

# Clinical Supervision Fidelity Scale (CSFS)

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## Introduction:

Programmatic fidelity refers to the degree to which a program follows a program model. A program model delineates the critical ingredients thought to relate to the model's effectiveness. The challenge of fidelity is to identify, and objectively measure, the critical ingredients of the model as reliably as possible. Programmatic fidelity ratings, even when rudimentary, can serve as a check on whether an intervention (independent variable) was implemented as intended. This can allow staff and administrators to better understand if a program's success or failure is related to a successful or failed implementation.

The fidelity scale below is based on extant research on effective clinical supervision. We used Derik Milne's definition of clinical supervision (below) (Milne, 2007) to inform the scales development.

*"Clinical supervision is the formal provision, by approved supervisors, of a relationship based educational and training that is work focused and which manages, supports, develops and evaluates the work of colleague/s. The main methods that supervisors use are corrective feedback on the supervisee's performance, teaching and collaborative goal setting. It therefore differs from related activities, such as mentoring and coaching by incorporating an evaluative component. Clinical Supervision's objectives are "normative" (e.g. quality control), "restorative" (e.g. encouraging emotional processing) and "formative"(e.g. maintaining and facilitating supervisees' competence and general effectiveness.)"*

## Directions

The CSFS is designed to rate clinical supervision programs or sessions using archival supervisory minutes or, lacking minutes, interviews with supervisees. To use the scale, score a clinical supervision program or individual sessions by scoring each of the 12 fidelity items according to the weighted anchors to their right. The item scores and total score can be recorded on the score sheet provided. Scores can then serve as baseline measures for future reviews and to check for improvements or slippage. The scores are meant as feedback about the clinical supervision being offered in a given agency and are not meant as "grades". Higher scores are thought to increase the chances that the supervisory efforts will produce positive results for staff and clients.

<b>Clinical Supervision Fidelity Scale (CSFS) V1</b>					
<b>Item Numbers</b>	<b>1 = No Implementation</b>	<b>2=Low implementation</b>	<b>3= Moderate Implementation</b>	<b>4= High implementation</b>	<b>5= Full implementation</b>
<b>1. Formal:</b> A written policy on clinical supervision of the practice exists and is adhered to.	There is no written policy		There is a policy referring to CS but it is not adhered to.		There is a written policy and it is being followed.
<b>Rationale:</b> There are well over 200 models of clinical supervision (CS) and many people have their own interpretation of what CS is, including mentoring, coaching, in-services trainings, case conferences, etc. None of these activities sufficiently address the range of components associated with effective CS. A written policy can help sanction CS and to help prevent drift of a CS program away from the elements that make it effective.					
<b>Scoring:</b> When scoring a single CS session score the session on whether the session followed a written policy.					
<b>2. Structured:</b> A predetermined CS structure was used. 1. An agenda is used 2. There is a formative focus (improving clinical skills) 3. There is a restorative focus. Including celebrating successes. 4. There is a focus on group process 5. There is a normative focus on adherence to the model being used i.e. non-judgmental, used first person language as well as ethical practice issues such as confidentiality.	Based on the minutes, the CS groups completed an average of one of the five steps of the CSI structure in the 6 months prior to the evaluation.	Based on the minutes CS session completed an average of two of the five steps of the CSI structure in the 6 months prior to the evaluation.	Based on the minutes CS session completed an average of three of the five steps of the CSI structure in the 6 months prior to the evaluation.	Based on the minutes CS session completed an average of four of the five steps of the CSI structure in the 6 months prior to the evaluation.	Based on the minutes CS session an average of completed five of the five steps of the CSI structure in the 6 months prior to the evaluation.
<b>Rationale:</b> Supervision structure helps build uniformity into CS sessions and develops trust and psychological safety by allowing staff to know what to expect and how to prepare.					
<b>Scoring:</b> When scoring an individual CS session, determine the number of components used in the session, based on the minutes, and use the weights above. If minutes are unavailable interviews of supervisees can be used.					
<b>3. Consistent:</b> Supervisory Meetings are held consistently as scheduled	0-20% of CS sessions in the past 6 months occurred as scheduled	21- 40% of CS sessions in the past 6 months occurred as scheduled	41-60% of CS sessions in the past 6 months occurred as scheduled	61-80% of CS sessions in the past 6 months occurred as scheduled	81-100% of CS sessions in the past 6 months occurred as scheduled
<b>Rationale:</b> CS is unlikely to be successful in achieving desired outcomes for organizations, staff and clients if CS sessions are not held consistently.					
<b>Scoring:</b> When scoring a single supervisory session, if the session occurred the score is a 5. If it did not occur the score is a 1. If records are unavailable interviews of supervisees can be used. Duration can be reduced to 1 week or 1 month etc.					
<b>4. Attendance:</b> Staff attend supervision regularly	0-20% of staff attended supervision in the 6 months prior to the evaluation	21- 40% of staff attended supervision in the 6 months prior to the evaluation	41-60% of staff attended supervision in the 6 months prior to the evaluation	61-80% of staff attended supervision in the 6 months prior to the evaluation	81-100% of staff attended supervision in the 6 months prior to the evaluation
<b>Rationale:</b> The effectiveness of CS is directly related to individuals attending.					
<b>Scoring:</b> When scoring a single group session, use the number of CS members as the denominator and the number of attendees as the numerator, divide and multiply by 100 then compare to the weights above. When scoring a session with an individual, the scores are 1 = failed to attend and 5 attended. If records are unavailable interviews of supervisees can be used.					

