee. It has been evidenced over a sustained period that this model maximises accountability and minimises risk.
- The Lead Occupational Therapist will be supervised by the Care Group Lead Occupational Therapist responsible for their area.
- Where a supervisor is absent and as a result 2 consecutive supervision sessions have not taken place then an alternative arrangement will be put in place by the Lead Occupational Therapist. In the absence of the Lead Occupational Therapist the Care Group Lead/Professional Advisor Occupational Therapist will ensure alternative arrangements.
- Content of supervision sessions will remain confidential except in the interests of patient safety or when there are professional practice concerns.
- All occupational therapy staff will complete TURAS supervision modules.[1]

[1] https://learn.nes.nhs.scot/44565/allied-health-professions-ahp-learning-site/allied-health-professions-ahp-support-and-supervision/allied-health-professions-ahp-supervision-education-sessions/ahp-support-and-supervision-session-1-introduction-to-supervision

Section 1.3 of The AHP Clinical Supervision Policy describes Identifying a Supervisor. Within mental health services in order to ensure robust risk management in relation to patient safety it is deemed critical that the Lead Occupational Therapist is the decision maker in relation to allocation of supervisor. However in the situation where a staff member is not satisfied with the allocation then they should raise the matter with the Lead Occupational Therapist, expressing their concerns and a discussion will take place in order to find a satisfactory solution.

Role and Responsibilities of Supervisor

- Possess knowledge around different models of supervision.
- Negotiate the agenda with the supervisee.
- Be reflective of skills as a supervisor and discuss these during their own supervision.
- Be adaptable in approach as a supervisor taking a more directive approach when required.
- Create a non- judgmental environment.
- Support the supervisee in the development of their clinical practice.
- Facilitate reflection within supervision sessions and support the role of reflection at other times.
- Identify, in collaboration with the supervisee, appropriate goals for development.
- Identify instances of good practice and achievement.
- Work to the supervision agreement.
- Maintain a written record of supervision sessions and provide a copy to the supervisee in a timeous manner.
- Ensure governance of delegated tasks, helping the supervisee to develop competencies and skills to carry out their role.
- Ensure that clinical practice remains the focus of the sessions.
- Use EMIS routinely where possible to review cases within the supervision session.
- Have completed TURAS modules on supervision.
- Provide honest, professional feedback.

Role and Responsibilities of Supervisee

- Possess knowledge around different models of supervision.
- Take an active role in own supervision, bringing issues for discussion and making use of the support and learning offered.
- Engage with the reflective process around practice issues and in working towards agreed goals.
- Discuss freely any difficulties in relation to practice and reflect on same.
- Provide feedback to allow the evaluation of the supervision process.
- Work to the supervision agreement.
- ‘Act within the limits of their knowledge, skills and experience, highlighting when help is required.’ (HCPC 2012)
- Have completed the TURAS modules on supervision.
- Implement agreed actions from supervision.

Confidentiality

There is an expectation of confidentiality within the supervisory relationship. There may be occasions, however where this cannot be maintained. This may be pertinent for example if there are patient and/or staff safety concerns or where there are poor practice/competence or ill health concerns or legal matters. In these situations both parties should seek to have agreement, where possible, that issues can be shared with line management and professional leadership. There may be rare instances where agreement cannot be reached and in these circumstances the other party should where possible be advised that the other party is raising issues. A clear plan for this should be agreed and followed up, within specific timescales.

Supervision Agreements

Supervision agreements are core to supervision practice within the NHS GGC Mental Health Occupational Therapy service. Supervision agreements should be reviewed annually.

A Supervision agreement should refer to this guidance and should:

- Identify the parties in the agreement.
- State who holds copies of the agreement
- Have a review date.
- List the type of activities which may be involved in supervision
- Identify a model of supervision.
- Acknowledge that reflection is an active element of all supervision.
- Acknowledge that clinical notes will be reviewed as part of supervision.
- State how often and for how long supervision sessions will run
- Where supervision will take place
- Actions to be followed in the event of cancellation by either party
- Preparation required by either party prior to a supervision session
- That the supervisee is responsible for recording supervision session and providing copies for the supervisor
- The limits of confidentiality
- How to deal with conflict or disharmony should it arise

The Supervision Agreement Template is included at Appendix 1.

