

Clinical Supervision Records Checklist

If you are providing or receiving clinical supervision, consider reviewing your clinical supervision record-keeping practices with this checklist. The items in the checklist come from [Professional Practice Standards](#) 4.1 and 4.2 on providing and receiving clinical supervision.

How to use this checklist

Locate the documentation that relates to the supervision you are providing or receiving and have it open in front of you:

- If you are a clinical supervisor, locate the documentation that relates to the supervision of one to three supervisees.
- If you are a supervisee, locate the documentation that applies to the supervision that you receive.

Working through each item in the list, review your documentation to determine whether it aligns with the relevant standards. If you arrive at an item/indicator that seems to be missing from your documentation, it's possible the standard is not being met. In limited circumstances, an item/indicator may not apply.

Other tips

- Use the comments section to keep track of any insights, learning needs, and potential changes to your practices.
- Review at least three records to see if a pattern emerges.
- Take care to maintain confidentiality throughout your review process.

Clinical Supervision Records Checklist

Record Identifier: <i>(e.g. name, initials or reference number)</i>	Summary:
Date Reviewed:	
Reviewer name or initials:	

Met?	Indicator	Comments
PART 1		
The supervisory agreement:		
Purpose and Nature of the Relationship		
	Summarizes the plan, goals or intent of the supervision.	
	Describes the client population relevant to the supervision (e.g. individual, couple, family, group, child, adolescent).	
	Describes the modalities relevant to the clinical supervision (e.g. psychodynamic, CBT, systemic).	
	Identifies the responsibility the supervisor will assume for the well-being of the client.	
Methods and Frequency of the Supervision		
	Identifies supervision ratio and/or format. Note: Use comments to indicate whether the supervisor to supervisee ratio is: <ul style="list-style-type: none"> • 1:1, 1:2 or other, e.g. group of 8 supervisees to 1 supervisor • Peer supervision • Peer group supervision 	

	Identifies supervision methods (e.g. supervisee self-report, supervisor access to clinical records, review of video recordings, observation of sessions, etc.)	
	Identifies duration of supervisory sessions.	
	Identifies frequency of supervisory sessions.	
	Identifies the location and/or mode of the supervision (e.g. in-person, webinar, telephone)	
	Describes the evaluation / formative feedback process.	
	Summarizes arrangements for remuneration. Note: If no remuneration, score as NA.	
	Identifies process for renewing or terminating the agreement.	
Confidentiality		
	Describes the amount and type of information shared between supervisor and supervisee(s).	

	If applicable, addresses how client information will be confidentially transmitted between supervisor and supervisee.	
	Documents both parties' expectations for obtaining client informed consent.	
Conflict Resolution		
	Outlines a process for resolving conflicts or disputes.	
PART 2		
Records regarding clinical supervision include:		
	Name of the supervisor and/or supervisee(s).	
	Date(s) of the supervision session(s).	
	Duration of the session(s).	
	Fees paid, if applicable.	
	Summary of issues discussed during the consultation/supervision sessions.	
	Summary of the supervisee's learning needs	

	Summary of the learning plan to address identified deficit(s), if applicable. Note: This applies if there are noted gaps in the supervisee's practice and/or competence.	
	Directions or feedback given to the supervisee.	
	Documentation of incidents or professional observations that would call into question the supervisee's ability to practise psychotherapy safely and professionally.	