<b>5. Contracted:</b> A agreement specifying the reciprocal responsibilities of both supervisee and supervisor exists	0-20% of staff agreements within the last 6 months	21- 40% of staff agreements within the last 6 months	41-60% of staff agreements which within the last 6 months	61-80% of staff agreements within the last 6 months	81-100% of staff agreements within the last 6 months
<p><b>Rationale:</b> CS is not a passive process. Supervisees need to agree to attend, be prepared with case information and engage in CS in good faith if the process is to be successful. Supervisors need to agree to maintain confidentiality (see an example contract for exceptions), attend on time, be prepared and work in good faith on the three CS functions, noted below, to improve services within the institution. See example contract (Appendix #2).</p> <p><b>Scoring:</b> If scoring a group CS session the % of staff with agreements is used for the score based on the weights above. For and individual supervision session no agreement =1 and if there is a current agreement =5.</p>					
<b>6. Evaluative:</b> Staff focus on improving their clinical practice (described in the agreement) are evaluated through an observation of practice (audit and feedback)	0-20% of supervisees within the last 6 month have had their practice formally evaluated with audit and feedback	21- 40% of supervisees within the last 6 months have had their practice formally evaluated with audit and feedback	41-60% of supervisees within the last 6 months have had their practice formally evaluated with audit and feedback	61-80% of supervisees within the last 6 months have had their practice formally evaluated with audit and feedback	81-100% of supervisees within the last 6 months have had their practice formally evaluated with audit and feedback
<p><b>Rationale:</b> Clinical supervision differs from coaching and mentoring by being evaluative. Evaluation is required to help shape more effective interventions. The use of audit and feedback has demonstrated effectiveness in improving clinical skills. See best practices in audit and feedback (Appendix 1). Audit and feedback involves the observation and rating of a clinical practice and the provision of feedback intended to improve adherence of the practice to an objective standard.</p> <p><b>Scoring:</b> This item is measured over 6 months intervals because it is not expected that clinical practice will be measured for each session. If measuring specific sessions an evaluation of outcomes in the last six months would be scored a 5.</p>					
<b>7. Documented:</b> CS activities are documented and these files are available to supervisees	0-20% of CS sessions were documented and stored according to policy	21- 40% of CS sessions were documented and stored according to policy	41-60% of CS sessions were documented and stored according to policy	61-80% of CS sessions were documented and stored according to policy	81-100% of CS sessions were documented and stored according to policy
<p><b>Rationale:</b> Determining the fidelity of an intervention requires that data about the intervention be collected and available. Documentation also assists with continuity of CS over time.</p> <p><b>Scoring:</b> When scoring individual CS sessions if documentation is completed and submitted (stored) according to policy this is scored a 5. If CS is not documented or documented but not available it is scored as a 1.</p>					
<b>8. Professional:</b> Supervisors are trained to provide intervention specific supervision. If not intervention specific CS training exists rate training to clinically supervise	0-20% of Clinical supervisors were formally trained in providing intervention specific CS	21- 40% of Clinical supervisors were formally trained in providing intervention specific CS	41-60% of Clinical supervisors were formally trained in providing intervention specific CS	61-80% of Clinical supervisors were formally trained in providing intervention specific CS	81-100% of Clinical supervisors were formally trained in providing intervention specific CS
<p><b>Rationale:</b> Clinical supervision involves numerous competencies which require training and practice. Different models of supervision, while often similar in process and content to other models, need specific instruction and oversight to maintain fidelity.</p> <p><b>Scoring:</b> When scoring an individual session of CS the presence of a trained supervisor is scored a 5. An untrained supervisor is scored a 1.</p>					