Recording Mechanisms

Each supervision session must be recorded using the template provided at Appendix 2.
Patient initials only should be used.
Case Presentation Guidelines are also provided at Appendix 6 to assist supervisees in preparing for supervision.
The supervision record will be held electronically or in paper file by both the supervisor and the supervisee. Both parties should sign the record.

When a supervisee moves jobs or changes supervisor the supervision records will not be retained by the supervisor either in electronic or paper format. It is at the supervisee's discretion if they

retain a copy for their own record as it may contain information that relates to professional development and evidence of reflective practice.

The exception would be if there was an ongoing issue in relation to capability as the supervision records are likely to contain clinical information regarding supervisory advice and direction given to the supervisee by the supervisor. The retention period will be dependent on time of completion.

Supervision Log & Monitoring/ Audit process

A supervision log should be utilised with every supervision session and will provide for ongoing audit and monitoring (see Appendix 3). In addition feedback on supervision should be sought and discussed 6 monthly (see Appendix 5) for detailed feedback form.

Model of Supervision

There are a number of supervision models however possibly the most influential model in UK healthcare is that of Proctor (1986). Proctors describes Three Functions Interactions Model and is summarised within the NHSGGC AHP Supervision Policy (2017). He suggested a functional supervisory model based on the following three roles:

- Normative supervision (an administrative/managerial framework that focuses on the promotion and maintenance of good standards of work and of professional accountability).
- Formative supervision (an educational framework that develops individuals to realise their potential through skills development and learning).
- Restorative supervision (a supportive framework that maintains harmonious working relationships, in addition to supporting the (sometimes) emotional nature of the job.

Learning Styles

It is important that learning styles of both supervisor and supervisee are explored in order to get the best out of the supervisory relationship. If each understands the way learning is preferred, then effort can be made to take account of this during discussion and reflection.

As part of the supervision process both the supervisor and supervisee should consider, review and discuss learning styles to facilitate development. There are a large amount of resources and theories available. One such is Honey and Mumford:

http://erinevadoppijad.weebly.com/uploads/1/9/8/8/19882419/learning-styles-questionnaire-honeyand-mumford11.doc

Reflective practice

Becoming and being a reflective practitioner is embedded into the Royal College of Occupational Therapist's code of ethics and professional conduct, professional standards and career development framework.' *The ability to analyse your practice and reflect on what went well and what could be improved is a crucial element of being an occupational therapist and is essential for CPD*.' (RCOT Development Officer, 2019).

Reflection is a core aspect of supervision. There a range of reflective models that can be utilised during supervision and the supervisor and supervise should take time to discuss the most suitable models for the supervisees learning style. Supervisees should regularly complete reflections as part of the supervision process.

Some examples include Gibbs Reflective Style (1988) which describes 6 distinctive stages: description, feelings, evaluation, analysis, conclusion and action plan.
Schon Model (1991) describes reflection in action which is the experience itself. Thinking about it whilst it is happening; deciding how to act and acting immediately; reflection on action which is reflecting after something has happened; thinking about what might be done differently and using new information gained to the inform the reflector's experience to process feelings and actions.
Rolfe's Framework (2001) is based on the what, so what and now what. There are 3 levels with deeper reflection at each level.

Alternative Supervisory Arrangements

In some circumstances it may be necessary to make alternative supervision arrangements. If a supervisor is absent for 2 consecutive supervision sessions of the supervisee, then the Lead Occupational Therapist/Care Group Lead will identify temporary alternative arrangements. This may include providing an alternative 1:1 supervisor, group supervision, review of clinical reports or a combination of these approaches.

In the case where a supervisor is leaving post and will not be immediately replaced then the Lead Occupational Therapist should make alternative arrangements for the supervision of the staff member.

Conflict Resolution

Rarely and unfortunately there can be disharmony or conflict in the supervisory relationship. There is literature describing the range of causes for this which include; incompatible goals, differences in learning styles, role ambiguity/role conflict and personality. The literature reports that an effective supervision contract which clarifies the supervisory relationship, identifies goals, describes supervision methods, reviews clinical issues and includes provision for re-negotiating the contract or resolving supervision disagreement may be useful.

If there is disharmony or conflict in the supervisory relationship it is expected and encouraged that where possible the issues are raised in supervision where both parties have the opportunity to communicate with each other and try to resolve the issues collaboratively. This would be considered to be a win-win situation.

