Clinical supervision (CS) can be an invaluable source of support for nurses, but is sometimes viewed as a punitive system. Part 2 in our six-part series on nursing theories provides an overview of CS and its benefits.

**What is clinical supervision?**

CS is defined as “a regular and formal agreement to engage in a professional working relationship, facilitated by [a] supervisor to support [a] supervisee to reflect on practice, with the aim of developing quality care, accountability, personal competence and learning” (Cassedy, 2010) (Box 1). This usually means meeting with a colleague for an hour once a month, as part of your professional role, to discuss a practice issue and consider its implications for your personal and professional development. Group supervision may assist team building, understanding the roles of others, learning from case studies and debriefing serious clinical incidents.

This reflective conversation helps you to question: your own or accepted practice; how you understand and use management processes, structures and roles; your learning needs in relation to competence and confidence in practice; and how you understand your own and other people’s thoughts, feelings and behaviours.

**Where does it come from?**

CS was introduced as a means of staff support and practice development, often using Proctor’s model as a structure for professional reflection (White and Winstanley, 2014). This requires supervisees to reflect on the normative (practice standards and managerial processes), formative (learning needs) and restorative (emotional) aspects of their experiences, and is a useful tool to ensure different perspectives of an issue are considered. CS aims to address professional practice issues and development, so sessions must have a purpose, however the agenda is set by the supervisee.

Within nursing, our humanistic, person-centred philosophy (see part 1) is reflected in CS, where a non-directive approach is used to facilitate change. This starts with a specific experience, but generalises into the ability to reflect on practice and develop a stronger sense of autonomy and accountability.

**What does this mean for nurses?**

The person-centred approach allows you to practise being the nurse you become and decide how you want to develop. Identifying your own course of development and practice knowledge, encouraging engagement with organisational structures and processes, and supporting emotional resilience. You benefit through re-engaging with the aspects of your role that you enjoy, while developing strategies for managing, improving or reducing barriers to role satisfaction. The organisation and its service users benefit from your focus on practice improvement, personal development and energy to engage with them and colleagues. You can also develop a more strategic view that will promote effective communication with line managers and other branches of the organisation to enhance service delivery.

Preparation is needed to identify relevant experiences to explore in supervision, which should consider the implications of the experience, your learning and support needs, practice development and organisational change. Ethico-legal aspects of CS, such as confidentiality and record-keeping, professional accountability and escalating concerns are important (Nursing and Midwifery Council, 2015), but should not paralyse your ability to share your experiences. If you have serious concerns about your own practice, or that of your colleagues, access support mechanisms such as your professional body or trade union for help with escalating concerns.

**Conclusion**

CS is not a quick fix for organisations. The potential for enhanced personal and professional wellbeing, development of practice and engagement with quality improvement processes should outweigh time costs in the long-term.

**References**