<b>9. Supported:</b> Clinical supervisors participate in their own supervision to get support, build competencies and maintain fidelity to the model of supervision being used.	0-20% of Clinical supervisors attended their own supervision within the past 6 months	21- 40% of Clinical supervisors attended their own supervision within the past 6 months	41-60% of Clinical supervisors attended their own supervision within the past 6 months	61-80% of Clinical supervisors attended their own supervision within the past 6 months	81-100% of Clinical supervisors attended their own supervision within the past 6 months
<b>Rationale:</b> Social learning theory suggests that ongoing direct feedback on the accomplishment of learning goals can dramatically increase the success of learning initiatives.					
<b>Scoring:</b> When scoring a single individual or group supervision session the percentage attendance of the supervisor over the past 6 months is scored based on the weights above.					
<b>10. Restorative Function:</b> CS is intended to build reflective practice and to support staff	Based on the CS minutes 0-20% of CS sessions addressed the Restorative domain in the past 6 months	Based on the CS minutes 21- 40% of CS sessions addressed the Restorative domain in the past 6 months	Based on the CS minutes 41-60% of CS sessions addressed the Restorative domain in the past 6 months	Based on the CS minutes 61-80% of CS sessions addressed the Restorative domain in the past 6 months	81-100% of CS sessions addressed the Restorative domain in the past 6 months
<b>Rationale:</b> The evidence for the effectiveness of CS suggests that staff that reflect on their own practice including a focus on their own and collegial self care achieve a host of positive benefits.					
<b>Scoring:</b> When scoring a single individual or group supervision session if the Restorative dimensions was addressed the score is a 5 if not it is a 1. It is not expected that every group would address every function of CS.					
<b>11. Formative Function:</b> CS is intended to build competencies and increase staff knowledge of effective interventions	Based on the CS minutes 0-20% of CS sessions addressed the Formative domain in the past 6 months	Based on the CS minutes 21- 40% of CS sessions addressed the Formative domain in the past 6 months	Based on the CS minutes 41-60% of CS sessions addressed the Formative domain in the past 6 months	Based on the CS minutes 61-80% of CS sessions addressed the Formative domain in the past 6 months	Based on the CS minutes 81-100% of CS sessions addressed the Formative domain in the past 6 months
<b>Rationale:</b> Evidence suggests that clinical skills require practice and discriminative feedback in order to improve. Trainings alone are not an effective way to improve clinical skills.					
<b>Scoring:</b> When scoring a single individual or group supervision session, if the Formative dimension was addressed the score is a 5 if not it is a 1. It is not expected that every group would address every function of CS.					
<b>12. Normative Function:</b> CS is intended to maintain clinical and ethical accountability as well as accountability to the treatment philosophy including being non-judgmental and using first person language.	Based on the CS minutes 0-20% of CS sessions addressed the Normative domain in the past 6 months	Based on the CS minutes 21- 40% of CS sessions addressed the Normative domain in the past 6 months	Based on the CS minutes 41-60% of CS sessions addressed the Normative domain in the past 6 months	Based on the CS minutes 61-80% of CS sessions addressed the Normative domain in the past 6 months	Based on the CS minutes 81-100% of CS sessions addressed the Normative domain in the past 6 months
<b>Rationale:</b> CS involves an element of accountability. While this does not excuse CS becoming “snoopervision”, a failure to hold staff accountable to organizational and professional norms can lead to counterproductive, unethical and unprofessional conduct.					
<b>Scoring:</b> When scoring a single individual or group supervision session, if the Normative dimensions was addressed the score is a 5 if not it is a 1. It is not expected that every group would address every function of CS.					