Steps to follow for conflict resolution:

- Identify the problem and any unmet needs
- Arrange to discuss the problem and needs
- Describe the problem and needs from each person's perspective
- Consider the other persons point of view
- Negotiate a solution
- Follow up the solution (Adler & Towne 1996)

If and when efforts have been made to try to resolve issues and matters remain unresolved then this should be raised with the Lead Occupational Therapist/ Care Group Occupational Therapist depending on the band of staff involved. The Lead Occupational Therapist/ Care Group Lead will meet with the staff members separately and where indicated and acceptable to all parties will arrange a 3 way meeting to try to resolve the issues.

There can be a number of outcomes to these discussions including 3 way supervision for a period of time to assist the resumption of a more positive supervisory relationship, temporary change in supervisor with an agreed time scale, permanent change as a last resort.
A final option may be the use of the NHS GGC Mediation Framework utilising an impartial 3rd party. It should be noted that this is a confidential service and there is no formal feedback to the referrer.

References

Adler R & Towne N (1996) Looking Out Looking In, Interpersonal Communication (Harcourt Brace & Co).
Gibbs (1988) Learning by Doing: A Guide to Teaching and Learning Methods: London, Further Education Unit
Girling A. (2008). Professional Reflective Learning Framework for Practice. East Cambridge and Fenland Primary Care Trust
HCPC Standards of conduct performance and ethics (2016)
HCPC Standards of continuing professional development (2012)
NHS Greater Glasgow & Clyde AHP Supervision Policy (2017)
NHS GGC Mediation Policy
Proctor (1986) Functions of Supervision
Rolfe et al (2001) Framework on Reflective Practice
Royal College of Occupational Therapists Supervision Guidance for Occupational Therapists and their Managers (2016)
Schon (1991) The Reflective Practitioner, Aldershot, Ashgate Publishing Ltd

Appendix 1

Mental Health Occupational Therapy Services Supervision Agreement

"The supervisory relationship is based on trust and respect and is a supportive one formed between equals — irrespective of job title, role or band. This should enable the supervisor to facilitate and 'challenge' the supervisee to explore, and consider, alternative perspectives."

The supervisor will be a staff member of a more senior grade and will be allocated by the Lead Occupational Therapist.

Supervisee	Band	Supervisor	Start date	Review date

Supervisee Learning Style:	Supervisor Learning Style:

Agreed frequency of supervision (minimum 6 weekly):
1. Supervision will take place on a 4-6 weekly basis, minimally, for approx. 90 minutes or more frequently as mutually agreed.
2. Time for supervision will be protected with privacy respected and interruptions avoided.
3. Times and dates of supervision sessions will be documented in a Supervision Log and available for audit on request.
4. Supervision Record document will be completed at every session, signed and a copy retained by both parties.
5. In the instance of disagreement conflict resolution should be sought through the Lead Occupational Therapist in the first instance, including request for supervisory changes.
6. If either party fails to attend two consecutive sessions, without this being re-scheduled, this should be highlighted to the Lead Occupational Therapist/Care Group Lead Occupational Therapist.
7. The supervisee may refer to the operational manager or Care Group Lead if they have concerns regarding the supervisor's competency.
Supervision Recording
8. It is the responsibility of the supervisor to complete the Supervision Record.
9. The record should include key topics discussed, with any outcomes or decisions taken, identifying who is responsible for any future action.
10. The record, when complete, should be agreed by both parties and a copy may be held by each person.
11. Supervision records need to be kept confidential, with the proviso that if access is needed for the purpose of public interest, this should be enabled.
12. Decisions made in a supervision meeting concerning the care provided to a service user can be seen as part of the care process. Such decisions need to be recorded in the care records.
13. Identifiable service user information should not be recorded within supervision records. If cases are discussed, these need to be anonymised in any supervision record.

	Supervision Responsibilities
14.	The supervisor is responsible for the completion of the Supervision Record. Both parties will contribute to the completion and agree content.
15.	The supervisee will make effective use of supervision sessions, acting on the outcomes of supervision timeously.
16.	The supervisee be willing to learn and develop clinical skills and be challenged on practice.
17.	The supervisor will have adequate skills for the task of providing supervision.
18.	The supervisor will offer advice, support and challenge to enable in-depth reflection of practice, and to deal with difficult issues directly.
19.	The supervisor will report the supervisee if they repeatedly fail to attend supervision sessions to operational and /or professional manager.
20.	Both parties will prepare for supervision e.g. by having an agenda, or preparing notes.
21.	Both parties will keep all information confidential except where unsafe, illegal or unethical practices are discussed.

