



Clinical (Reflective) Supervision for Nurses and Midwives

The term “clinical (reflective) supervision”, as a form of supported reflective practice, is often misunderstood and poorly defined. Nurses and midwives use a range of supervision types in their professional practice. As such, the term supervision in clinical practice is often interpreted and applied in different ways.

For the purpose of this position statement, clinical (reflective) supervision is defined as:

“a formally structured professional arrangement between a supervisor and one or more supervisees. It is a purposely constructed regular meeting that provides for critical reflection on the work issues brought to that space by the supervisee(s). It is a confidential relationship within the ethical and legal parameters of practice. Clinical supervision facilitates development of reflective practice and the professional skills of the supervisee(s) through increased awareness and understanding of the complex human and ethical issues within their workplace.”¹

Psychology, psychiatry, social work, counselling and mental health nursing have an extensive history of utilising clinical (reflective) supervision for professional practice.

For clarification clinical (reflective) supervision differs from other forms of supervision such as line management, clinical teaching, preceptorship, mentoring/coaching and performance development.²

Clinical (reflective) supervision is one form of reflective practice and aims to support nurses and midwives to develop knowledge, skills and competence across clinical, professional, interpersonal, and relational domains that enhance the delivery of safe and effective care to health care consumers. Participation in clinical (reflective) supervision is voluntary and not compulsory for employment.

Reflective practice

Nationally, reflective practice is a core component of contemporary, professional nursing and midwifery practice as identified by the Nursing and Midwifery Board of Australia’s *Registered nurse standards for practice*³, *Enrolled nurse standards for practice*⁴ and *Midwife standards for practice*.⁵

Clinical (reflective) supervision utilises the relationship between the supervisor and supervisee to facilitate enhanced reflective practice processes. This should include a secure and trusting relationship between supervisor and supervisee. Dependability and regularity of supervisory sessions are essential. There must be time allowed for personal reflection and careful attention to reactions and emotions that may be induced. The supervisor must be able to listen attentively, allow space for reflection and discovery as well as provide support and guidance as needed. Thus, enabling supervisees to gain greater insight and more fully explore the impact of certain work events or situations on their practice than they may have without a supervisor.⁶ This develops not only the individual’s clinical knowledge and skills, but also their professional identity, self-awareness, resilience and emotional intelligence in the workplace. Ultimately, this will inform and contribute to the care provided and the culture of the overall work environment which assists in addressing and preventing issues such as vicarious trauma, and workplace bullying.

Clinical (reflective) supervision has been promoted as an important strategy to support all nurses and midwives, as well as a process to enhance patient care and promote ongoing professional development. Research has demonstrated clinical supervision leads to positive outcomes for nurses and midwives’ professional discipline, growth and identity; promotes quality improvement and competent best practice; contributes to a positive practice environment; and, can improve the recruitment and retention of staff.^{7 8}



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Reflective practice, which is a critical component of clinical supervision, may form part of a nurse or midwives continuing professional development, where appropriate. Continuing professional development inclusive of planning and reflection (which can be in the form of clinical supervision), is essential for nurses and midwives to keep up to date with the rapidly changing health care environment and to support professional practice.

It is the position of the Australian Nursing and Midwifery Federation that:

1. Clinical (reflective) supervision is an important component of nursing and midwifery practice. As such, regular clinical (reflective) supervision should be available to nurses and midwives during protected work time including those employed part time, or on a casual/relief basis.
2. Best practice clinical (reflective) supervision incorporates the following the elements:
 - a. A trusting alliance.
The supervisory relationship is underpinned by trust and confidentiality (within ethical and professional boundaries). Thus, clinical (reflective) supervision should not be provided by direct line managers or those responsible for management/oversight of other professional domains of practice of the supervisee/s.
 - b. A conducive environment.
Clinical (reflective) supervision requires a venue that is private, ideally away from the supervisee's work/clinical area, which reduces the possibility of the supervision being interrupted.
 - c. The supervisor.
Where possible, supervisees, are able to choose their supervisor, and if working in groups, other supervisees. Clinical (reflective) supervision should be provided by professionals who have undertaken specific supervisor education in clinical (reflective) supervision, including ongoing professional development in clinical (reflective) supervision, and engage in their own clinical (reflective) supervision;
 - d. A jointly approved agreement.
The supervisory relationship operates under an agreement established by the supervisor and supervisee/s which outlines their responsibilities, roles and expectations, clear structures on length and frequency of meetings, boundaries, processes and goals. The agenda for clinical (reflective) supervision should be set by the supervisee.
 - e. Established and effective evaluation processes.
Regular evaluation of the trusting alliance and agreement are undertaken.^{9 10}
3. Clinical (reflective) supervision models should be implemented at every level of the nursing and midwifery profession. Training should also be made available to all involved in clinical (reflective) supervision. This includes those undertaking nursing and midwifery education programs. Access to clinical (reflective) supervision should not be restricted to the provision of direct clinical care. It should also be made available to those working in direct non-clinical relationships with clients, including management, administration, education, research, advisory, regulatory, and policy development roles. A clear implementation strategy for clinical (reflective) supervision should be developed and followed.
4. Best practice should be the goal of every health service. An organisational commitment to the professional development of nurses and midwives through support and provision of clinical (reflective) supervision demonstrates their commitment to quality of care and continuous quality improvement.



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5. Clinical (reflective) supervision should be embedded in health care organisational policies and protocols reflecting a culture that values learning, continuing quality improvement, and the health and wellbeing of employees. Such policies and protocols should include enabling structures and guidelines necessary for clinical (reflective) supervision to be implemented. This may include, but is not limited to, components of best practice clinical (reflective) supervision and how they will be provided, allowance for the productivity impacts of protected time for clinical (reflective) supervision, educational skill level (and preparedness) of supervisors, and staffing and allocation of resources.
6. Organisations demonstrate leadership in implementing clinical (reflective) supervision, whereby every level of the health care team participates in clinical (reflective) supervision. To support implementation at every level of the nursing and midwifery profession, education should be provided to ensure the purpose of clinical (reflective) supervision is understood and embedded in practice.
7. To facilitate the implementation of clinical (reflective) supervision frameworks, governments have a responsibility to set health service performance indicators that incorporate the professional development of nurses and midwives. Government support for nurses and midwives to access clinical (reflective) supervision translates to a broader public health promotion strategy with positive outcomes on continuous quality improvement of health care services, consumer access to quality care, and retention and development of the nursing and midwifery workforce.
8. Professional nursing and midwifery organisations and health care facilities need to work together to advocate for nurses and midwives to access clinical (reflective) supervision through influencing government policies and priorities.
9. Ongoing research should be undertaken to continue to examine the role of clinical (reflective) supervision in nursing and midwifery, and the impact on individuals, organisational culture, risk management, and consumers of health care.

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