Clinical Supervision Fidelity Scale (CSFS) Score Sheet		
Fidelity Items	Score (1-5)	Comments and Recommendations
<b>1. Formal:</b> A written policy on clinical supervision exists and is adhered to.		
<b>2. Structured:</b> A predetermined structure, including required components of the CS was used. 1. Review last meetings minutes 2. Seek new focus for current CS session 3. Address issues based on one of the 3 major functions of supervision 4. Address group process issues 5. Record Minutes		
<b>2. Consistent:</b> Supervisory Meetings are held consistently		
<b>3. Attended:</b> Staff attend supervision regularly		
<b>5. Contracted:</b> A formal signed contract specifying the reciprocal responsibilities of both supervisee and supervisor exists		
<b>6. Evaluated:</b> The clinical goals of the staff are formally evaluated with audit and feedback		
<b>7. Documented:</b> CS activities are documented and these documents are accessible		
<b>8. Professional:</b> Supervisors were trained to provide supervision		
<b>9. Supported:</b> Clinical supervisors participate in their own supervision to get support, build competencies and maintain fidelity to the model of supervision being used.		
<b>10. Restorative:</b> CS involves the support of staff emotional processing and reflective practice		
<b>11. Formative:</b> CS involves the development and refinement of specific competencies		
<b>12. Normative:</b> CS maintains clinical and ethical accountability		

## Appendix 1

## Best Practices in Audit and Feedback, from:

Ivers, N. M., Sales, A., Colquhoun, H., Michie, S., Foy, R., Francis, J. J., & Grimshaw, J. M. (2014). No more 'business as usual' with audit and feedback interventions: towards an agenda for a reinvigorated intervention. *Implement Sci*, 9(1), 14.

<b>Best practices when designing Audit and Feedback interventions</b>	
Audit components	<ol style="list-style-type: none"> <li>1. Audit data is valid</li> <li>2. Audit data based on recent performance</li> <li>3. Audit data are about individuals own behavior</li> <li>4. Audit cycles are repeated with new data presented over time</li> </ol>
Feedback Components	<ol style="list-style-type: none"> <li>1. Presentation is multimodal including either text and talking or text and graphical material</li> <li>2. Delivery comes from a trusted source</li> <li>3. Feedback includes comparison data with relevant others (norms)</li> </ol>
Nature of behavioral change required	<ol style="list-style-type: none"> <li>1. Target behavior is likely to be amenable to feedback</li> <li>2. Recipients are capable or responsible for improvement</li> </ol>
Target Goals and Action Plan	<ol style="list-style-type: none"> <li>1. Target performance goal is provided</li> <li>2. Goals set for the target behavior are aligned with personal and organizational priorities</li> <li>3. Goals for the target behavior are specific, measurable, achievable, relevant, time bound.</li> <li>4. A clear action plan is provided when discrepancies are evident</li> </ol>

CLINICAL SUPERVISION AGREEMENT

This agreement is intended to define the responsibilities of the supervisor and the supervisee participating in clinical supervision (CS).

**Collaboratively we agree to:**

- Work together on agreed upon supervision goals
- Protect agreed upon appointment times
- Work honestly and respectfully to encourage feedback and challenge reflective skills and practice issues

**As the supervisee, I agree to:**

- Be prepared for supervisory sessions
- Make effective use of the time available
- Be open to receiving supervision and support

**As the supervisor, I agree to:**

- Keep information shared in sessions confidential unless behavior is unsafe, unethical or illegal
- Redirect issues to a clinical focus
- Offer support in order to encourage reflection
- Document and evaluate supervision efforts
- Utilize my own supervision to be an effective supervisor

**Mutually agreed upon goal(s) for clinical supervision**

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**Mutually agreed upon strategies for achieving clinical goals**

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**Logistics:**

Frequency and duration of meetings: \_\_\_\_\_

Duration of collaborative supervision relationship: \_\_\_\_\_

Next Agreement Review Date: \_\_\_\_\_

\_\_\_\_\_  
Signed Staff

\_\_\_\_\_  
Signed Supervisor