We confirm we have read and agree to abide by the HCPC and our individual professions Code of Conduct/Ethics;

Supervisee signature:	**Date:**

Supervisor signature:	**Date:**

Appendix 2

Mental Health Occupational Therapy Services Supervision Record

The purpose of supervision is to:

- Promote wellbeing.
- Develop knowledge, skills and values.
- Support personal and professional development.
- Promote competent practice, safe and effective person centred practice.

Supervisee	Band	Supervisor	Date	Format	Length of session

Before attending your supervision session it is helpful for you to consider the following questions:	Notes:
How have things been since the last session, think of something that has been successful and you are proud of?	
What should be the focus of today?	
What would be a good outcome from the session?	

Progress and review of previous action points	Session agenda items

Area of discussion	Summary of Discussion/ Learning Points	Decisions/ Actions	Lead	Timescale
<u>Clinical Practice (use of EMIS)</u> Include; Caseload/workload numbers Detailed analysis/reflection of minimum 2 cases (case presentation/complex case review where applicable) Review of clinical records Facilitation of groups/group development (where applicable) Clinical specialist role				
<u>Personal/Professional Development</u> Include; • Training attended/completed (include mandatory training) • TURAS/CPD objectives • Application to practice and service development				
<u>Leadership/Governance</u> Include; Staff relationships/ team dynamics Supervisory responsibilities Service improvement/development				

Area of discussion	Summary of Discussion/ Learning Points	Decisions/ Actions	Lead	Timescale
<u>Operational/Managerial</u> Include; Service developments/changes Application of policies Staff governance/HR duties Audit/quality improvement Financial management				
<u>Wellbeing</u> Include; Job satisfaction Time/work management Rewards and challenges Support mechanisms				
Review & Evaluate session Consider; What worked well about the session? What could have made the session better? What might we still have to look at in the next session?				
Other points				
Signed Supervisor:	**Date**			
Signed Supervisee:	**Date**			

Appendix 3

Mental Health Occupational Therapy Services Supervision Log

Supervisee	Supervisor	Date Agreement signed	Date Agreement reviewed

Date Planned	Date Completed	Format*	Cancelled by whom and reason	Date Planned	Date Completed	Format*	Cancelled by whom and reason

*Format: 1:1 in person; video call; telephone; group

Appendix 4

Mental Health Occupational Therapy Services Reflective Template

"The ability to analyse your practice and reflect on what went well and what could be improved is a crucial element of being an occupational therapist and is essential for CPD."

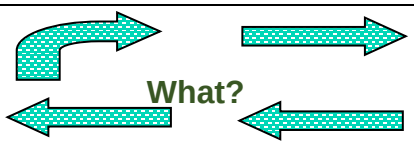
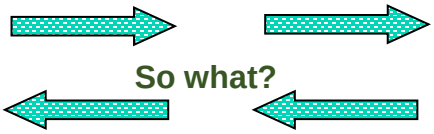
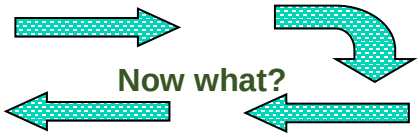
Dr Stephanie Tempest, RCOT Professional Development Manager

This simple template adapts the 'What? So what? Now what?' model of reflection (Rolfe et al, 2001) to give you the opportunity to take just five minutes to capture learning for your portfolio and to consider what support you might need. These reflections can be referred back to in supervision now and in the future.

Reflection by:	**Date:**

What?
What incident or activity prompted you to reflect?
So what?
Why was it important to you?
Now what?
What will this mean for your professional development?

Then what?
What additional support do you need now or might you need in the future?

Rolfe et al Framework on Reflective practice (2001)		
Descriptive level of reflection	**Theory & knowledge building level of reflection**	**Action-orientated level of reflection**
		
…is the • problem/ diffculty • reason for being stuck • reason for feeling bad • reason we don't get on, etc.? …was my role in the situation? …was I trying to achieve? …actions did I take? …was the response of others? …were the consequences: • for my patient • for myself • for others? …feelings did it invoke • in the patients • in myself • in others? …was good/bad • about the experience?	…does this tell me/teach me/imply/mean about: • me • my patient • others • our relationship • my patient's care • the model of care I am using • my attitudes • etc., etc.? …was going though my mind as I acted? …did I base my actions on? …other knowledge can I bring to the situation? …could/should I have done to make it better? …is my new understanding of the situation? …broader issues arise from the situation?	…do I need to do in order to: • make things better • stop being stuck • improve my patient's care • resolve the situation • feel better • get on better • etc., etc.? …broader issues need to be considered if this action is to be successful …might be the consequences of this action?

Questions to consider:	
• What did I learn? • How did I acquire my learning? • How have I applied my learning practice? • What did not go so well or was not so good?	• How do I feel about what happened? • What do the others feel? • What have I learnt from the experience? • What do I need to do next? • (Aslop 1995; Cross 1997)

Appendix 5

Mental Health Occupational Therapy Services Supervision Feedback Form

"Without feedback, good practice is not reinforced, poor performance is not corrected, and the path to improvement not identified." BMJ, 2008

Supervisee	Band	Supervisor	Feedback date

Supervision Arrangements			
Frequency of supervision sessions	4 weekly ☐	6 weekly ☐	Less Frequent ☐
Do you have an agreed supervision contact?		Yes ☐	No ☐
Are your supervision goals and objectives being met?		All of the time ☐	
		Most of the time ☐	
		Sometimes ☐	
		Never ☐	
How can supervision be improved to meet your objectives?			
Supervision Recording			
Are your supervision sessions documented and signed?		All of the time ☐	
		Most of the time ☐	
		Sometimes ☐	
		Never ☐	
Clinical Practice & Skills: have your supervision sessions enabled you to:			
Effectively reflect on your clinical practice:		All of the time ☐	
		Most of the time ☐	
		Sometimes ☐	
		Never ☐	
Explore alternative ways of working with service users:		All of the time ☐	
		Most of the time ☐	
		Sometimes ☐	
		Never ☐	
Explore dynamics/boundaries with service users:		All of the time ☐	
		Most of the time ☐	
		Sometimes ☐	
		Never ☐	
Discuss clinical reasoning skills:		All of the time ☐	
		Most of the time ☐	
		Sometimes ☐	
		Never ☐	

Professional/personal development: has supervision enabled you to:	
Receive constructive feedback:	All of the time ☐
	Most of the time ☐
	Sometimes ☐
	Never ☐
Feel validated & supported:	All of the time ☐
	Most of the time ☐
	Sometimes ☐
	Never ☐
Discuss personal and professional development:	All of the time ☐
	Most of the time ☐
	Sometimes ☐
	Never ☐
Discuss opportunities for learning:	All of the time ☐
	Most of the time ☐
	Sometimes ☐
	Never ☐

What are the most beneficial aspects of your supervision?
What aspects require improvement?
List 3 priority action points to improve supervision; • • •

Supervisee signature:	**Date:**

Supervisor signature:	**Date:**

Appendix 6

Mental Health Occupational Therapy Services Case Presentation Guidelines

The general purpose of a case study is to:
→ describe an individual patient/situation (case), in detail;
→ identify the key issues of the case;
→ analyse the case using relevant theoretical Occupational Therapy models/concepts;
→ recommend a course of action for that particular case

Present a synopsis of the case in a logical manner, demonstrating your ability to synthesise and relay clinical findings in a systematic and professional manner. Your presentation should also illustrate comprehensive and rigorous clinical reasoning skills.

Occupational Profile	Age, gender, early life, social network/ structures, relationships, family composition, education, work and leisure pursuits, housing.
Diagnosis/History	Diagnosis, mental Health, substance use, medical history, forensic and any significant trauma, risk factors.
Presenting problems and functional implications	Impact on Occupational performance.
Occupational Therapy Process	Assessment, clinical reasoning, treatment planning, activity analysis, outcome measures. Consider theory and frames of reference. Interaction style
MDT	Other disciplines involved and how their intervention relates to your role.

Example discussion points:
• Current clinical concerns (anything that you are unsure of about the case of anything you would like help with). • Do other professionals relate to the patient in the same way as you? • Discuss challenges and rewards in working with this patient. • Treatment decisions you are not sure about. • Boundary management. • Termination of treatment.